Board of Directors Meeting in Public

Thursday 27 July 2023 from 13:00 – 15:30
The Rufus Centre, Steppingley Road, Flitwick, Bedford, MK45 1AH

12:15 – 13:00 Lunch
13:00 – 15:30 Trust Board in Public
15:35 – 16:05 People Participation Teatime Presentation

Agenda

Opening Matters

1	Welcome and Apologies for Absence*	Note	Eileen Taylor	13:00
2	Patient Story: Luton Walking Group	Note		
3	Declarations of Interests	Assurance	All	13:25
4	Minutes of the Previous Meeting held in Public on 25 May 2023	Approve	Eileen Taylor	
5	Action Log and Matters Arising from the Minutes	Assurance	All	
6	Matters Arising from Trust Board Meeting in Private*	Assurance	Eileen Taylor	

Strategy

7	Chair's Report	Assurance	Eileen Taylor	13:30
8	Chief Executive's Report	Assurance	Paul Calaminus	13:40
9	Integrated Care & Commissioning Committee Assurance Report	Assurance	Richard Carr	13:50
10	People Participation Committee Assurance Report	Assurance	Aamir Ahmad	13:55
11	Audit Committee Assurance Report • NHSE Self-Certification • Modern Day Slavery Statement	Assurance	Anit Chandarana	14:00

Quality & Performance

12	Quality Assurance Committee Assurance Report	Assurance	Prof Dame Donna Kinnair	14:05
13	Quality Report	Assurance	Dr Amar Shah	14:10
14	Performance Report	Assurance	Dr Amar Shah Edwin Ndlovu	14:20
15	**5 Minute Break**			14:30

People

16	Appointments & Remuneration Committee Assurance Report	Assurance	Ken Batty	14:35
17	People & Culture Committee Assurance Report	Assurance	Ken Batty	14:40
18	People Report	Assurance	Tanya Carter	14:45
19	Safer Staffing	Assurance	Lorraine Sunduza	15:00

Finance

20	Finance, Business & Investment Committee Assurance Report	Assurance	Susan Lees	15:10
21	Finance Report	Assurance	Mohit Venkataram	15:15

Closing Matters

22	Board of Directors Forward Plan	Note	Eileen Taylor	15:25
23	Any Other Urgent Business*: *previously notified to the Chair*	Note	Eileen Taylor	
24	Questions from the Public*		Eileen Taylor	
25	Dates of Next Meeting • Thursday 28 September 2023 (London) • Thursday 30 November 2023 (Luton) • Thursday 25 January 2024 (London) • Thursday 28 March 2024 (Bedford)			
26	Close			15:30

*verbal update

Eileen Taylor
Chair of the Trust

15:35 – 16:05 A People Participation teatime presentation will focus on volunteering

East London NHS Foundation Trust

Board of Directors Register of Interests: to year ending 31 May 2023

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, Place2Be • Psychotherapy Student, Regents University • Mentor at Mosaic, an LGBT+ young persons charity • Volunteer Counsellor at Naz a charity in West London
Ken Batty	Senior Independent Director	• Property Companies: • Director, 97 Langney Road Ltd • Director, Effingbat Properties Ltd • Director, Ken Batty in London Ltd • Chair of Trustees, Mosaic LGBT+ Young Persons Trust • Chair of Nominations Committee, Royal College of Emergency Medicine • Member, Queen Mary University of London (QMUL) Council (Medical faculty is Barts and the London Medical and Dental School) • Vice Chair, Inner Circle Educational Trust • Trustee of Dr Frost Learning
David Bridle	Chief Medical Officer	• Member, British Medical Association • Member, Medical Protection Society • Member, Royal College of Psychiatrists • Member, General Medical Council

Name	Job Title	Interests Declared
Paul Calaminus	Chief Executive (until 18 August 2023)	• North East London NHS Foundation Trust Chief Executive Officer (wef 21 August 2023) • 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 • Member of Central Bedfordshire Health and Wellbeing Committee • Member of BLMK Bedfordshire Care Alliance Committee • Member of North East London Integrated Care Board • Member of North East London Population Health and Integrated Care Committee • Member of North East London NED Remuneration Committee • Member of North East London Mental Health, Learning Disability & Autism Committee • Member of City and Hackney Integrated Commissioning Board • Wife is Civil Servant in Department of Health
Richard Carr	Non-Executive Director	• Director, Richard Carr Consulting Ltd, Management Consultancy • Managing Director, East Midlands Development Company • Interim Managing Director, Colchester Amphora Holdings Ltd (from 2023 March) • Chair, Independent Improvement Board that has been appointed to oversee the Cambridgeshire and Peterborough Combined Authority
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 • Chartered Fellow – Chartered Institute of Personnel Development (CIPD)
Anit Chandarana	Non-Executive Director	• Director General, Department for Transport (Network Rail secondment) • Member of the Advisory Board Panel, National Railway Museum
Peter Cornforth	Non-Executive Director	• Director, Good Way Ltd – music venue operator • Director, Field Doctor Ltd – frozen meals producer • Director, Kind Canyon Digital Ltd – music rights owner • Director, Barking Enterprise Centres CIC – business support • Director, Music Venue Properties Ltd. – community benefit • Governor, John Whitgift Foundation – care homes and schools • Trustee, The Ormiston Trust • Parent Member, National Autistic Society • Independent Investment Advisory Group – Property, Transport for London

Name	Job Title	Interests Declared
Professor Sir Sam Everington KBE	Non-Executive Director	• GP Partner in Tower Hamlets since 1989 in Bromley By Bow Health • Member of Tower Hamlets GP Care group (CIC) • General Practice, based on the same site as the Bromley by Bow Centre (Charity) • 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 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- • Member of the Royal College of GPs 1989- • Council member RCGP November 2022- • 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- • 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
Richard Fradgley	Executive Director of Integrated Care	• Social Worker registered with Social Work England • Member, North East London Integrated Care Board Mental Health Learning Disabilities and Autism Collaborative Sub-Committee • Member, North East London Integrated Care Board Community Services Collaborative Sub-Committee

Name	Job Title	Interests Declared
Samanthi Gibbens	Interim Chief Finance Officer (until 14 July 2023)	• Director of Health & Care Space Newham Ltd a joint venture between ELFT and London Borough of Newham) • Appointed and due to leave ELFT and start in July 2023 as Chief Finance & Investment Officer at Barnet, Enfield and Haringey Mental Health NHS Trust and Camden and Islington NHS Foundation Trust • Husband is a senior staff member in logistics and vaccine operations at NHS England • Brother is a senior Public Health Commissioning and Contract Manager at NHS England – East of England
Philippa Graves	Chief Digital Officer	• Board Member, Digital Strategy Board for BLMK • Board Member, Patient Held Record Board for NEL
Professor Dame Donna Kinnair DBE	Non-Executive Director	• Board Member, NHS Race and Health Observatory • Patron, Trinity College Medical Society • Trustee, Burdett Trust for Nursing • Non-Executive Director at Royal Free Hospital NHS FT • Director at DDK Consultancy Ltd (provides ad hoc training and other consultancy support; clients NHS organisations).
Susan Lees	Non-Executive Director	• Non-Executive Director, North East London Foundation Trust • Non-Executive Director Barking, Havering and Redbridge University Hospital Trust
Claire McKenna	Interim Chief Nurse (from 21 August 2023)	• None.
Edwin Ndlovu	Chief Operating Officer	• Member of UNISON • Member of Race Health Observatory Mental Health Working Group

Name	Job Title	Interests Declared
Dr Amar Shah	Chief Quality Officer	• Director, AS Healthcare Improvement Ltd (private consulting and teaching related to healthcare improvement) • National Improvement Lead for mental health and Chair of QI faculty, Royal College of Psychiatrists • Chair of the Expert Reference Group on quality at NHS Providers • Member of the Q advisory board (Health Foundation) • Council member at the Healthcare Costing for Value Institute, at the Healthcare Financial Management Association (HFMA) • Faculty member with the Institute for Healthcare Improvement (IHI), US and member of the Scientific Advisory Group at IHI • Honorary visiting professor, University of Leicester • Honorary visiting professor, City University London • Member, General Medical Council • Member, Royal College of Psychiatrists • Wife is a GP on the bank at ELFT
Lorraine Sunduza	Chief Nurse / Deputy Chief Executive – London (until 20 August 2023) Interim Chief Executive (from 21 August 2023)	• Member of NHS England London People Board including the EDI Committee • Member of Unison
Eileen Taylor	Substantive chair from 1 January 2023	• Non-Executive Director, Senior Independent Director at – MUFG Securities EMEA plc • MUFG Bank London Branch - Chair Joint Remuneration Committee and Member Audit Committee • Member of the US Democratic Party • Joint Chair, East London NHS Foundation Trust (ELFT) and North East London NHS Foundation Trust (NELFT) • Chair of the NEL Mental Health, Learning Disabilities and Autism Provider Collaborative • Chair of Mid and South Essex Collaborative

Name	Job Title	Interests Declared
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) • Director of East End Health Network Co Ltd • Member of Apna NHS • Member NEL Finance Committee • Member NEL MH and LD Collaborative • Partner at Leighton Road Surgery • Wife works as a partnership tax manager at Towers and Hamlin
Deborah Wheeler	Non-Executive Director	• Non-Executive Director at North East London NHS Foundation Trust • 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) • Design Team member for Clarity Crafts, a UK crafting company • Son is a bank employee of ELFT
Cathy Lilley	Director of Corporate Governance (Company Secretary)	• None

Board of Directors

DRAFT Minutes of the Board of Directors meeting held in public on Thursday, 25 May 2023 from 1.00pm at Toynbee Hall, 28 Commercial Street, London E1 6LS

Present:

Eileen Taylor	Trust Chair
Aamir Ahmad	Vice-Chair (London)
Ken Batty	Non-Executive Director
Dr David Bridle	Chief Medical Officer
Paul Calaminus	Chief Executive
Richard Carr	Non-Executive Director
Tanya Carter	Chief People Officer
Anit Chandarana	Non-Executive Director
Prof Sir Sam Everington	Non-Executive Director
Richard Fradgley	Executive Director of Integrated Care and Deputy CEO
Samanthi Gibbens	Interim Chief Finance Officer
Philippa Graves	Chief Digital Officer
Professor Dame Donna Kinnair	Non-Executive Director
Susan Lees	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	Vice-Chair (Bedfordshire & Luton)

In attendance:

Sophie Akehurst	Senior People Participation Lead
Vashali Ashar	Medical Director for Primary Care
Yasmin Begum	Governor
Deborah Dover	Director of Patient Safety
Derek Feeley	Board Adviser
Steve Gladwin	Communications, ELFT
Jay Harris	Communications
Sarah Khan	Interim Chief of Staff
Toitei Kurima	People Participation Lead, Primary Care
Christina Guevara	Lead ACP, Cauldwell Medical Centre
Alice Langley	Managing Director, Camden Division, Camden & Islington NHS FT
Cathy Lilley	Director of Corporate Governance
Nicki McCoy	Corporate Secretariat Manager
Linda McRoberts	Minute Taker
Beverley Morris	Governor
Day Njovana	Borough Director, Tower Hamlets
John Power	Peer Support Worker
Julie Roye	Head of Nursing, Primary Care
Joyce Tucker	Service User, Cauldwell Medical Centre
Stephanie Quitaleg	Senior Executive Assistant

In attendance online:

Gren Bingham	Governor
Alice James	Client Services Manager, MSI Group Ltd (healthcare recruitment agency)

Norbert Lieckfeldt	Corporate Governance Manager
Khtija Malik	Governor
Jamu Patel	Governor
Jermaine McKenzie	Central & North West London NHS FT
Caroline Ogunsola	Governor

Apologies:

Peter Cornforth	Non-Executive Director

The minutes are produced in the order of the agenda

1 Welcome and Apologies for Absence

1.1 Eileen Taylor welcomed everyone to the meeting of the Trust Board held in public. She particularly welcomed Sue Lees to her first Board meeting since her appointment and Deborah Wheeler on her return from two months' sabbatical, as well as Day Njovana and Alice Langley, both joining to observe.

Eileen reminded everyone that this is a meeting of the Trust Board held in public. Questions relating to agenda items can be asked at the end of the meeting if time allows and questions submitted online will be answered online after the meeting.

Eileen recognised it is:

- Mental health awareness month
- National conversation week – to focus on how conversations can counteract loneliness
- National People Participation week next week, and
- Today marks three years since the tragic murder of George Floyd and ELFT will be holding a minute's silence at 2pm in remembrance.

1.2 Apologies were noted as above

2 Patient Story: Inequalities Project with Forensic Community Service Users

2.1 Eileen welcomed John Power to the meeting and thanked him for his report on inequalities which had been circulated with the papers.

2.2 John Power introduced himself as a peer support worker in the forensics mental health system who had been an inpatient at John Howard and Wolfson House for some years and left the system about five years ago. He undertook a peer support training course and subsequently began the inequalities work, which he explained, highlighting:

- The aim was to find out about inequalities in the system of mental health, particularly for the BAME community.
- This began with just two people and grew fairly rapidly as more service users were referred.
- People were interviewed and traumatic stories were fed back, from experiences through schools, the police and mental health services, etc. This became very emotional; there was one person who preferred to tell people he was in prison rather than tell them he was in a mental health hospital.
- After group discussions, people were asked to offer each other words of healing.
- From these conversations, the idea grew of having a 'Think Tank' to solve problems where doctors are joined by patients who have been through the system and could help.

2.3 In discussion, the Board:

- Praised John for the impressive way he had handled people's trauma, suggesting this demonstrates peer support can be clinical work and part of people's healing journeys.
- Asked about the disparity of power and how this could be improved to work better together, John explained that people are wary of expressing their true feelings in case that results in their medication being increased. He suggested patients would talk to doctors more if doctors would mingle more at a 'lower level'.
- Noted that John found doctors usually distance themselves from religion but it can be a large part of someone's journey. A connection with spirituality is denied to people in hospital which is a gap, as it is a need not being met; there was an example of a patient who had absconded from hospital to go to church. Agreed improving work with people on spirituality and culture would improve working relationships. There is an opportunity for the new people participation staff to support John with the work he is doing and introductions will be made.
  ACTION: Lorraine Sunduza
- Highlighted the need for discussion at Board level about spiritual services and suggested a deep dive on this, either at Board or at Quality Assurance Committee.
  ACTION: Lorraine Sunduza
  Thanked John for his valuable presentation.

3 Declarations of Interests

3.1. There were no additional declarations in respect of agenda items.

In addition to the declarations in the Register of Interests report circulated, it was noted Lorraine Sunduza is a member of NHS London People Board.

4 Minutes of the Previous Meeting Held on 30 March 2023

4.1 The minutes of the meeting held in public on 30 March 2023 were **APPROVED** as a correct record, subject to the following amendments:

- Para 4.1: the date of the previous minutes stated 24 November in the text, this should have read 26 January 2023, as correctly stated in the heading for that item.
- Para 7.2 Chair's report – reference to the Evergreen Unit: for clarity, this will be changed to read: *The intention is to minimise sending young people out of area …* (currently reads 'There is no longer a need to send young people out of area').
- Para 11.1 People Participation Committee Assurance report – reference to Newham Recovery College: for clarity, this will be changed to read: *The development of the Newham Recovery College* (currently states 'opening of the college').
- Para 14.2 to be changed to provide clarity on which systems are being integrated: *Received assurance that inter-operability has been built within the Trust's new Integration Engine which is progressing on schedule. The TIE is a healthcare integration platform that supports the Trust's operations, providing an interface between the various information systems*.
- Para 12.2 as well as reviewing the terms of reference for the Research and Innovation Committee, it was agreed there would be a report summarising research.

5 Action Log and Matters Arising from the Minutes

5.1 **Action Log**
The three actions are due in July and are in progress.

5.2 **Matters Arising from Trust Board in Private**
There were no matters arising not covered on the agenda.

6 Chair's Report

6.1 Eileen Taylor presented the Chair's Report which is structured around the four priority areas of patient leadership, staff support and empowerment, Board effectiveness and system leadership, highlighting:

- The importance and power of communications and interactions with patients and service users and noted a strength of the collaboratives is that service users are members of the committees. Discussions have taken place on their motivations and what they felt about the committees; the key messages are:
  - It was clear that it was felt the Mental Health, Learning Disability and Autism Committee has been predominantly about mental health, so the next meeting will shift to focus on autism.
  - A person who is a carer for her adult son with autism, presented her experiences to the NELFT Board recently. This powerful story of patient leadership has the potential for being a QI project.
- In July there will be community fayres being held as part of celebrating the NHS 75th birthday. These are being held in collaboration with both BLMK and NEL ICSs and fellow provider Trusts.
- ELFT was represented this week by four Governors and the Corporate Governance Manager at the NHS Providers Governors Conference, where they were showcasing what NHS Providers have deemed as good practice on the work undertaken to ensure our Council remained informed and engaged during the process of recruiting to the post of Joint Chair. There was a lot of interest in the communications approach and also on the Governor developed key lines of enquiry framework.

6.2 Aamir Ahmad reported on visiting the people participation team with Peter Cornforth in April, highlighting:

- It was striking how much the team has grown and the depth of feeling they have for what they are doing – their lived experience is now being used as a strength.
- The support for each other in the team was clear; a culture which is hoped is demonstrated in all teams.
- The main issue for the team is the finance system which has been the cause of problems for some time particularly around the timely payment of expenses to service users, acknowledging that late payment would not be tolerated for substantive staff and so resolution must be prioritised.
  ACTION: Samanthi Gibbens
- People participation is one of ELFT's strength and the team is spear-heading dissemination through the ICSs, showing tolerance and understanding of different cultures.

6.3 Donna Kinnair reported on the recent visit with Ken Batty to the Tower Hamlets home treatment team:

- This is a community based team who signpost very effectively to keep people out of hospital. They can arrange long-term stays for people that use the service in the crisis house.
- The team are really proud that: they take people who are unwell, keep them out of hospital and see improvements in a week or two; they have achieved recognition from the Royal College of Psychiatrists; they have a system of shadowing to ensure staff can cope with the intensity of the work before they take it on.
- They feel that carers are a critical part of their team and they work with families as well. They have learned how to communicate with families and carers as well as service users. They also use Dialog+ for feedback.

- Their biggest issue is that they are all receiving parking tickets at Mile End Hospital.
- The team valued the visit and are very proud of being part of ELFT.

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

8 Chief Executive's Report

8.1 Paul Calaminus presented the key points from his report:

- Operational pressure on services: services are no longer seeing peaks and troughs and have been working in a period of sustained pressure for some time.
- Industrial action: more strike action has been announced for a few days' time. The response from staff has been impressive but there are knock-on effects.
- There was a successful BLMK mental health summit led by service users in March which had strong attendance from across the whole of the ICS area. A set of priorities for the mental health collaborative in BLMK is being drafted.
- PLACE (Patient Led Assessment of the Care Environment) results show scores lower than expected across all six domains and compared to benchmarking data. Action plans are in place to address the specific issues and identify opportunities to improve the scores.
- Professor Stefan Priebe retired having played a key role in establishing research within the Trust, and in pioneering the involvement of patients and service users in research.
- There was a formal launch of the Youth Resilience Unit, led by Queen Mary University of London based in Newham.
- The falls service in Bedfordshire is doing pioneering work with the fire brigade. They are working with a population where there are fire and health risks. There has been good feedback on their work and the ambulance service is also becoming involved.
- Staff changes: Dr David Bridle is now the substantive Chief Medical Officer and Kevin Curnow has been appointed as the Chief Financial Officer. ELFT's thanks go to Samanthi Gibbens for her contribution as Acting CFO and she is wished well in her future role.

8.2 In discussion the Board:

- Suggested a discussion to consider the strategic response to the sustained pressure would be helpful.
- Noted that the associate roles are new and what works well and what does not will be monitored to identify their career pathways. The intention is also to learn from colleagues in primary care where these roles are now embedded.

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

9 Integrated Care & Commissioning Committee Assurance Report

9.1 Richard Carr presented the report of the meeting held on 4 May 2023, highlighting that:

- ELFT is playing a lead role in the Mental Health, Learning Disability and Autism Collaborative.
- There is now a proposal to establish a Perinatal Provider Collaborative with the Trust as the lead provider. The Finance, Business & Investment Committee (FBIC) will also review the proposal as it is important to understand the risks involved.
- The Committee has now signed off the population health dashboard, acknowledging it will develop over time.

- The internal audit report on population health identified some helpful recommendations, such as how to make it simpler for the Trust to understand the role of being an Anchor Institution.

9.2 In discussion the Board:

- Raised the need for the health system to understand the significance of anticipated population growth and to recognise that working with local authorities to optimise potential for infrastructure is a strategically important area.
- Noted there are now stronger relationships with local authority partners overall which should improve planning.
- Commended the report's clarity in providing an update on its work.

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

10 Quality Assurance Committee Assurance Report

10.1 Donna Kinnair presented the report of the meeting held on 2 May 2023 highlighting:

- QAC will be monitoring the impacts of the junior doctors' industrial action.
- Presentations from community mental health services in Tower Hamlets, Newham and Hackney about some re-design, such as crisis hubs. There are challenges in staffing but equally in Newham they are very proud of the recovery college development and the employment working partnership which has placed 60 service users into employment, which is a great example of working on the wider determinants of health.

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

11 Quality Report

11.1 Amar Shah presented the report, highlighting:

- In January the report looked at 'getting the basics right' from the point of view of service users and carers; this report looks at the same question from the staff perspective and outlines the work under way on the main themes identified from a feedback review.
- The quality improvement section shares the plan for next year. There are two major programmes of work:
  - Inpatient quality and safety: builds on the work already started on therapeutic engagement and motivation, and broadens this to look at how we reliably implement the work on violence, flow and trauma informed care; this involves every inpatient unit. The opportunity is to take an improvement approach and use the data to inform learning.
  - Equity: the first year of the pursuing equity programme has just been completed and the second part is in design and will start during the summer.

11.2 In discussion the Board:

- Commented that while feedback from Exec walkrounds showed 'hygiene factors' as an issue, the factors staff were proud of were very important and worth celebrating.
- Highlighted that one of the factors that 'gets in the way' for staff continues to be the time to hire new people and readiness for their first day. It was confirmed the project on this has concluded; it identified issues across teams and many of these have seen a marked improvement, such as smartcards being issued more quickly.

- Suggested the staff quarterly pulse survey results are reviewed as the motivation score has plummeted, although there is an improvement in people thinking they can improve their area of work. The advocacy score is improving which is positive. **ACTION: Tanya Carter**
- Appreciated it was useful to see the triangulation of Exec walkround and requested the NED visits are reported in the same way to identify similarity of themes. **ACTION: Paul Calaminus**
- Commented that there is a large number of issues raised by staff about the environment, ergonomics, etc. and yet the PLACE scores appeared to be a surprise. Stressed the need to ensure cleanliness, even where external contractors manage buildings and suggested this is about leadership, as there is a need to be involved in supporting local managers in enforcing contracts and standards. This is clearly important to staff and part of 'getting the basics right'. Noted PLACE scores will be added to the triangulation review; this is the first year of taking this triangulation approach and so the aim will be to see improvements in scores year on year.
- Highlighted the amount of staff who said that QI projects were empowering them to improve services for the people they served even if the QI project had stalled.

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

12 Performance Report

12.1 Amar Shah, Edwin Ndlovu and David Bridle presented the report highlighting:

- The report now includes an expanded safety section from the integrated patient safety report that is considered at QAC.
- The equity section shows the difference between use of restrictive practices and access to Talking Therapies and CAMHS for white and BAME patients is narrowing, which is good progress. However, access to mental health services and non-attendance at appointments are widening based on ethnicity and deprivation. It is important this is now visible through the reporting and there is work under way in each borough to focus on reducing these equity gaps.
- There is operational pressure across all services, particularly access to beds. This has been increasingly difficult recently and it is important to identify how to improve this. Currently working with system partners on opportunities to provide access.
- ADHD and autism waits are also increasing. Young people numbers are high and is often at the point they transition to adult services. This is a national issue.
- Careful monitoring of workforce is essential due to the operational pressures.
- Majority of safety incidents and levels of harm are low harm, and the rates and categories are fairly stable.
- Unexpected deaths have decreased which is the result of more accurate reporting.
- Two Prevention of Future Death notices received: one about a 34 year old lady who died in March 2022 in hospital from a pulmonary embolism and the second a 60 year old man who died in February 2022 in the community.
- Staff have participated in established and new learning opportunities, e.g. the after action reviews. The Trust is co-designing the new Patient Safety Incident Response Framework (PSIRF) which aims to improve safety and will change reporting.

12.2 In discussion the Board:

- Noted that Newham CAMHS has seen increased waiting lists; these are not linked to ADHD and are largely due to greater demand. Newham is undertaking QI work to test out new ways of working focusing on assessment of need at point of contact and ensuring triage is carried out quickly with the aim of increasing capacity on the treatment list. Also received assurance that through the collaborative, it has been

possible to adjust slightly how money is spent between boroughs to help with Newham's waiting times.

- Emphasised the need to look at what ELFT could be doing systematically about ADHD rather than managing waiting lists, e.g. send a questionnaire to service users on the waiting list so that some of the background work is done, and suggested need to ensure service users focus on what they want to achieve and encourage self-management. Received assurance that there is a MDT team who is reviewing this; – an initial driver diagram has been developed to enable the thinking through of a range of options.
- Noted that primary care have had huge demand and are managing very high numbers of contacts; a range of different solutions are being tried, such as digital solutions, care navigation to link patients to wider solutions in the system, also having a patient education day and working with acute hospital so people can be navigated into different parts of the system.
- Commended the continual improvement of this report.

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

13 People Plan Report

13.1 Tanya Carter presented the report, highlighting:

- The Agenda for Change pay award has been approved by the Government. The Trust has offered to stagger the increase to provide support as in some cases people's increased earnings will result in a reduction in pay due to tax increases.
- The temporary staffing project includes reviewing opportunities to work with NELFT on a collaborative Bank.
- Employee relations activity is consistently high.
- Statutory and mandatory training was previously reported as a challenge; there has now been a 5% increase in compliance since the last Board meeting. The aim is to achieve 90% within twelve months.
- Looking at wider determinants of mental health for staff. Currently there is a focus on men and a men's network is being launched.

13.2 In discussion the Board:

- Suggested looking at ways to support staff with the cost of living through a 'Marmot' lens.. Ideas included investigating whether the Trust could introduce mechanisms, such as negotiating reduced mortgage rates, encouraging housing associations to support those with key worker status, or being a guarantor for the rent.
- Requested clarity in the report of progress against the targets in the people plan and how it can be tracked. As the focus on people is important in the overall strategy, it is important to know whether headway is being made. Received assurance that work is in progress on this and the report will be re-shaped to show where the Trust is against the metrics; this will be reviewed at the People & Culture Committee.
- Noted it has been agreed to review with the auditors at how best to report on Freedom to Speak Up, as there is a need to ensure people are finding the service useful and that there is an effective feedback loop to management.
- Received assurance that work is ongoing to improve achievement of recruitment targets through a range of projects. Requested that vacancy figures are broken down by staff levels/banding to show where vacancies are based.
- Suggested the need to bear in mind that there may be an increasing supervision burden on teams as new staff are recruited, especially from abroad, as they may need additional support to bring them up to speed.

- The People & Culture Committee will in future receive the people plan report and will provide an assurance report on progress, risks, etc to the Board in line with other Committees' assurance reporting.

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

14 Leadership in ELFT

14.1 Lorraine Sunduza reported:

- A level of variation was identified, particularly in leadership.
- During the pandemic leadership approach was 'command and control' which is not sustainable.
- A number of leaders have moved on through retirement or promotion so there are new leaders who have joined at a difficult time.
- This project asked people "what are the leadership behaviours ELFT should expect from everybody?" There has been a positive and supportive response.
- The aim is to create a 'bundle' that teams can use and that can be used to measure and direct efforts where support is required.
- A summary of all the behaviours identified has been developed.
- It is proposed that attention is paid to:
    - Away days: these are important for teams to connect, however, there is variation on whether they take place and their quality. Also want to increase 'huddles' and will establish a definition for this (a place to check-in).
    - Supervision: this also varies in terms of whether it takes place and the quality; it is important to ensure this meets requirements and is a positive experience.
- Also looking at quality of life measure for staff and at meaningful people participation as there is a need to ensure it is done consistently and there is a way to measure and improve.
- An implementation plan is being co-produced with staff and service users, to ensure the right measures are identified and there is an appropriate, consistent and transparent application across the Trust.
- The People & Culture Committee will receive regular updates on the project and an update report on measures will be presented to the Board.
- There will be a communications plan for the project.

14.2 In discussion the Board:

- Commended the leadership framework as a really useful tool.
- Noted that feedback from leaders and their teams had resulted in the same areas being raised. The one additional area raised by groups reviewing the feedback was about being a leader in a system and it was agreed this will be factored in.
- Received assurance that embedding this framework in training and development and in the appraisal process will be part of the implementation plan.
- Noted the aim is for this to become part of business as usual and for people to use the framework to help them.
- Agreed this should connect to ELFT's mission and all leaders need to be able to articulate ELFT's vision
- Noted that the Board should also be role modelling good system leadership and leading the way in defining good system leaders.

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

15 ELFT Charitable Funds Committee Assurance Report

15.1 Aamir Ahmad presented the report of the meeting held on 20 April 2023, noting thanks to Mohit Venkataram's drive in progressing the establishment of the charity. He highlighted:

- The Trust is working with (and has received matched funding from) the London Borough of Tower Hamlets on the healthier wealthier families project which focuses on working with children with serious long-term conditions and looking at how to help the families receive more money; the emphasis is to look beyond medical needs.

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

16 Finance, Business & Investment Committee Assurance Report

16.1 Aamir Ahmad thanked Samanthi Gibbens for her focus and energy on system engagement. He presented the report of the meeting held on 9 May 2023, noting:

- ELFT is carrying a lot of risk.
- There is more pressure on FV and this needs to be achieved in a bigger more ambitious way than previously.
- Capital is a concern and it is difficult to see how the Trust's aspirations can be met with the small amount of capital held. The aim is to work with ICS colleagues to identify solutions.

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

17 Finance Report

17.1 Samanthi Gibbens presented the report to the 31 March 2023, noting:

- At month 12 there is a surplus of just under £2m against an initial break-even plan.
- There was some increase around the assumptions to the Agenda for Change pay award, some smaller income adjustments and an increase in agency towards the end of the year.
- Only 50% of FV was achieved last year. Targets were only discussed with directorates at Q3 and this year planning has started much earlier.
- The cash position remains at £134.5m.
- The Trust continues to be in segment 1 (maximum autonomy, minimum risk) under NHS England (NHSE) risk rating segmentation framework.

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

18 Financial Planning

18.1 Samanthi Gibbens reported:

- The plan submission to NHSE resulted in a £5.4m surplus for ELFT in line with NEL ICS plan submission which was breakeven.
- The FV challenge is higher than last year at 3.5% of turnover. Targets are devolved to directorates; some of the work has helped with the phasing of FV.
- Planning process for the Mental Health Investment Standards (MHIS) money and Service Development Fund (SDF) funding was via the collaborative structures in both ICS areas.
- Main income contracts with NEL and BLMK are being finalised.
- Trust budget setting is progressing well, and the Board will be kept updated.

18.2 In discussion the Board:

- Recognised the need to apply assumptions as instructed.
- Suggested there is a need to think longer term, not just a single year.
- Received assurance there has been constructive engagement in the community collaboratives and both ICSs. Across them there is about £2bn worth of public money so it must be understood what the outcomes and value are.
- Suggested considering a larger contingency, as last year's FV was not achieved and there is usually a need for more than is assumed. Noted thinking about contingency planning at system level as well as corporate level would be helpful.
- Recommended looking at five year strategies for digital and estates which present opportunities to support the Trust and could enable a five year financial vision.
- Noted the need for as much money as possible to be focused on front line services and to ensure ongoing discussions with partners on opportunities for improvement.

19 Board of Directors Forward Plan

Noted.

22 Any Other Business

22.1 **Modelling Accessibility**
It was suggested the Board could role model accessible meetings, e.g. venues with good acoustics should be sought and shorter meetings or more breaks in the meeting arranged.

23 Questions from the Public

23.1 Yasmin Begum asked 'who the ICS is for and, if it is for service users, why don't they know about it?' She gave the example of a woman with medical conditions living in over-crowded accommodation with four children. If the ICS is there to support people like her, why doesn't she know about it?

Paul Calaminus responded that:

- The ICS is for the populations of their geography.
- The challenge for the ICS is to connect with the population and improve on previous efforts to build connections.
- Consideration needs to be given as to what can be done together given the resources available.
- He would be happy to discuss this further with Yasmin outside the meeting to explore links with the Council of Governors, etc.
  ACTION: Paul Calaminus

23.2 Questions submitted online will be responded to after the meeting.

24 Date of the Next Meeting

- Thursday 27 July 2023

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

The meeting closed at 3.30pm

ELFT
Action Log Trust Board (Part 1)

BOARD OF DIRECTORS MEETING IN PUBLIC: Action log following meeting held on 25 May 2023

Ref	Meeting Date	Agenda item	Action Point	Executive Lead	Due Date	Status	Comments
371	30-Mar-23	CEO Report	Report on the Trust's education, research and innovation activity to be presented at a future Board/committee meeting	DB	27-Jul-23	Closed	Proposal is for the education, research and innovation annual report be presented at QAC as scheduled; going forward recommendation that education, research and innovation will be reported to the new People & Culture Committee; and included on forward plan
373	25-May-23	Patient Story	Share the Trust's spirituality lead contact details with John Power	LS	27-Jul-23		
370	26-Jan-23	Safer Staffing	Review presentation of table showing variance from actual to planned nursing rates to provide more clarity	LS	27-Jul-23	In progress	Included in the next Safer Staffing report to Board
376	25-May-23	Quality Report	Review reasons for motivation score plummeting in the staff quarterly pulse survey scores	TC	27-Jul-23	Closed	Taken through the People & Culture Committee and included on the forward plan
374	25-May-23	Patient Story	Include deep dive on the Trust's spiritual services at a future QAC	LS	28-Sep-23	Closed	Included in QAC forward plan
375	25-May-23	Chair's Report	Review challenges with the finance system to ensure timely payment of expenses for service users working in people participation	SG	28-Sep-23		
377	25-May-23	Quality Report	Consideration to be given to the inclusion of NED visits in the feedback triangulation	PC	28-Sep-23	Closed	Will be integrated into the current walkround process and thematic analysis; and will be fed back through the Quality
378	25-May-23	Questions	Explore links with the Council of Governors and feedback loop in respect of ICSs	PC	28-Sep-23		
372	30-Mar-23	QAC Assurance Report	Reporting sub-committees to QAC to be reviewed/updated; consideration to be given to appropriate reporting lines for the Trust's Research Committee	CL	29-Nov-23	In progress	See action 372. A review of all Board tier 2 and tier 3 committees being undertaken - completion expected in the autumn

In progress
In progress with delay
Closed
Forward plan
Not due

East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
27 July 2023

Title	Chair's Report
Author	Eileen Taylor, 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:

13 July 2023	Council of Governors Meeting
27 June 2023	Meeting with Council of Governors regarding CEO appointment
9 June 2023	Audit Committee: Fit & Proper Persons Requirements

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 Governors 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. Introduction

1.1. This report updates the Board on the Chair's main activities, Non-Executive Director (NED) visits and Council of Governor discussions as part of the Board's commitment to public accountability.

1.2. The report also provides a summary of discussions at the Council of Governors (the Council) so that these views may inform Board decisions.

2. Chair's update

2.1. Since my appointment as Joint Chair of East London Foundation Trust (ELFT) and North East London NHS Foundation Trust (NELFT) on 1 January 2023, I have shared my vision for both trusts: to improve equity of access and population health outcomes across the communities we serve.

2.2. Underpinning this vision, I have four priorities:

- **Patient leadership:** empowering the people who use our services and working with service users and carers to improve access, experience, outcomes and equity.
- **Staff support and empowerment:** driving equity of opportunity for our staff and ensuring that staff at every level are supported and empowered.
- **Board effectiveness:** creating a board environment that feels accessible to patients, communities and staff and ensuring evidence-based decision-making.
- **System leadership:** contributing and leading effectively in the systems we work in, including being an anchor institution, recognising that both ELFT and NELFT are involved in two or more Integrated Care Systems (ICSs).

My updates to the Board are structured in line with these priorities.

Patient leadership

2.3. In May, I heard a powerful presentation from Marcella Cooper, member of the North East London (NEL) Mental Health, Learning Disability and Autism Collaborative Committee, and mother of and carer for her adult son Mitchell who is autistic and also has learning disabilities. Marcella is an inspiration and her voice has been important in ensuring that the Collaborative Committee balances its focus effectively between the priorities of our autistic and learning disability (LD) service users and our mental health (MH) service users' priorities. I was therefore particularly glad to have the opportunity to attend the launch of the Inner NEL LD Health Needs Assessment on 28 June.

2.4. The use of an acting troupe whose members have learning disabilities powerfully demonstrated the inequalities faced by this community. The day resulted in recommendations of what matters to the learning disability community and, once finalised, we will embed in the work of the NEL Mental Health, Learning Disability and Autism Collaborative Committee.

Staff support and empowerment

2.5. During June, Paul Calaminus and I unveiled Covid Memorial Plaques at the East Ham Care Centre, the City & Hackney Centre for Mental Health, the John Howard Centre and the Tower Hamlets Mental Health Unit. Each of these events was deeply moving and I have felt such a sense of pride in our staff for everything they did for our service users and for each other during the Covid-19 pandemic, in the face of so many challenges.

2.6. Earlier this month and in June, a number of our junior doctor colleagues again took part in industrial action and some consultant colleagues took part in industrial action for the first time this month. I continue to support their right to take strike action and recognise that this will again have been a very difficult decision, personally and professionally. I would like to recognise and thank all of the staff who helped to keep services running and our service users safe during these periods.

Board effectiveness

2.7. As you will be aware, since the last meeting of the Board, Paul Calaminus has been appointed as Chief Executive of NELFT and is to start there full time from the end of August. I am delighted that Lorraine Sunduza has been appointed as our Interim Chief Executive and will begin her new appointment at the same time. Claire McKenna has been appointed as Acting Chief Nurse and I am delighted to welcome her to the Board.

2.8. Paul has been an outstanding Chief Executive and I have no doubt that NELFT will flourish under his leadership as ELFT will under Lorraine's. The developing collaboration between ELFT and NELFT can only be strengthened by these appointments and I feel confident of positive impact across the populations that the two trusts serve.

2.9. The NELFT and ELFT Boards met for their second joint session on 6 June with the aim of continuing to build connections and relationships and agreeing the role of the two Boards in enabling and supporting effective collaboration to improve outcomes for the populations we serve. We reflected on the things that have already been achieved collaboratively and that collaboration is happening at multiple levels of our organisations. We also discussed priorities for the future and agreed the principle that we should collaborate 'as the default' where it will bring benefits to our service users, our populations and our staff. We agreed that we will continue to meet as two Boards on a bimonthly basis.

2.10. On 29 June we were very fortunate to have Dr Robin DiAngelo, American author and academic, join us virtually to facilitate a Board Development Session aimed at furthering our work to become an anti-racist organisation. The event reminded me that, although there is the intent to be an anti-racist organisation, we need to do more to keep it front of mind in the leadership and at all levels of the organisation. Working with Lorraine Sunduza supported by Tanya Carter, I will champion this work at ELFT.

System leadership

2.11. On 13 June I attended the NEL Integrated Care Partnership (ICP) where we discussed the question of how we as partners would define ICS success. Key themes included:

- Focusing on what matters to our local population and communities and involving them in designing services
- Closing the gaps between health, social care and the voluntary, community and social enterprise sectors
- Focusing on prevention and setting clear objectives around issues such as childhood obesity
- Developing our community health services so that fewer people require acute care and the length of acute hospital stays is reduced.

We also discussed how we can truly know that services are delivering compassionate care and reflected that our measures must be aligned to what matters to users of services.

2.12. On 14 and 15 June I attended the NHS ConfedExpo in Manchester and was able to attend a number of fascinating sessions. One of the most powerful focused on the 'business case' for tackling health inequalities where the financial case is just as compelling as the overwhelming moral case. The speakers' presentations emphasised the importance of really interrogating our access and outcomes data to identify and understand health inequalities and of taking action within our spheres of influence. The presentations felt very relevant to our commitments as a Marmot Trust and as an anchor institution in our local communities.

2.13. Earlier this month on 12 July I attended the Bedford, Luton and Milton Keynes Chairs Meeting where we discussed how partners can collaborate on good employment for local residents.

2.14. 5 July marked the 75th anniversary of the founding of the NHS and on 12 July I was delighted to attend the celebratory NHS 75 London Community Fayre attended by members of our staff, our service users and carers, our partners and members of our local communities and I relished the opportunity to speak with them. The positive energy in the room was palpable for the full three hours. I was delighted that so many of our Governors were able to join us and I want to thank them for being such a visible and supportive presence at the Trust.

3. Council of Governors update

3.1. Paul Calaminus and I met with Governors virtually on 27 June following Paul's appointment as CEO of NELFT to offer assurance around the way forward. Governors were, as ever, supportive, saddened that Paul would be leaving the Trust but feeling confident in the strength and effectiveness of our Board to continue to deliver for our local populations.

3.2. I was unable to attend the Council meeting on 13 July and am grateful to our Vice-Chair, Deborah Wheeler, for chairing the meeting. The Council was very pleased to celebrate the news of Lorraine Sunduza's appointment as Interim CEO.

3.3. Governors received assurance around the discussions with the Metropolitan Police and Bedfordshire Police about the implications (and opportunities) of implementing the Right Care, Right Person model as envisaged by the police services. As ever, they focused on the voice of the service user and encouraged the Trust to put the needs of those in mental health crisis at the centre of the discussions.

3.4. Following on from the previous meeting's main topic of staff wellbeing, Governors requested an update from the Trust's new Cost of Living Coordinator Susan Downing. Susan outlined her policy of encouraging staff and service users to regard her cost of living 'hacks' which she shares widely. These are communicated as opportunities to release sufficient funds for activities or goods that promote wellbeing rather than having to 'cut back'. In discussion, the Council encouraged the Trust to look further at broadening benefits advice, something the Council heard was already being carried out through ELFT Charity funding.

3.5. "Getting digital right for our service users" was one of the five priority themes previously agreed by the Council, and the meeting welcomed three digital team members as well as Rachel Vincent, a service user and member of the People Participation Digital Community. They updated the Council on the various ways both the Digital and People Participation Teams are working to address the issues of patient access and sharing of records, as well as bridging the digital divide.

3.6. In group discussions, Governors considered the question of 'What more can ELFT do to overcome digital exclusion?" and the feedback included requests:

- To use opportunities such as our Recovery Colleges and peer support to provide training and support;
- To offer access through direct funding or access to the internet at Trust facilities.

There was also concern that the internet can pose risks and service users new to it should be alerted to these, for example to the risk of online fraud. As ever, the full feedback will be reported back to the teams presenting.

3.7. Governors agreed that the Trust had provided the appropriate training, development and guidance to Governors to ensure they are equipped with the skills and knowledge to carry out their roles.

3.8. Governors ratified the updated version of the Business Development Framework by the Significant Business and Strategy Committee (SBSC). The Framework contains key lines of enquiry to consider when entering into new service delivery opportunities and is, to my knowledge, unique among trusts. It is used by Trust staff to assess new opportunities just as much as it is used by the Committee or the wider Council to seek assurance when the Trust considers delivering a new service. It also gives guidance to those tendering for services from the Trust about what is importance to us. I was particularly heartened to see a strengthened focus on patient experience, staff wellbeing, and recognition of the new integrated/system-led way of working.

3.9. Governors received an update from the Communications and Engagement Committee as well as progress on the previously agreed Membership Engagement Plan, focusing in the main on the successful NHS 75 Fayres in Bedfordshire and East London (see item 2.14)

3.10. Following queries raised by a number of Governors, the Council concluded with a session on how the Trust and, in particular, the NEDs are receiving assurance around learning as a result of serious incident (SI) reviews and how learning is shared and taken forward in the Trust. Chair of the Quality Assurance Committee, Dame Donna Kinnair (via recorded video), and Deborah Wheeler both outlined the way they receive assurance around this, following on from a presentation by Dr Deborah Dover, the Trust's Director of Patient Safety. The Council challenged the Trust to share knowledge of this process and the Trust's learning with the wider public in a more accessible way, whilst acknowledging that this can pose problems when linked to specific cases.

3.11. This was a good, important and respectful discussion. As the Vice-Chair outlined in her introduction, we must never forget that, while in many SIs there is no harm, some of the learning comes to us through cases of harm caused to patients or the immense sadness of an untimely death.

4. NED visits

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

- The Podiatry Team – Tower Hamlets
- Primary Care: Caudwell Medical Centre
- Forensics: Aldgate Ward
- The Quality Assurance Team
- Hackney CAMHS

All visits took place face to face.

4.2. NEDs took the opportunity to thank the staff working in these services for their professionalism, commitment, enthusiasm and personal contributions to improving the lives of the people we serve.

4.3. For the first time we have been holding joint NED/Governor site visits (the Cauldwell Medical Centre, the Quality Assurance Team and the Hackney CAMHS visits) and it has been a positive experience for all concerned.

5. Fit & Proper Persons Requirements

5.1 At its meeting on 9 June 2023 the Audit Committee received a report from me confirming that, having considered all the matters outline in the Regulated Activities Regulations and all the information and documentary evidence provided to me, for the period 1 April 2022 to 31 March 2023 the Trust's Board Directors meet the Fit & Proper Persons Requirements, and that 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. My declaration is attached at appendix 1.

6. Action Being Requested

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

NHS
East London
NHS Foundation Trust

Annual Fit and Proper Persons Declaration 2023
27 July 2023

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 **New and ongoing fitness:** 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:

- Annual and ongoing declarations of interest for all Board Directors. 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.
- Social media checks for Board Directors
- 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.

3 Ongoing Fitness

3.1 During March-April 2023, Board Directors completed the annual Fit and Proper Persons Requirements self-declaration form.

3.2 The Trust 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 Chair and also determined that she continued to meet the FPPR requirements.

3.3 Assurance is provided that in 2023:

- Social media checks for Board Directors completed – no issues identified
- All Board Directors have current DBS checks
- Search of insolvency and bankruptcy register, Companies House register, Charity Commission's register of removed trustees completed – no issues identified
- Confirmation that Directors remain on the relevant professional register
- As part of the recruitment process as described in para 2.3 above, both new NEDs met all the pre-employment checks and completed the relevant forms.

3.4 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 NEDs. The appraisal record for Executive Directors on the online Learning Management System will reflect the discussions and the following statement will be made:

> *I confirm that, having considered all the matters outlined in the Regulated Activities Regulations, and based on the discussion that we have had as part of this appraisal, this person meets the Fit and Proper Person Regulation requirements, and I am satisfied that there are no other grounds under which the individual would be ineligible to continue in the post. In line with CQC best practice the individual will complete a declaration of interest form.*

In addition, a new facility on the staff records management system (ESR) to record FPPR checks.

3.5 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. During the year none were identified and/or shared with the Chair.

4 Actions to Strengthen

4.1 An action plan was developed to strengthen the Trust's process and procedures underpinning the FPPR taking into account the learning following the enquiries by BBC East into the qualification claims by a Board Director in 2021, the recommendations from the internal audit report into the Trust's FPPR processes and actions identified to strengthen compliance with the NHSE provider licence identified in the 2022 review.

4.2 The Audit Committee has been kept updated on progress with the range of actions identified.

4.3 Good progress has been made with the majority of actions completed with four actions in progress; these, however, do not impact on the effectiveness of the FPPR process.

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.

East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
27 July 2023

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 CQC inspections of 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 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 Trust services have continued to experience high demand with our operational pressures remaining significant in mental health, community health and primary care services. There have been particular pressures in Emergency Departments, with some patients waiting for extended periods of time beyond the 12 hour maximum waiting time. This has been reflected too in very high levels of occupancy within inpatient units. A significant proportion of those presenting in crisis are new to services, and key drivers of crisis are increasingly often social, financial and housing related factors.

2.2 At ICS level, the Trust is working with system partners to identify further alternatives to both admission and A&E for those in crisis, additional inpatient capacity, and work to reduce length of stay on inpatient wards. Particularly within the North East London area, both ELFT and NELFT continue to share inpatient capacity to maximise the responsiveness of the mental health crisis system to those in the highest levels of distress.

2.3 The Trust has also been engaged in ICS level work with East London Metropolitan Police Borough Commanders in response to correspondence from the Metropolitan Police Commissioner relating to the implementation of Right Care Right Person across the Capital. This is an approach in which the police and mental health trusts work with other system partners to ensure that the most appropriate response is available for those in mental health crisis. Particular areas of interest and focus will be the further development of street triage across North East London (a service that is already available in Bedfordshire and the City of London) alongside work to ensure that Section 136 of the Mental Health Act is used as effectively and appropriately as possible.

2.4 Work also continues to establish virtual ward/Hospital at Home provision in both ICSs and this remains a significant opportunity to both improve the provision of care and address demand and capacity challenges.

2.5 As I reported in May, in this context, focusing on our people and ensuring support systems are in place and safe staff levels are being achieved continues also to be an important area of focus.

3.0 Industrial Action

3.1 Service and clinical leads have been meeting throughout July to plan for the impact of the Junior Doctors 5 day strike from 13 -18 July, as well as the medical consultants strike (20-21 July). This industrial action has had a considerable impact on the provision of services including the requirement to cancel and re-book some appointments.

3.2 Daily local, trustwide and ICS level meetings took place throughout the period of industrial action to monitor how services were affected and tackle any issues that arose. On the days of industrial action, acute and crisis services were prioritised.

3.3 The Trust also took part in public messaging advising our staff and the public to use NHS services wisely during the periods of industrial action and to pursue alternatives for support with physical health and mental health issues such as GP services, pharmacy services, crisis cafes, voluntary organisations and helplines.

3.4 We continue to monitor the impact of industrial action by other professional groups and industries that could impact on our workforce and services - such as the education and transport sectors.

4.0 New Hospital's Programme Announcement

4.1 In May, the Government announced the trusts that will be prioritised in its New Hospital Programme. Unfortunately, ELFT's proposal to build a new mental health inpatient unit on the Bedford Health Village site was not one of these. All schemes within the New Hospital Programme have to follow a business case process, including being reviewed and agreed by ministers.

4.2 The Trust has for some time been scoping the development of a new mental health unit to provide local inpatient care in Bedford. People who live in Bedford and Central Bedfordshire and who need an admission to hospital currently have to travel to Townsend Court in Houghton Regis, or Oakley Court or the Luton Centre for Mental Health in Luton.

4.3 The Trust is exploring other options to expedite some of the changes and developments required. We remain committed to working with partners to provide a high-quality environment in Bedford for people in our care to begin their recovery, and to provide the best setting for staff to use their skills and flourish

5.0 Long Term NHS Workforce Plan

5.1 The Government launched its Long Term NHS Workforce plan at the end of June setting out actions to increase training places including doubling medical school places, to 15,000 per year by 2031/32 and increasing nursing training places by 80% by 2031/32. The plan also sets out how placement capacity will be increased to enable this expansion.

5.2 The plan falls into three distinct areas for development:

Training: significantly increase education and training opportunities, increase apprenticeships and alternative routes into professional roles, to deliver more doctors, dentists, nurses, midwives and other professional groups. It includes new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.

Retention: ensure that the NHS keeps greater numbers of current staff within the health service by supporting career development and offering more flexibility in

working patterns. Alongside improving culture and leadership across NHS organisations.

Reform: improve productivity by adopting new ways of working and training, build broader teams with flexible skills, boosting education and training to deliver more staff in roles and services where they are needed most. It states an aim of ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.

5.3 This workforce plan will be a key part of the ICS and Trust level workforce planning and development over future years, providing the opportunity to develop the Trust workforce to meet future demands for healthcare over the next ten years.

6.0 Rapid Review into Inpatient Mental Health Services Report

6.1 The Government has published the results of their rapid review into data on mental health inpatient settings. The purpose of the review was to consider the way that data and evidence relating to mental health inpatient settings and pathways is collected, processed and used to identify risks early and mitigate these to protect the safety of patients. It included quantitative information and qualitative evidence from patients, carers and staff. The review did not seek to investigate any particular trust or provider, nor to cover ground covered in other reports.

6.2 Five 5 key themes were highlighted. These were:

- Measuring what matters
- Patient, carer and staff voice
- Freeing up time to care
- Getting the most out of what we have
- Data on its own is not enough

6.3 There are specific recommendations for Trust Boards, relating to Board membership, skills in data interpretation, Mental Health Act understanding, use of reports and Board Assessment Frameworks and how the voice of families and carers is heard at Bord level. It also makes recommendations about visits to inpatient services. We will be reviewing our practice as a Trust and Board in the light of these to ensure that learning for the ELFT board is taken forward and any necessary changes are made.

7.0 Announcement of Health Services Safety Inspectorate Review of MH Inpatient Services

7.1 The Secretary of State has announced that in October a new *Health Services Safety Investigations Body* will be formally established and will commence a national investigation into mental health inpatient care settings. It will investigate a range of issues, including how young people with mental health needs can be better cared for, how providers can learn from tragic deaths that take place in

their care, how out-of-area placements are handled, and how staffing models can be improved.

The recommendations from this far-reaching investigation are intended to help service providers to improve safety standards in mental health facilities across the country.

8.0 CQC Visit Feedback

8.1 The Care Quality Commission have released the report from the focused inspection carried out on the four acute wards (two in London and two in Luton and Bedfordshire) for adults of working age and psychiatric intensive care units which were inspected in February this year. The report is available on the CQC website.

8.2 This was a focused inspection, looking specifically at learning from serious incidents of suicide and self-harm relating to our inpatient wards, across a small sample of our services, the overall rating for 'Acute Wards for Adults of Working Age' has not been re-rated.

8.3 Only the ‘safe’ domain for this service line has been rated as part of this inspection. This has gone from ‘Good’ to ‘Requires Improvement’. The Trust overall rating remains the same.

8.4 The CQC highlighted a number of positive areas including improved procedures and recognised positive themes. Below are some examples:

- “Service improvements had taken place as a result of learning from serious incidents”
- “Ward environments were safe and clean”
- The wards had enough nurses and doctors. Escalation processes for staff when they were short staffed or needed additional staff had improved”
- “On all wards the observation, ligature risk mitigation and patient search processes had improved.”
- “Most staff were well informed about incidents. The trust developed a suite of online training covering suicide prevention, ligatures, observations, and patient searches to support staff in learning lessons from previous incidents”
- “The Trust rolled out a trust wide quality improvement project to understand the challenges in observation procedures. This led to individual teams across the services working on a range of project areas around observations exploring local solutions.”
- “Patients and their families were involved in serious incident investigations. (…) This had a powerful impact in understanding and how the application of operational processes played a vital role in patient safety”

8.5 There were also areas identified in the report as areas for improvement. Whilst the CQC only visited four wards, it is likely that these are challenges in other parts of the organisation so this will be reviewed as a Trust wide level. The themes include:

- The availability and accuracy of Statutory and Mandatory training and staff compliance with this

- Access to regular supervision and annual appraisals
- Consistent environmental checks being conducted
- Improvements to the serious incident process, including that staff responsible for delivering actions following SIs and the senior managers are involved in the development of action plans, and that signed off serious incident action plans reflect the latest changes in the action plan to ensure effective sharing of learning across the Trust

8.6 The Trust is responding to the areas for improvement identified in the CQC's inspection report in the form of an action plan. The report identifies two 'must do' actions that the Trust is required to undertake to ensure that it complies with the regulations set out in the Health and Social Care Act (2008), and a further nine actions that the Trust 'should' undertake to improve the service it provides.

8.7 Relevant action leads have already been identified and they will be working alongside local leads to deliver the action plan. The progress of these actions will be reported regularly.

9.0 ICB/collaborative Update

9.1 In both North East London (NEL) and Bedfordshire, Luton and Milton Keynes (BLMK) Integrated Care systems, staff consultation has been taking place, as the ICBs move to a new operating model, constrained by the requirement to reduce operating costs by up to 30%. The consultation processes are now coming to a close, and I would like to recognise the continued work and commitment of ICB colleagues to develop new ways of working and help address operational pressures whilst such significant organisational changes take place.

9.2 Within the North East London Integrated Care System there has continued to be work to develop the Mental Health collaborative. The NEL MHLDA Collaborative Committee met for the fifth time on 21 July 2023. Lived Experience Leaders are contributing enormously to discussions and have significantly influenced the agenda, bringing greater attention to variation and inequities in experience, access, and outcomes for people with learning disabilities and autism. As part of the Provider Collaborative Innovators Scheme offer, NHS England will be facilitating two system governance workshops (scheduled August and September) to help us explore our transition to a joint committee, and models for delegation. As part of the work of this collaborative, a service user led needs assessment for Learning Disabilities was launched earlier this month as a further effort to ensure that the voice of service users is at the centre of our work. There has also been good progress on the work to understand need and outcomes across North East London, and the first draft of this diagnostic work has been shared formally with the collaborative committee. This will give a strong basis for developing future models, funding and outcomes across North East London.

9.3 The North East London Community Health Collaborative also continues to develop its role within the integrated care system. Current priorities include developing co-production with providers, including those in the voluntary, community and social enterprise sector; and strengthening service user leadership and coproduction. There is a particular focus on the development of

virtual wards, Speech and Language Therapy, community phlebotomy, and strong links with the Babies, Children and Young People's programme across the ICS. As part of this work the Collaborative has also overseen a review of speech and language therapy for babies, children and young people across NEL, helping to determine where there is unwarranted variation in waiting times and outcomes.

9.4 In the Bedfordshire, Luton and Milton Keynes Mental Health, Learning Disability and Autism Collaborative collaborative priorities have been developed by our experts by experience into a vision, key themes and drivers with a focus on improving access, communication, continuity of care, empowerment and personalisation. These will now be tested across BLMK and will underpin strategy and outcome development across our clinical networks and place based plans. A people participation lead has been recruited for the collaborative and will develop the expert by experience capacity across the system supporting delivery of our priorities across our pathways, clinical networks and at place. The operating model for how the collaborative will discharge the ICB (Integrated Care Board) functions and deliver against the collaborative and place based priorities is being developed with ICB, Central and North West London Foundation Trust (CNWL) and place based leads. In the meantime the current BLMK mental health programme continues to work with system partners to focus on delivery of the long term plan as well as addressing key system priorities such as the urgent and emergency care and Section 117 accommodation pathways.

10.0 Two Luton GP Practices to Join ELFT

10.1 Kingsway Health Centre and Bramingham Park Medical Centre in Luton will join the Trust on 1 October 2023.

10.2 The two practices have more than 30 staff and provide care to more than 16,000 members of the Luton community.

10.3 The Luton practices will join the ELFT Primary Care Directorate which includes Leighton Road Surgery in Leighton Buzzard, Cauldwell Medical Centre in Bedford and East London's Newham Transitional Practice, Health E1 and Greenhouse practices.

10.4 The new contract will see Bramingham Park Medical Centre become a branch surgery of Kingsway Health Centre, providing stability and shared expertise and support for teams and patients across both sites.

11.0 Two Community Mental Health Hubs for Luton

11.1 Two Community Mental Health Hubs have been established in Luton to provide joined-up and holistic care for service users. The Hubs will serve the North and South of Luton and replace the Community Mental Health Teams (CMHTs).

11.2 The multi-disciplinary hubs provide a more coordinated model of care built around the needs of our service users and their carers delivered through closer partnership working across health, social care and voluntary sector partners. The hubs aim to promote positive mental health based around a recovery and strengths based model, and to improve access to appropriate services and

resources, reducing the need for hospital admission through more effective working with partners in community settings.

11.3 The change is part of the Trust's community mental health transformation programme, developing new ways of bringing together primary and secondary care with social care, other local authority services, the third sector and local communities to support people with severe mental health needs.

12.0 New Community Hub for Dunstable

12.1 ELFT services are among partners providing support for the Dunstable community through a new integrated health and care hub. Grove View brings together a broad range of services to support people's physical, social care and mental health need all under one roof. The hub build also includes the development of 98 new one and two-bed homes for the over 55s. The development of the hub has been led by Central Bedfordshire Council.

12.2 The hub aims to deliver improved care locally through the integration of primary care, community, mental health and social care services, as well as the provision of wellbeing services through the voluntary sector, and a range of ELFT mental health and community health services will be based at the site.

13.0 Bedfordshire Research Hub

13.1 The development of the new partnership hub for health research in Bedfordshire and Luton continues. The aim of this hub will be to help improve patient care in primary and community healthcare services. The Trust and the Department of Public Health and Primary Care at the University of Cambridge have forged a strategic partnership to help tackle major areas of unmet health needs in the community, the first partnership of its kind for the University.

13.2 The partnership hub will address some of the region's most important healthcare problems, including frailty amongst older people, long-term medical conditions, narrowing health inequities, and optimising the configuration of primary and community healthcare to best address the needs of the local population.

13.3 The initiative will draw heavily on the multidisciplinary excellence of the Department of Public Health and Primary Care. The University is ranked as one of the two leading centres in population health sciences in the UK in the Research Excellence Framework 2021, which provides an ideal context in which to host this new hub, providing expertise in a range of quantitative and qualitative disciplines.

13.4 A key focus of this hub – which will be based in the Department's Primary Care Unit -- will be on primary care services, as the first point of contact in the healthcare system, acting as the 'front door' of the NHS. They include general practice, pharmacy, dental and optometry services.

13.5 The work will also include a focus on community health services which are mainly delivered in people's homes and provide care for people from birth to end

of life, including supporting people with complex health and care needs to live independently in their own home for as long as possible.

13.6 The new partnership hub will carry out its research programmes working closely with healthcare staff in primary and community health and social care services in the area and with the patients and carers of Bedfordshire and Luton. It will also help to bring new academic opportunities to GPs and community healthcare professionals in the area, offering training and support to help them get started on their research journeys.

14.0 Research: Lessening the Risk of Cardiovascular Disease in People with a Severe Mental Illness

14.1 The Trust and City University, London have launched an innovative joint research initiative, PEGASUS, dedicated to lessening the risk of cardiovascular disease (CVD) in individuals with severe mental illness (SMI). Funded by the National Institute of Health and Care Research, PEGASUS is a five-year research programme that will commence in October 2023 and conclude in September 2028.

14.2 Statistically, people affected by serious mental illness have a life expectancy 15-20 years shorter than the average population with CVD being the leading cause of mortality. Standard healthy lifestyle interventions, though effective in the general population, often fall short in helping those with SMI. Additionally, psychiatric medication side effects can exacerbate physical health complications.

14.3 People from black and minority ethnic communities can be at increased risk of both SMI and CVD. This programme of research will have a workstream dedicated to working with communities to address health inequalities.

14.4 The PEGASUS programme is set to partner with current mental health service users, along with mental and physical health care professionals, in the co-creation of a group clinic. This clinic's objective is to mitigate CVD risk for all individuals with SMI. The research team includes members who have personally used mental health services, ensuring their unique insights are integrated into shaping the research direction.

15.0 COVID Remembrance Plaques Unveiled

15.1 A further four COVID Remembrance plaques have been unveiled by the Trust Chair and myself at key Trust sites: City & Hackney Centre for Mental Health, The John Howard Centre, East Ham Care Centre and Trust Headquarters. The plaques aim to mark the outstanding work and enduring spirit of staff during the challenging times of the pandemic.

15.2 The events have been an opportunity for local leads to pay tribute to staff who set aside their own needs and the needs of their families to be at work supporting patients, service user and their colleagues. They have been a chance to express the gratitude of the Trust Board to staff, and to acknowledge the ongoing impact of the pandemic on service demand. They have also been an opportunity to remember all those who lost their lives to COVID-19. The plaques remember ‘A

time of Quiet Courage' which exemplifies the manner in which staff supported the national effort.

16.0 NHS 75 Celebrations

16.1 The Trust fully marked NHS 75 with two events, one in Bedfordshire and one in East London to come together with staff, service users, patients, governors and members of the public.

16.2 The Bedfordshire Big NHS 75 Show celebration took place at The Forest Centre in Marston Moretaine on 5 July. It included the NHS 75 King, Colin Goodship, who was born on 5 July 1948 so was the same age as the NHS. Bedfordshire, Luton and Milton Keynes Integrated Care Board (BLMK ICB) and BCHS services were among the many stallholders present at the event. I had the pleasure of welcoming people to the event and talked about the evolution of the NHS since 1948 and how proud I am of the work of the Trust and staff.

16.3 A second NHS 75 took place on 12 July for East London in Toynbee Hall, Aldgate. Over 120 people enjoyed NHS 75 cupcakes, fruit and refreshments. A special guest was a 95 year old retired nurse who trained and work in East London her whole life. Chair Eileen Taylor addressed the crowd and talked about how valued the NHS is by people and the value of care provided on the basis of need rather than the ability to pay.

16.4 Staff who share the same birthday as the NHS were invited to a special birthday lunch with myself and Deputy Chief Executive and Chief Nurse, Lorraine Sunduza. I also wrote to all staff on 5 July reflecting on the journey of the NHS and the many medical, technical, scientific and pharmaceutical breakthroughs it has seen, as well as the pressures and challenges it has faced and continues to face. Staff from all corners of the Trust also donned their running shoes to take part in park runs to celebrate the 75th anniversary of the NHS.

16.5 The Trust will be presenting staff with a special commemorative NHS 75 pin as a keepsake to remind them that they have played their role in the national health of the population.

17.0 Events and Awareness Days

17.1 The Trust also marked a number of events and awareness days over the past two months to pledge our support and recognition of these.

17.2 40 staff attended London Pride on Saturday 1 July. The LGBTQ+ staff network organised an ELFT blimp inflatable which was tied to four staff at all times to anchor it.

17.3 We marked Armed Forces Day on 24 June with a series of blogs on the Trust website and social media to highlight the challenges faced by veterans. Additionally, an afternoon event took place in Leighton Buzzard for veterans.

17.4 On 22 June, the Trust published the story behind Windrush Day on the ELFT website and internal staff bulletin, and used social media to mark the contribution

in 1948 of the first 1,000 passengers from the West Indies and the continuing contribution of staff today.

17.5 A number of events took place across the Trust for Carers Week during 5-11 June to celebrate carers and provide a hub for resources and networking. The Trust also published some blogs from staff about the challenges of being a carer which had high readership on social media.

17.6 The theme for this year's Dying Matters Awareness Week from 8-14 May was talking about death, grief and dying in the work place. Chief People Officer Tanya Carter and Emma Robinson, Tower Hamlets Deputy Lead Nurse/End of Life Lead hosted a session for staff about starting conversations when a staff member is bereaved or supporting a close family member, what can help and what does not help.

17.7 A series of events took place locally for Learning Disabilities Awareness Week. Staff joined forces with local voluntary sector group activities.

17.8 The Trust used the opportunity of the focus on men's health during Men's Health Week (12-18 June) to launch a Trust Men's Health Staff Network alongside our other staff networks. We also published a series of blogs from high profile ELFT staff talking about their own approach to their health.

18.0 Awards

18.1 *Royal College of Psychiatry Awards*
Dr James Cai won the RCPsych 'Foundation Doctor of the Year' category in recognition of his proactivity in supporting QI colleagues with their Right Support, Right Time project.

18.2 *Community Children's Matron in Top 75 Nursing Times List*
Newham Community Children's Matron, Rebecca Daniels, at ELFT has been named as one of 75 nurses and midwives to have made a significant contribution to their services. She was singled out for her caring support for babies, children and young people (BCYP) with life limiting care needs at home and at school.

18.3 *HSJ Digital Awards 2023 for Bedfordshire Collaboration*
The Bedfordshire Community Health Service Single Point of Access team alongside NHS East of England, East of England Ambulance Service Trust (EEAST), BCHS and other partner urgent community response teams have received the Improving Urgent and Emergency Care Through Digital Award at the HSJ Digital Awards 2023. The award was for the Access to the Stack programme and the use of the cleric digital portal enabler for transferring patients to urgent response teams.

18.4 *Global Research Professorship Award*
Newham Consultant Paediatrician Dr Michelle Hays has been appointed to a Professorship at the National Institute for Health and Care Research (NIHR). The Global Research Professorship Award, which is NIHR's flagship career development award, aims to enable key industry research leaders to strengthen research leadership in academia. They are awarded to academic leaders with proven track-records of applied health research across low-or-middle-income

countries (LMICs). Recipients of the award will receive up to £2 million from 2023-2028 to fund their research and support teams, in addition to leadership development.

18.5 *RCN Foundation Impact Award*
Fartun Ali, a staff nurse working in forensics services at the John Howard Centre in Hackney, has been awarded a Margaret Parkinson Into Nursing Impact Award by the RCN Foundation. She won the award for her outstanding achievement in pre-registration student nursing and midwifery. The award comes with a grant to enable her to pursue research for an MSc in Mental Health Nursing.

18.6 Plans are also underway for our Staff Awards Ceremony and party to acknowledge the work and achievements of staff across the whole Trust. The event will take place on 19 October. The nomination window closed at the end of June and we have received 600 nominations, almost double the usual number.

19.0 Announcements

19.1 Dr Cathy Lavelle has been appointed as the Trust's Medical Director for Children's Services and for the NCEL (North Central East London) CAMHS Provider Collaborative New Care Models programme. Cathy's ELFT Medical Director role will include the New Models of Care for CAMHS as well as all Trust CAMHS services and SCYPS (Specialist Children and Young People's Services). She moves from her current role of Clinical Director for ELFT Children's Services and Clinical Director for the NCEL CAMHS Provider Collaborative from July 1, 2023.

19.2 Dr Sarah Dracass has been appointed as Medical Director for the Adult/Older Adult Mental Health Inpatient and Urgent Care Pathways in North East London. This joint role will cover Inpatient Services in ELFT and Inpatient and Urgent Care Services in NELFT. It is a new role which is being piloted to provide leadership that enables ELFT and NELFT, working closely together, to deliver high quality inpatient care in a responsive manner whenever it is needed for people across the North East London area. Sarah will be working across both Trusts and in close collaboration and collectively with other clinical leaders, managers, patient leaders and other stakeholders in the Trusts and the wider systems.

She has been Clinical Director in Tower Hamlets for six years and a consultant in the Tower Hamlets Early Intervention Service and a trainer for Junior Doctors on the East London rotation for 11 years.

19.3 Following the appointment of Chief Nurse and Deputy Chief Nurse, Lorraine Sunduza, as Interim Chief Executive, I am delighted to be able to report that Claire McKenna has been appointed Interim Chief Nurse from 21 August. Claire has extensive nursing knowledge and experience in ELFT. For most of her early career Claire specialised in Child and Adolescent Mental Health services, working her way up to being Service Manager and Lead Nurse for the Coborn Centre for Adolescent Mental Health. She then moved to become Lead Nurse for the Newham Centre for Mental Health and then most recently Director of Nursing, Luton and Bedfordshire Mental Health Services. Claire has also for

many years been the Network Lead of ELFTAbility, the Trust's staff network for people with disabilities. She has been a role model as she is very open about having dyslexia, the impact of this and how the Trust can support people so they can flourish in their roles.

19.4 I am also pleased to report that our new Chief Pharmacist, Dr Stuart Banham, joined us on 1 June 2023. Stuart was previously the Chief Pharmacist in Herefordshire and Worcestershire Health and Care Trust, a mental health and community health trust like ours, and has a range of experience in different settings, including working as a senior pharmacist in an acute trust and in an ambulance service.

I would like to take this opportunity to thank our Deputy Chief Pharmacist, Andrea Okoloekwe, who has acted in this role on an interim basis for the past 2 years. She stepped into this role in the midst of the pandemic and was instrumental in rapidly setting up pharmacy arrangements when ELFT was selected to be the lead provider of the vaccination programme, on top of her mainstream pharmacy workload. We are indebted to her for her leadership during this time, and have valued her hard work and dedication in supporting services and patient care.

19.5 I would also like to take the opportunity to thank Angela Bartley, Consultant in Public Health and Director of Population Health for all her work within the Trust. Angela is leaving the Trust to undertake a PhD, and I would like to thank her for all her work in establishing public health within the Trust, driving our work as a Marmot Trust, and for her enormous contribution to work on population health.

20.0 Action Being Requested

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

NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
27 July 2023

Title	Integrated Care & Commissioning Committee (ICCC) 13 July 2023 – Committee Chair's Report
Committee Chair	Richard Carr, Non-Executive Director and Chair of Integrated Care and Commissioning Committee
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 Integrated Care and Commissioning Committee (ICCC) meeting held on 13 July 2023.

Key messages

Annual Population Health Report

- The report presented an update on progress against the strategic priority around population health, showcasing examples of the work ELFT has undertaken in the last year and giving recommendations against each objective
- An editorial group comprised of the public health team, colleagues from people participation and service users shaped the content and recommendations; the recommendations are organised based on the six strategic priorities, consideration of spend within the system and need for wider services to be aligned towards prevention
- The report also contained specific data packs on population health for every area of the Trust aimed at assisting with service planning
- Three key headline messages were identified from the recommendations for greater traction within the Trust and amongst partners: the scope for expansion of the Healthier Wealthier Families initiative, the drive to provide local employment for service users and young adults, and the focus on improving the physical health of service users
- Work with a graphic designer will ensure the report is easy to read and navigate, and there are proposals for promoting ELFT's population health work to a wider audience
- The committee requested further articulation around methods for translating the strategy into operational plans and a more explicit demonstration of how this work supports delivery of both ICS strategies.

Collaboratives: In its discussions on the development of the collaboratives in Bedfordshire, Luton & Milton Keynes (BLMK) and North East London (NEL), the committee highlighted the importance of maintaining momentum on outcomes for service users and suggested that this could be a useful focus for Non-Executive Directors when engaging with ICB colleagues.

BLMK Mental Health, Learning Disabilities and Autism Collaborative

- The strategy and outcome priorities were identified at a service user and carer led summit in March and are being developed into a vision, key themes and drivers to underpin the strategy across clinical networks and place based plans
- A paper will be taken to the ICB in September requesting permission for a shadow launch of the collaborative with a joint committee and pooled commissioning arrangements
- Place based design workshops planned for July and September will ensure inclusivity and the determination of how the ICS functions will be discharged by the collaborative will also be workshopped
- A new people participation lead has been appointed to lead on development of the expert by experience capacity, and senior leaders have received coaching around bold and creative innovation in order to re-imagine commissioning with partners
- A communications plan is being developed with the expert by experience group along with a collaborative identity
- Next steps include working alongside partners who have existing relationships with children and young people with learning disabilities and autism at place, with an appreciative enquiry approach around what works well and where improvements could be made.

NEL Mental Health, Learning Disabilities and Autism Collaborative

- Work to identify a clear set of functions that will be delegated into a future joint committee is ongoing
- Improvement networks are maturing, particularly with links between the children and young person's network and North Central & East London (NCEL) CAMHS collaborative around joint coordination to secure non-recurrent funding
- The profound and positive effect of the involvement of lived experience leaders is helping to raise profile of learning disabilities and autism in a positive way
- A process of peer consulting to understand the cost benefit and value of the spend in NEL took place with two workshops gathering intelligence from service users and carers on how the services are operating
- First joint Working Together group for ELFT and NELFT is planned for July bringing together groups of lived experience leaders
- The ICS restructure is having an impact on the operating model for the collaborative; however, it has afforded the opportunity for joint roles to be explored
- A number of projects are under way and more granular detail of these will be brought to a future meeting.

NEL Community Services Collaborative

- Work taking place to define the scope of this collaborative around accountability, how it will feature in future planning rounds and the resources it will have available
- Present focus is on strengthening governance, developing co-production, sharing learning from the MHLDA collaboratives and developing a community services mapping exercise
- The committee acknowledged the ongoing challenges in this area and encouraged a keener focus on two or three tangibles that can provide measurable delivery outcomes by year end.

BLMK Joint Forward Plan

- The plan identifies the priorities of the BLMK ICS to deliver an integrated care strategy and the key opportunities to improve outcomes with a focus on partnership working, cross cutting programme areas and forward planning; further discussion required around the operationalisation of these strategic priorities
- Ongoing system challenges around finance, an aging and growing population and inequalities are highlighted, noting that the Mental Health, Learning Disabilities and Autism Collaborative provides an important mitigation against some of these challenges
- The committee highlighted the opportunity for the plan to read across to the population health report and become a system owned strategy.

Board Assurance Framework – Risks 1, 2 and 9

Risk 1: *If the Trust does not build and sustain the right organisational capability and capacity to support integrated care this may impact adversely on our ability to deliver our strategic objective to improve population health*

Risk 2: *If the Trust does not build and sustain effective partnerships with other health, care, voluntary sector and other key organisations, this may impact adversely on our ability to deliver the Trust strategy*

Risk 9: *If the Trust does not effectively manage its commissioning responsibilities and associated risks as a lead provider or lead commissioner, this will impact on the quality and experience of care for service users and patients*

- There has been no response to date from the NHS England around conditions required for the development of the proposed perinatal new models of care provider collaborative
- A new strategy for the NCEL CAMHS collaborative has been finalised and the score will be reviewed once a detailed operational plan is in place
- There were no changes proposed to the risk scores for risks 1, 2 and 9, and agreement that appropriate controls are in place and operating effectively.

Previous Minutes: The approved minutes of the Integrated Care & Commissioning Committee are available on request by Board Directors from the Director of Corporate Governance.

NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
27 July 2023

Title	People Participation Committee (PPC) 16 June 2023 – 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 (PPC) meeting held on 16 June 2023.

Key messages

Trustwide Working Together Group Priorities Update: Peer Support Workers

- TWWTG priorities identified by service users and carers is a focus for the Trust throughout the year. The PPC receives updates on one of the priorities at each meeting
- Significant progress has been made with the embedding of peer support workers within teams with proactive approaches now being made by teams
- The infrastructure has improved with an Executive lead for peer support – Lorraine Sunduza; a peer support training lead is now also in post and is reviewing training development and career progression opportunities; Borough lead peer support workers are also now in place to support the development of peer support alongside teams
- Working with some partner Trusts on transferrable training so that people can move between Trusts to minimise having to repeat training
- The digital team is aiming to develop a digital package for service users although there are funding challenges
- Sharing success stories was requested as these could be used by the Working Together Groups to encourage others to undertake the training.

Crisis Services

- Discussions took place on the meaning of 'crisis' and crisis prevention
- Challenges shared included the focus by services on crisis lines; the pressures in A&E and the experience of patients with mental health difficulties who present in A&E; the language can seem punitive and crisis is not specifically related to mental health. Current financial
- Examples of good practice shared included drop in centres at autism hubs in some London boroughs to help with daily tasks in life which can help avert crisis
- A range of suggestions to improve and support the challenges were discussed, some of which are already being taken forward, include enhancing early intervention as pre-crisis support and preventative elements of care; being in work can be valuable by providing routine and purpose so providing opportunities such as through peer support worker roles can be effective; every contact counts; regular contact can be an effective way of helping people not go into crisis; GPs being involved more to avoid repetitive conversations; more people to be trained in mental health first aid
- There is an opportunity of establishing a 'crisis think tank' across Trust partners to focus on prevention work
- Meetings will be arranged to review what works and identifying the measures of success.

Carers Strategy

- The carers, friends and family strategy is aligned to the Trust's vision and sits alongside plans produced in local areas; the aim is to recognise the importance of carers for our community and that they are partners working alongside the Trust
- The five priorities are:
- Improving identification and recognition of carers, including young carers

- Staff being aware of carers and trained to engage with carers effectively
- Clear pathways to access support for carers and help in a crisis
- Carer voice and involvement
- Ensuring the right support is in place for young carers
- A Carers Strategy Implementation Group has been established to share what is working well, any challenges and learning; the aim is to ensure the strategy is understood and implemented consistently across the Trust
- Introducing measurements of success is challenging; the starting point will be identifying and recording carers' information on RiO
- The financial implications for carers is challenging; the ELFT Charity has supported an initiative that assists families who look after children to access benefits and this has seen some significant financial benefits to families
- Next steps include carers' awareness training; and intranet and internet options to ensure information is easily accessible for carers
- The committee recommended the establishment of a carer support group and the development of a vision of what a 'good life' for a carer looks like and supported the idea of introducing carer support workers

Terms of Reference

- The updated terms of reference were approved (attached at appendix 1)
- The terms had been updated in particular on strengthening how the committee will review the quality of services provided by the Trust and reflecting the influence the Trust has on embedding people participation approach in both ICSs where the Trust provides services.

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:*

- Continued development of PP with PP leads recruited for AHPs, and specialist drug and alcohol services; EDI PP lead being advertised and plans in place to recruit a PPL for estates and facilities. In addition two new patient safety partners with lived experience have been appointed to work across patient safety and PP
- A new training lead is in place focusing on the development of new roles and reviewing career development
- Continuing to work with partners in the Integrated Care Systems – leading on the recruitment for PP leads in both NEL and BLMK
- The Committee agreed there were no changes to the risk score and that appropriate controls are in place and operating effectively, and requested future reports included a progress update together with next steps.

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

East London
NHS Foundation Trust

People Participation Committee

Terms of Reference

1. Authority

1.1 The People Participation Committee (Committee) is constituted as a standing committee of the Trust's Board of Directors (Board). Its constitution and terms of reference are set out below, subject to amendment and approval by the Board.

1.2 The Committee is authorised by the Board to act within these terms of reference.

1.3 The Committee is authorised to obtain such internal information as is necessary and expedient to fulfil its duties. All members of staff are expected to co-operate with any request made by the Committee.

1.4 These terms of reference shall be read in conjunction with the Trust's Scheme of Delegation, Standing Orders, Constitution and Standing Financial Instructions as appropriate.

2. Purpose

2.1 The Trust puts service users and carers at the centre of everything that we do. The Committee demonstrates the Trust's commitment to public involvement by bringing Governors, people participation and members of the Trust's Executive Team together with service user and carers from the Working Together Groups (WTGs).

2.2 At the Committee meetings, the delivery of our health services is discussed at a more strategic level. We want service users and carers to have a say in how we run the Trust because we believe that they are experts about services through using them and through lived experience. It is about working together so that we can offer a better service for all.

2.3 The Committee's purpose is to provide the Board with assurance on the Trust's overall approach to people participation and ensure that there is a culture of continuous, positive improvement driven by engagement and co-production with people with lived experience in the communities we serve.

3. Duties

3.1 Agree and review the Trust-wide Working Together Group (TWWTG) priorities.

3.2 Review the quality of services provided by the Trust by:

- Receiving regular progress updates on the TWWTG priorities
- Receiving progress updates at each meeting on directorates' TWWTG priorities through presentations by Borough Directors/Directorates
- Considering information on the process of engaging, listening and acting on feedback from the communities we serve in relation to the quality of our services
- Bringing to the attention of the Executive Team issues that could not be resolved by the WTGs and updates on the many and varied different ways that the public are being involved in the Trust.

3.3 Improve people participation with a focus on recovery, population health and service improvement.

3.4 Receive progress reports on how and the impact of the Trust collaboration to embed people participation in both the Integrated Care Systems where the Trust provides services.

3.5 Support and oversee the development of the people participation, carers and volunteers' strategies, and subsequently recommend them to the Board for approval.

3.6 Monitor the implementation of both the people participation, carers and volunteers' strategies ensuring they are delivered in a proactive and efficient way, driving improvements in patient experience.

3.7 Ensure that a culture of people participation is embedded in the Trust to support our service improvement projects, quality reviews and other developments

3.8 Ensure learning from people participation is embedded in the day to day co-production, service delivery, service redesign and transformation work.

3.9 Ensure the needs and interests of service users are taken into consideration with particular focus on diversity and inclusion.

3.10 Working with the Council of Governors' Communications & Engagement Committee, contribute to the development and review of the Trust's Membership Engagement Plan on an annual basis for approval by the Council and Trust Board

3.11 Review and monitor any risks from the Board Assurance Framework relating to improving patient experience that have been assigned to the Committee by the Board.

4. Membership

4.1 The members of the Committee will be appointed by the Board and comprise:

- Two Non-Executive Directors, one of whom will be the chair of the Committee
- Chair of the Trust
- Director of People Participation
- Chief Executive
- Chief Medical Officer
- Chief Nurse
- Chief Operations Officer
- Corporate Governance Manager
- Director of Corporate Governance
- Two Governors (self-nominations for each meeting, coordinated by the Corporate Governance Manager)
- Senior People Participation Leads
- Working Together Group representatives (two to be elected at each Working Together Group/User Involvement Group).

4.2 The chair of the Committee shall be appointed by the Board.

4.3 In the absence of the chair of the Committee, one of the other Non-Executive Director members will chair the Committee meeting.

5. Quorum

5.1 A quorum shall be seven members of whom one must be a Non-Executive Director, one must be an Executive Director and at least four must be non-staff members (service users and carers).

5.2 If the Committee is not quorate, the meeting may be postponed at the discretion of the Committee chair. If the meeting takes place and is not quorate, no decisions may be made at this meeting and such matters will be deferred until the next quorate meeting.

6. Attendance at Meetings

6.1 All members are expected to attend each meeting.

6.2 Borough/Service Directors and other staff or other representatives may be invited by the Committee chair to attend for all or part of any meeting as appropriate.

6.3 The name and role of those attending the meeting will be recorded; Working Together Group (WTG) members representing may request for their name not to be included.

6.4 Attendance at meetings may be by face to face or remotely. Remote meetings may involve the use of telephone and/or electronic conference facilities. Any Committee member with the agreement of the Committee chair may participate in a meeting by way of telephone, computer or any other electronic means of communication provided that each person is able to hear and speak. A person participating in this way is deemed to be present in person although their actual location shall be noted in the minutes; and will be counted in a quorum and entitled to vote.

7. Support to the Committee

7.1 The Director of Corporate Governance and Director of People Participation will jointly act as Company Secretary to the Committee and working with the Executive Director lead will:

- Agree the agenda with the chair of the Committee
- Ensure that meeting papers are distributed in good time
- Ensure that all the minutes are taken, action points and matters arising are recorded and followed up
- Advise the Committee on pertinent areas
- Draft the assurance report for the Board following each Committee meeting
- Draft the Committee's annual report of the review of its effectiveness and reviewing the terms of reference.

8. Frequency of Meetings

8.1 The Committee will meet at least four times a year and as required to fulfil its duties as the Committee chair shall decide.

8.2 Where a decision needs to be taken outside the normal cycle of meetings, and where the matter is not deemed by the Committee chair to require an additional meeting to be called, the decision may be made via email. This approach will be used on an exceptions basis. Decisions via email will be reported to the next meeting and the wording of the decision minuted.

9. Conflicts of Interest

9.1 Where Committee members are involved in discussion, care should be taken to recognise and avoid conflicts of interest.

9.2 Where a Committee member or attendee has an interest, or becomes aware of an interest which could lead to a conflict of interest in the event of the Committee and subsequently the Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, is subject to the provisions of the Trust's Standards of Business Conduct Policy or other protocols or arrangements relating to the management of Conflicts of Interest.

9.3 At the beginning of each meeting as a standing agenda item, the Committee chair will ask members to highlight any conflicts of interest and identify any items/issues that may raise a conflict of interest for any Board member.

9.4 If any member or attendee has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that interest as early as possible and not participate in the discussions. The Committee chair has the authority to request that member or invitee to withdraw until its consideration has been completed.

9.5 An up to date Register of Interests will be available on the Trust's website for public scrutiny.

10. Reporting and Minutes

10.1 The Committee chair will provide an assurance report to the Board after each meeting; this will be drafted by the Director of Corporate Governance. The report will set out the matters discussed together with any recommendations to the Board.

10.2 The Committee chair will highlight to the Board any pertinent issues and/or those that require disclosure, escalation, action or approval of the full Board.

10.3 The minutes of the Committee meetings will be formally recorded and a draft copy circulated to Committee members together with the action log as soon after the meeting as possible.

10.4 The Council of Governors via its Communications & Engagement Committee will receive regular updates from their Governor representatives on the People Participation Committee and in particular identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

10.5 The approved minutes will be available to the Board on request.

10.6 The Committee will report to the Board annually on its work. The report will highlight the progress made within services as well as those issues that have been more difficult to improve. This report will inform the section on people participation and patient experience in the Trust's Annual Report.

10.7 The Committee will receive and agree a description of its work (in the form of an annual forward plan) and review progress against this plan.

11. Review

11.1 The Committee will undertake an annual review of its effectiveness and provide a report to the Board of its findings, highlighting areas for improvement

11.2 Terms of reference will be reviewed annually and presented to the Board for ratification.

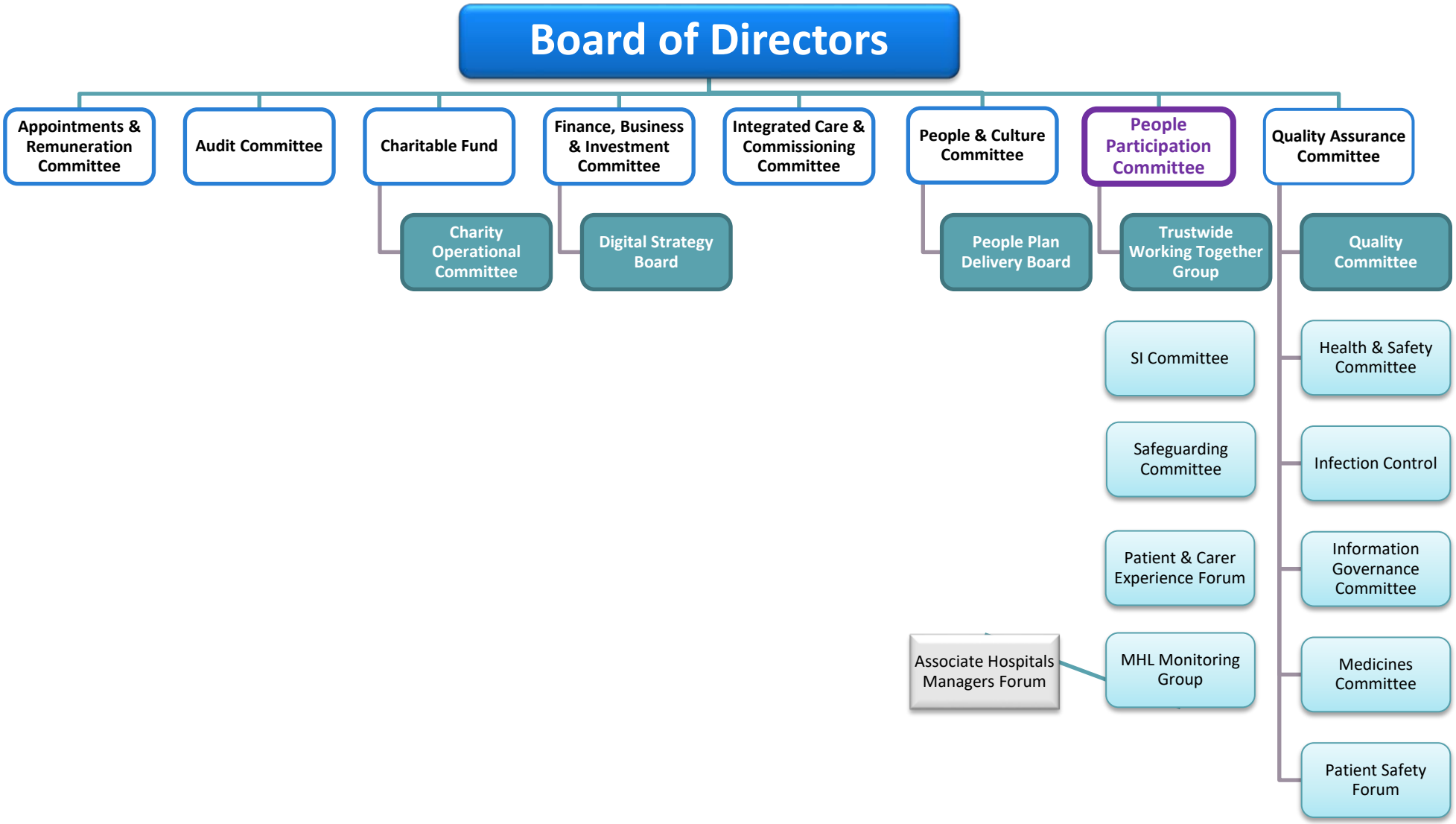
12. Review Dates

12.1 Terms of reference were last reviewed and approved in:

- September 2021

12.2 Next review date:

- June 2024


Board of Directors
Appointments & Remuneration Committee
Audit Committee
Charitable Fund
Finance, Business & Investment Committee
Integrated Care & Commissioning Committee
People & Culture Committee
People Participation Committee
Quality Assurance Committee
Charity Operational Committee
Digital Strategy Board
People Plan Delivery Board
Trustwide Working Together Group
Quality Committee
SI Committee
Health & Safety Committee
Safeguarding Committee
Infection Control
Patient & Carer Experience Forum
Information Governance Committee
Associate Hospitals Managers Forum
MHL Monitoring Group
Medicines Committee
Patient Safety Forum

NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
27 July 2023

Title	Audit Committee Meetings held on 9 June, 29 June and 13 July 2023 – Committee Chair's Assurance Report
Chair of the meeting	Anit Chandarana, Non-Executive Director and Chair of the Audit Committee
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 Audit Committee extraordinary meetings held on 9 and 29 June 2023 and the Audit Committee held on 13 July 2023
- The Board is asked to ratify the following for publication on the Trust's website:
  - The Trust's self-certification declaration and corporate governance statement in respect of compliance with NHS England's provider licence conditions and requirements (appendix 2)
  - The Trust's Modern Slavery and Human Trafficking statement 2023 (appendix 3).

Key messages

Joint summary of key messages from the meetings held on 29 June and 13 July 2023

External Audit Progress Update

- At the Audit Committee meeting on 13 July 2023 the Trust's external auditors Mazars LLP confirmed substantial completion of the audit report. Three items reported as outstanding at the extraordinary Audit Committee meeting on 29 June are now resolved. A further slight amendment is possible following work on a technical issue around the Trust's Local Government Pension Scheme (LGPS) net asset ceiling; confirmation of the resolution of this is to be advised via email to committee members
- The receipt of assurance on the Trust's liability in relation to the LGPS remains a risk and will again impact on the schedule of publication and laying of the Trust's annual report and accounts before Parliament. Despite national discussions on this issue which affects other trusts and central government departments, there is currently no method to apply pressure on the LGPS fund auditors to accelerate their process which is expected to be completed by November 2023
- An alternative pathway to meet both the NHS deadline for receipt of the annual report and accounts and the laying before Parliament is to accept a qualification on the accounts; however, this is not an option the Trust is prepared to take
- The committee approved the draft annual report and accounts and welcomed the expected presentation of a final completion report, with the exception of the delayed assurance on the final LGPS position, at the September Audit Committee meeting
- The Committee thanked both Mazars and the finance team for the positive experience and assurance provided this year and noted a detailed debrief session between the two teams will be undertaken with any resulting actions to be monitored and reviewed by the committee.

Annual Report and Accounts 2022-2023

- Due to the implications of the delay in being able to finalise the annual accounts and the knock-on effect in the presenting of the 2022-2023 annual report and accounts to members and the Council of Governors, the Chair, CEO and CFO will present an overview of the annual report and accounts together with an explanation of the cause of the delay at the Council's meeting in September. Mazars also offered to attend to answer any questions.

Internal Audit Progress Update

- The Trust's data security and protection toolkit received substantial assurance with the one resulting action already evidenced and closed. Further assurance received that business continuity, data retrieval and disaster recovery plans are fully tested in line with NHSE requirements and whenever any systems experience a shutdown
- A strengthening of controls around the process for exit payments was noted following a review with one action agreed around training for both existing and new managers

- The committee requested further assurance on the delayed actions in relation to local authority section 75 agreements.

Cyber Security
- An update on the current cyber security landscape was provided with the work being undertaken to increase ELFT's resilience to the increasingly high level of threat to the NHS highlighted
- Assurance was received around the actions the Trust's cyber team have taken in direct response to the recent data exfiltration at Barts and the defending and blocking of an attempted targeted cyberattack in January 2023; however, the need to continue to practice speedy and robust business continuity plans was emphasised.

Counter Fraud Update
- A recent benchmarking exercise against 25 mental health trusts showed ELFT as having the highest number of fraud and Covid vaccine fraud referrals. Although this may be a demonstration of a strong reporting culture, the committee urged no complacency around this
- System weaknesses in the National Immunisation and Vaccine System (NIVS) resulted in a high level of Covid vaccine pass fraud and this has been fed back to the supplier and NHSE
- The updated counter fraud and bribery policy was approved.

BAF Risk 7 Financial Viability – Deep Dive
- A deep dive into the Trust's financial viability risk in light of the non-achievement of target in 2022-2023 was presented; to date £18.45m of schemes have been identified against the target for 2023-2024 of £20.8m
- Examples of the ongoing work to embed an FV culture into directorate agendas and the larger proportion of schemes designed around recurrent transformation and waste reduction schemes were welcomed; clarity around ownership of plans and FV budgets note as a positive step towards driving this area of organisational change
- Some examples of transformational work in progress were provided and a recognition of the impact some centrally held schemes will have in releasing cash savings in multiple services Trust-wide, particularly in relation to digital and estates initiatives
- A recommendation to broaden the management actions in the BAF to develop a value improvement culture was approved and a rewording to sharpen the focus on accountability and ownership of plans with a greater emphasis on efficiency and the need for recurrent savings going forward was requested
- The committee urged some caution around the profiling of scheme deliveries which is heavily weighted towards Q3 and Q4.

Board Assurance Framework
- The Committee approved the combining of the people risks 5 and 6 following a recommendation by the People & Culture Committee due to significant overlap and duplication of actions; risk 5 has been reworded accordingly
- A recommendation to increase the current risk score from Significant 16 to 20 and the target risk score from High 9 to High 12 was also agreed based on the increasing external factors impacting on recruitment, retention and wellbeing which the Trust has limited control over
- Further assurance on the examination of associated risks by other committees was requested
- The BAF summaries are attached at appendix 1.

Annual Review of Standing Financial Instructions
- Once finalised, it is the intention for the SFIs to be standardised across the system.

NHSE Self-Certification and Corporate Governance Statement
- 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 declaration and corporate governance statement for ratification by the Trust Board (attached at appendix 2).

Key messages from the meeting held on 9 June 2023

External Audit Update

- Mazars LLP confirmed that good progress is being made against the audit completion plan and a positive report on findings and value for money is expected to be confirmed at the additional Audit Committee meeting on 29 June 2023
- No areas of concern found in relation to the significant risks around management override controls of journals and accrual issues previously identified; fraud and revenue expenditure recognition and the valuation of land and buildings work are both in the process of being finalised with no issues to highlight
- Mazars have undertaken specific work to ensure accurate and timely disclosures on exit packages, assurance around IFRS16 calculations and a review of PFI accounting
- A significant risk remains around the timely receipt of assurance on the Trust's Local Government Pension Scheme (LGPS) liability which again impacts on the schedule of publication and laying of the Trust's annual report and accounts before Parliament. The committee requested a list of options to mitigate this risk be presented, noting that there are national discussions under way around this issue as it affects other trusts and central government departments
- The collaborative and constructive relationship that has fostered a smooth external audit process this year was acknowledged, and both Mazars and the finance team were thanked for their contributions to this.

Annual Report and Accounts 2022-2023

- The annual governance statement also includes details of the actions taken to strengthen internal controls around exit packages as reported in 2021-2022 along with confirmation of the retrospective Treasury approval which raised no further issues
- The committee recommended a strengthening of the statements around the Trust's capacity to handle risk with an emphasis on the valuable role people participation plays in our understanding and triangulating of risk, as well as how the risk framework evidences how seriously the Trust takes issues such as cyber security.

Asset Valuation

- Assurance was received around the valuation of land and buildings, following both desktop and physical valuations undertaken by a team of external valuers, noting however that the ongoing impact of inflation on replacement building costs has driven an increased valuation position.

Internal Audit Update

- The internal audit annual report was received; the head of audit's opinion places the Trust at level 2, i.e. 'having an adequate and effective framework for risk management, governance and internal control, with further enhancements identified to ensure it remains so'
- Confirmation received that, with follow up actions prioritised by the Exec team, all outstanding reports for 2022-2023 are now concluded
- Further assurance was provided by the Chief Digital Officer around areas of improvement identified in the secure remote working report and that a detailed action plan is in place
- The committee commended the valuable level of assurance provided to the Trust by the work of the internal audit team.

Counter Fraud Update

- The committee welcomed confirmation that all new staff are now completing fraud and bribery training as part of their induction programme and the extension of this to include bank staff who are employed on a regular basis
- Work has been undertaken with people and culture to develop processes and timeframes to assist with more timely responses on actions and recommendations following investigations
- The counter fraud annual report was received which confirmed ELFT being assessed as green for 2022-2023 with the maintenance of compliance levels.

Waivers and Breaches Report

- Assurance received on a robust process of review, scrutiny and follow up which has led to a reduction in the number of waivers and their value during 2022-2023.

Charitable Funds Annual Review 2022-2023

- Focused work is continuing to encourage equity between the number of bids being received from Bedfordshire and Luton against those from East London
- Grants provide the opportunity for innovative projects to benefit service users; however, this needs to be balanced with further assurance to evidence that funds are being used for their intended purposes
- The amount of work that has been completed to finalise the set-up of the charity including the formulation of four key principles for bid submissions, fund consolidation and raising of the fund's profile Trust-wide was acknowledged.

Governance Compliance Statements

- **Fit and Proper Persons Requirement:** The Trust has demonstrated its compliance with the Health and Social Care Act regulations and in providing assurance for the public that all Board Directors remain fit and proper for their roles. The declaration is included in the Chair's Report to the Trust Board for 27 July 2023 meeting.
- **Modern Slavery and Human Trafficking Statement:** Having received appropriate assurance that the Trust is taking all steps to ensure modern slavery and human trafficking is not taking place in our business, with staff or within the supply chain, the Committee approved the statement (subject to a review of the wording around the Trust's ability to fully mitigate risks in every supply chain) for ratification by the Trust Board and for publication on the Trust's website (attached at appendix 3).

Review of Internal Audit and Counter Fraud Services

- A private session was held to conduct the annual performance reviews of the Counter Fraud and Internal Audit teams.

Previous Minutes: The approved minutes of the previous Audit Committee meetings are available on request by Board Directors from the Director of Corporate Governance.

Appendix 1: Board Assurance Framework - Dashboard

BOARD ASSURANCE FRAMEWORK 2023-20234: Dashboard												
Strategic Priority	**Risk No**	**Risk Description**	**Executive Lead**	**Lead Committee**	**Risk Score**							
					Resi-dual	**Apr/ May**	**Jun/ Jul**	**Aug/ Sept**	**Oct/ Nov**	**Dec/ Jan**	**Feb/ Mar**	**Target**
Improved population health outcomes	1	If the Trust does not build and sustain the right organisational capability and capacity to support **integrated care** this may impact adversely on our ability to deliver our strategic objective to improve population health	Executive Director of Integrated Care	ICCC	**12**	**12** ↔	**12** ↔					**8**
	2	If the Trust does not build and sustain **effective partnerships** with other health, care, voluntary sector and other key organisations, this may impact adversely on our ability to deliver the Trust strategy	Executive Director of Integrated Care	ICCC	**12**	**8** ↔	**8** ↔					**8**
	9	If the Trust does not effectively manage its **commissioning responsibilities** and associated risks as a lead provider or lead commissioner, this will impact on the quality and experience of care for service users and patients	Executive Director of Commercial Development	ICCC	**12**	**16** ↑	**16** ↔					**8**
Improved patient experience	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	Chief Executive	PPC	**12**	**12** ↔						**8**
	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	Chief Nurse	QAC	**12**	**12** ↔	**12** ↔					**9**
Improved staff experience	5	If issues affecting **staff experience** including the recruitment and retention of people with the right skills are not effectively planned for and addressed, this will adversely impact on staff motivation, engagement, retention and satisfaction	Chief People Officer	P&CC	**16**	**20** ↑						**12** ↑
Improved value	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	Chief Finance Officer / Chief Nurse	FBIC	**12**	**16** ↑	**16** ↔					**9**
	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	Chief Digital Officer	FBIC	**20**	**20** ↔	**20** ↔					**8**

Risk Matrix					
Likelihood/ Frequency ↓	**Consequence/Impact →**				
	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
5 Almost Certain	**Moderate 5**	**High 10**	**Significant 15**	**Significant 20**	**Significant 25**
4 Likely	**Moderate 4**	**High 8**	**High 12**	**Significant 16**	**Significant 20**
3 Possible	**Low 3**	**Moderate 6**	**High 9**	**High 12**	**Significant 15**
2 Unlikely	**Low 2**	**Moderate 4**	**Moderate 6**	**High 8**	**High 10**
1 Rare	**Low 1**	**Low 2**	**Low 3**	**Moderate 4**	**Moderate 5**

Trust Board Committees	
FBIC	Finance, Business & Investment Committee
ICCC	Integrated Care & Commissioning Committee
PPC	People Participation Committee
QAC	Quality Assurance Committee
P&CC	People & Culture Committee

Board Assurance Framework – Summary of Changes

BAF Risks	Updates
DEEP DIVE: Strategic Priority: Improved population health	
Risk 1 *If the Trust does not build and sustain the right organisational capability and capacity to support integrated care, this may impact adversely on our ability to deliver our strategic objective to improve population health* **Current risk score: 12 High** **Target risk score: 8 High**	• Continued progress in developing and influencing integrated models of care, both within Trust services, and across other partners, and building relationships with key influencers • Ensuring Trust response to current increased system demand pressures is fully developed and integrated with other providers
Risk 2 *If the Trust does not build and sustain effective partnerships with other health, care, voluntary sector and other key organisations, this may impact adversely on our ability to deliver the Trust strategy* **Current risk score: 12 High** **Target risk score: 8 High**	• Continued work to build knowledge and momentum around Mental Health Learning Disability & Autism and community collaboratives in NEL and an MHLDA collaborative in BLMK • Trust continues to demonstrate commitment, effort and capacity into working with partners to develop appropriate architecture that will support the Trust to continue to deliver its strategy
Risk 9 *If the Trust does not effectively manage its commissioning responsibilities and associated risks as a lead provider or lead commissioner, this will impact on the quality and experience of care for service users and patients* **Current risk score: 12 High** **Target risk score: 8 High**	Although there is a robust infrastructure in place, further consideration as to how this will work in practice to be given to the expectation that NMC programme will become part of the MHLDA collaborative
Strategic Priority: Improved experience of care	
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* **Current risk score: 12 High** **Target risk score: 8 High**	• Continued work with ICS and place structures to embed PP and co-production in ways of working to reduce the variation • BLK service user conference to set priorities for the ICS work on mental health • Recruitment of Specialist Directorate and two autism PPL roles • Developing PPL role in Estates and Facilities
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* **Current risk score: 12 High** **Target risk score: 9 High**	• Demand remains high in crisis services and bed occupancy. Trustwide QI programme on optimising flow; work led by CQO across NEL on standardising data and to understand causes of delays in each ED; focused work on mental health urgent and emergency care across NEL • Trustwide therapeutic engagement programme for inpatient teams commenced and being taken forward by each team as a QI project with clinical and service user input. Follow up learning session planned for March • Four CQC unannounced inspections February 2023 following information request for all SI related to inpatient deaths by suicide and incidents of serious self-harm of detained patients. Concerns raised on Gardner ward shared and addressed; no significant escalation feedback provided immediately following the visits. Headline feedback received with no indication of significant safety concerns. Focused report to be issued and learning will be applied to the Trust's CQC ongoing readiness work

BAF Risks	Updates
Strategic priority: improved staff experience	
Risk 5: *If the Trust fails to effectively plan for, recruit and retain people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy* **Current risk score: 16 Significant** **Target risk score: 9 High**	• Continued challenges to recruit to certain professional groups • Ongoing challenges to staff feeling valued in the context of industrial action owing to pay and the cost of living challenges • Progress with international recruitment activity across a number of professional groups • Interim winter rates for Bank staff until 31 March 2023 • Ongoing work to reduce agency spend • Focused work to improve the statutory and mandatory training/appraisal compliance rates • Repurpose the lead employer mass vaccination team to define projects to transform the P&C service
Risk 6: *If issues affecting staff experience are not effectively addressed, this will adversely impact on staff motivation, engagement and satisfaction* **Current risk score: 16 Significant** **Target risk score: 9 High**	• Co-produced approach to the development of a more ambitious equality plan with staff and network leads • 2022 National Staff Survey concluded with a Trust response rate of 33% compared to 48% in 2021 and an average of 47.0% for mental health, learning disabilities and community health services Trusts. Continuing discussions with NEL colleagues and London-wide HRD networks to identify reasons for low response rates • Trust is developing its just culture and trauma informed approaches work • Recent to staff on recognition, wellbeing and support has provided useful insights in terms of where to focus
Strategic priority: Improved value	
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* **Current risk score: 16 Significant** **Target risk score: 9 High**	• FV gap from target at end 2022/23 has meant reliance on non-recurrent measures to deliver breakeven/surplus, which is not sustainable. FV planning to date is short of the £17.5m target. Plans so far are not developed sufficiently to provide assurance that schemes will deliver from April 2023 onwards, so will continue to be mitigated by non-recurrent measures • Delivery of recurrent FV is a NHSE performance measure and across systems in demonstrating the Trust's ability to maintain financial stability, given the national and system reductions and constraints on income
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* **Current risk score: 20 Significant** **Target risk score: 8 High**	• There has not been a great deal of change • Main changes are due to lack of resilient links – 3 outages based on current provision. Manual remediation in place but takes time to implement • Cyber training for Board took place in January 2023 • Estates and Cyber Strategies presented at March 2023 FBIC • CPSG now also focuses on monitoring capital spend for both Estates and Digital

BAF Risk 1	If the Trust does not build and sustain the right organisational capability and capacity to support **integrated care** this may impact adversely on our ability to deliver our strategic objective to improve population health

Strategic Priority	Improved population health outcomes
Review Date	1 July 2023
Executive Lead	Executive Director of Integrated Care
Lead Committee	Integrated Care & Commissioning Committee

Risk Score 2023/2024							
Residual	Apr/May	Jun/Jul	Aug/Sept	Oct/Nov	Dec/Jan 24	Feb/Mar 24	Target
12	12 ↔	12 ↔					8

Context
• Trust continues to make significant progress in developing integrated models of care, both within Trust services, and across other partners, including primary care, social care, acute trusts and the voluntary sector • To properly move to the next stage of improving population health outcomes, and delivering the next stage of NHS LTP implementation, the Trust needs to ensure internal capability and capacity is developed to support transformation, in particular in delivering MHS and CHS around PCNs, and ensuring smooth and effective intermediate care (both rapid response and discharge to assess) between hospital and community • This includes delivering on the community mental health framework transformation, and the delivery of the Aging Well and Fuller programmes, both in B&L and London. These nationally defined integrated care programmes require sustained focus on service model, workforce, system leadership and digital/ informatics development. Also includes ensuring the Trust response to current system demand pressures is fully developed and integrated with other providers • Current specific issues include the delivery of social care functions on behalf of local authorities in Bedford Borough, Central Bedfordshire and Luton, in the context of demand and financial pressures, the community transformation agenda, and the forthcoming potential for review of s.75 agreement

Progress		
What's going well inc future opportunities	**What are the current challenges inc future risks**	**How are these challenges being managed**
• Community mental health transformation progressing, planning for next year underway with further substantive investment into community MH services; social work re-integration identified by Newham system exec as one of areas for 12 week LGA/Kings Fund development programme • System leadership module launched Jan 2023 • Integrated care competencies published • Marmot next steps in place and being mobilised • Fuller report publication with Trust-wide seminar planned for January 2023 to initiate more detailed focus and planning and work underway with partners in place-based systems • ELFT and CBC led pilot for neighbourhood working in Leighton Buzzard being evaluated; opportunity to align new B&L research hub (partnership between ELFT and University of Cambridge) for long term conditions to neighbourhood working to test new models of care	• Winter pressures, and requirements to ensure flow at a time of significantly increased demand • Financial environment uncertain, especially for CHS and pressures on LA budgets • Developing new service model for social care in Bedford, Central Bedfordshire and Luton • Finalising execution plan for population health strategic outcome • Tower Hamlets CHS review; moving from traditional commissioner-led process to more collaborative approach • Significant variation on virtual ward development; opportunity to capitalise on more community led model • New directors of adult social services in B&L • NEL ICB's management of change process may reduce system-wide capacity for supporting the planning and improvement of mental health, learning disabilities and autism, and community health services	• Executive leadership of/involvement in system response to winter and financial pressures • Meetings in place with B&L DASSs to take forward next steps in social care design • Public health team have developed population health metrics • New ELFT community health forum established to share learning and address variation in virtual ward development • Partnership work underway with Cambridgeshire Community Services to ensure a B&L-wide response to virtual wards and urgent and emergency care • Working closely with NEL and BLMK ICBs to ensure the right skills, capacity and capability is within our places to support integrated care
Risk score: Remains at High 12		

BAF Risk 2	If the Trust does not build and sustain **effective partnerships** with other health, care, voluntary sector and other key organisations, this may impact adversely on our ability to deliver the Trust strategy

Strategic Priority	Improved population health outcomes
Review Date	1 July 2023
Executive Lead	Executive Director of Integrated Care
Lead Committee	Integrated Care & Commissioning Committee

Risk Score 2023/2024							
Residual	Apr/May	Jun/Jul	Aug/Sept	Oct/Nov	Dec/Jan 24	Feb/Mar 24	Target
8	8 ↔	8 ↔					8

Context

- Trust continues to work purposefully and proactively to be a trusted system partner in our ICSs and place-based partnerships. Trust Executive have established excellent working relationships in our ICSs and where appropriate have taken on leadership roles for ICS programmes/workstreams
- The two ICSs have had different approaches to responding to the new system design framework/legislation. There are differences in approach across each of the place-based systems, as a consequence of differences in population needs and assets, patterns of services, relationships, history and politics. The Trust is working flexibly in response to the difference in each of the systems, whilst also sharing learning where this is applicable and appropriate
- Current strategic issues include the recent publication of the delegation guidance, and NHS FT provider licence consultation, and the detailed design work underway in both systems; ensuring that the Trust has influence in the same, and the development of provider collaboratives at the heart of ICS development
- Significant progress made in developing our partnerships through our emerging provider collaboratives and there is evidence of effective collaboration to improve outcomes, tackle inequity and drive forward value for money between our services, there is not a recognised and robust assessment that captures the maturity and effectiveness of our relationships within our partnerships. NHSE has developed a provider collaborative maturity matrix that could partially assist us with this. NEL and BLMK MHLDA Collaboratives intend to self-assess against the matrix to understand its full utility in this regard

Progress

What's going well inc future opportunities	What are the current challenges inc future risks	How are these challenges being managed
• First NEL MHLDA Collaborative Committee held Nov 2022, with workplan underway • Work to develop mental health strategic objective in NEL, led by service users and carers • BLMK ICB approved development of an MHLDA Collaborative in BLMK: design process under way with system partners • Work also underway to develop the Bedfordshire Care Alliance • Trust is working in partnership with Cambridgeshire Community Services to develop a Bedfordshire-wide approach to urgent and emergency care and virtual wards • Joint work with NELFT to design future ways of working, including appointment of Joint Chair • NELFT NED appointed to ELFT Board; and ELFT NED appointed to NELFT Board	• Development of NEL CHS Alliance is making progress but at a slower pace • Relationships between various operating tiers of the ICS, in particular what a delegation and governance arrangements might be across the ICS (e.g. provider collaborative) in relation to place based delegation and governance arrangements, is a major area of debate and focus at present, in both ICSs • NEL ICB management of change consultation with staff	• CHS collaborative executive now in place • Continued work to build knowledge and momentum around the MHLDA collaborative amongst partners • Ongoing joint working with NEL ICB executives • NHSE Innovator support from NHSE and peer learning

Risk score: Remains at High 8, reflecting the significant effort, commitment and capacity the Trust is putting into working with partners to develop appropriate architecture that will support the Trust to continue to deliver its strategy

BAF 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

Strategic Priority	Improved patient experience
Review Date	1 June 2023
Executive Lead	Chief Executive
Lead Committee	People Participation Committee

Risk Score 2023/2024					
Residual	Apr/June	July/Sept	Oct/Dec	Jan/Mar 24	Target
12	12 ↔				8

Context

- Variation across the Trust in the level of patient and wider involvement in the planning and delivery of services
- Service users set PP priorities
- PPC oversees work programmes, including development of peer support roles, increased involvement in QI projects, and implementation of the carers strategy
- Use of Force Act requires changes to practice and governance iro use of force in MH wards for NHS and police. Work on implementing this Act continues with oversight by QAC

Gaps in Control or Assurance

- Patient experience data collated at Trust wide level; Care Opinion introduced as Trust-wide tool
- Wider population input into service development and population health developments
- Corporate PP in infrastructure and approach
- Development of ICS approaches

Progress

What's going well inc future opportunities	Current challenges inc future risks	How challenges are being managed
• Continued work with ICS/place structures to embed PP/coproduction in ways of working to reduce variation • Co-production of new models for commissioning/delivery in NCEL CAMHs collaborative • Continued recruitment to PP Lead roles inc a BLMK Allied Health Professional PPL sitting across ELFT and CNWL; specialist drug and alcohol PPL; and advertising an EDI PPL • New training lead in place reviewing career development and developing new roles • Recruited two new patient safety partners with lived experience working across patient safety/PP • BLMK service user conference setting priorities for the ICS work on mental health • Agreement of Service User Priorities for NEL MHLDA Collaborative • Revised Trustwide Working Together Group priorities • Service user led accreditation process continues to roll out across the Trust • Use of service user experience measures and dashboard developing • Work with Network Rail expanded to national level, building on the impact of the work in NEL • Roll out of Dialog and Dialog+ • Strengthening Trust's approach to carers following launch of the Trust's carers' strategy • Peer support work continues to develop, with further recruitment to PSW roles • Young people involvement including in LGBTQ network • Focused work on suicide with Trust Suicide Prevention Lead and on digital offer, co-ordinated through Digital PP Lead • Work on inequalities including Patient & Carer Race Equality Framework (PCREF) as part of MHA implementation	• Variation across the Trust in involvement in service delivery and planning • Variation between ICS areas in prioritisation of this approach • Trust-wide data collection and synthesis • Wider population input into service development and population health developments • Improving corporate processes to support increasing levels of co-production	• Development of new ways of approaching wider involvement. Leighton Buzzard pilot approach has now begun, involving wider population. CMHT transformation work continuing to engage with wider populations • Recruitment to Corporate PPL role • Developing PPL role in estates and facilities • Continued work with developing ICS and place structures to embed PP and coproduction in ways of working • Implementation of Care Opinion to support the collation of patient experience data • Work on becoming a Marmot Trust

Risk score: Remains at **High 12**

BAF 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

Strategic Priority	Improved experience of care
Review Date	30 June 2023
Executive Lead	Chief Nurse
Lead Committee	Quality Assurance Committee

Risk Score 2023/2024							
Residual	Apr/May	Jun/Jul	Aug/Sept	Oct/Nov	Dec/Jan 24	Feb/Mar 24	Target
12	12 ↔	12 ↔					9

Context

- Demand remains high in crisis services and bed occupancy consistently high above 90%. Growing waiting list for 18 teams with adult ADHD and adult autism specifically affected
- Delays for patients in ED remains a challenge; work completed on standardising data and availability across the system. Case note audit undertaken to identify bottlenecks within each NEL ED pathway and shared with teams
- CQC unannounced inspections in four wards following information request for all SI related to inpatient deaths by suicide and incidents of serious self-harm of detained patients. Report now received and published. Trust's rating went from 'good' to 'requires improvement' for safe; however, overall service remains 'outstanding'. Range of positive feedback as well as a number of areas for improvement including 'MUST' do actions (to comply with legal obligations); and 'SHOULD' take actions to prevent non-compliance with legal requirements in the future or to improve services
- Two recently received PFDs; all issues identified in each PFD currently being carefully considered

Gaps in Control or Assurance

- Framework to enable teams to have a consistent way to ensure processes are in place to effectively manage referrals and waiting lists to minimise harm
- **G1** CHS and primary care clinical practice assurance programme
- **G2** Support a reduction in SIs
- **G3** Improve learning from patient safety incidents and issues. Patient Safety Forum monitors progress of patient safety related workstream – reporting to Quality Committee
- **G4** Embedding and understanding of primary care services and ensure corporate functions support adequately
- **G5** Comprehensive CQC readiness including well-led. CQC preparation process with plan for overview of quality, safety and leadership with smart actions to monitor and track progress

Progress

What's going well inc future opportunities	What are the current challenges inc future risks	How are these challenges being managed
• Joint and coordinated management of bed occupancy, flow and discharges • ICS level partnership work which supports our out of hospital offer • Exec/NED walkrounds continued with teams • Therapeutic engagement programme for inpatient teams • Co-designing leadership standard for all leaders at all levels in the Trust	• Demand in operational services continues to increase including waiting lists particularly for adult ADHD and adult autism • Delays for patients in ED resulting in increased number of decision to admit and 12 hour breaches • Recruitment challenges due to vacancies with additional requirements for MH transformation work • Training uptake requiring release of staff due to covering of wards and increased training needs iro infection control/prevention and PFDs • SI investigations delays due to capacity issues • Industrial action: Recent periods of industrial action by junior doctors with further industrial action ahead disrupting routine clinical care in particular	• Services continue to review delivery based on risks of patients group and staff availability • Standardised recovery plans for waiting lists/backlogs, overseen via internal performance management structures • New analytics in PowerBI to support community-based teams to view/manage caseloads and waits in real-time • London-wide programme of work for ADHD inc PC and ICB; Trust-wide workshop on adult autism planned in July • Work completed on standardising data and making this available across the system. Case note audit to identify bottlenecks within each NEL ED pathway has been completed and shared with teams. NEL-wide event on crisis pathway has taken place • Operational T&F groups with system partners to tackle issues like care home vaccination requirement and blood bottle shortages • Trust managing issues via our Gold Emergency Management structure which feeds into a weekly Directors Huddle

Risk Score: Remains at High 12

BAF Risk 5	If issues affecting **staff experience** are not effectively addressed, this will adversely impact on staff motivation, engagement and satisfaction

Strategic Priority	Improved staff experience
Review Date	29 June 2023
Executive Lead	Chief People Officer
Lead Committee	People & Culture Committee

Risk Score 2023/2024						
Residual	Apr/Jun	Jul/Sept	Oct/Nov	Dec/Jan 24	Feb/Mar 24	Target
16	20 ↑					12

Context

Retention: Trust has continued to pay revised mileage for staff for a further 12 months to aid retention and support staff during the cost-of-living crisis. Hardship grants ongoing. Trust-wide conversations under way in terms of addressing the inequity of inner/outer London HCAS
Recruitment: Time to hire below Trust target at 35.4 days against a target of 45 days; vacancy rate is 8.9%**.** c70 international nurses were recruited following visit to Sri Lanka in May. Exploring further consultant recruitment and other professions challenges
Temporary Staffing: Creating a temporary staffing function through the use of technology to replicate the successes with the NEL Lead Employer set up. Plans being developed to implement 247 Time, a new direct engagement model
Bank and Bank Pay: Executive team considering request from staffside to consider giving bank staff a pay award with the aim to address anomalies with the composition of bank pay rates, ensure the Trust remains competitive so it can attract quality candidates
Wellbeing: Trust-wide work focusing on leadership culture and behaviours to improve leadership standards across the Trust**; f**inalising arrangements to implement Wage Stream software to enable bank staff to draw down payments for bank shifts as soon as they are worked in order to mitigate financial impacts for staff; focusing on Men as a segment of the workforce
Internal audit: Deep dive on the revised controls in relation to exit payments identified 1 low and 1 medium action
Growing and developing for the future: Some challenges with data on LMS that impacted compliance which had declined owing to the review of the mapping of staff to courses but this has since increased to 76% in April. Plans are in place to improve the compliance rates and to achieve the Trust target of 90%; working more closely with service directors to increase attendance at statutory and mandatory courses.
Belonging in the NHS: A revised EDI plan 2023-2026 and EDI governance framework developed

Gaps in Control or Assurance

- Agency recruitment project initially focusing on doctors, now being broadened across all staff groups
- A project manager was recently recruited and made some good progress but has since left and we are re-recruiting
- Internal audit deep dive conducted to review the revised controls in relation to exit payments
- A new People & Culture Committee has been established to focus on all people related issues

Progress

What's going well inc future opportunities	What are the current challenges inc future risks	How are these challenges being managed
Mass vaccination Lead Employer/Workforce Management Model (WMM): Trust to continue delivering the Lead Employer WMM. Plans being developed to repurpose to a project management team to lead the delivery of the P&C transformation projects **Recruitment:** Budget authorisation forms are now recorded in the recruitment system TRAC. **Wellbeing offers** ongoing; the Trust is supporting staff: revised bank rates; continued mileage rates; Cohort 6 of the Non-Violence Resistance (NVR) training (parenting classes for staff) **Development:** Non-clinical senior leaders programme under way; trying to secure additional funding to deliver more programmes	• Current challenges in P&C include the volume of staff required to deliver the many competing and interdependent priorities against an over establishment and the necessity for savings • **Time to hire** remains below target • General staffing and recruitment challenges Trust-wide coupled with the impacts of workload on staff • Recent industrial action	• Prioritising the workstreams with clear project plans, time scales and deliverables • Funding from NEL ICB will help to reduce funding gap • Industrial action: Managing impact through planning, the good will of consultants and application of the 'Acting Down' policy • Aiming to resource all requirements • Working with key stakeholders to look at new roles etc. • Improving bank rates to reduce reliance on agency workers. There is a Trust wide review of High-Cost Area Supplements (HCAS) for outer London and fringe areas.

Risk description and risk score: As risks 5 and 6 are inextricably linked and there is significant overlap in terms of mitigating actions, previous risk 5 and 6 have been amalgamated to provide a more focused and less repetitive overview. Current risk score has increased from Significant 16 to Significant 20 due to increasing external factors and cost of living concerns for staff; many of these factors are outside of the Trust's control

BAF 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

Strategic Priority	Improved value
Review Date	1 July 2023
Executive Lead	Chief Finance Officer/Chief Nurse
Lead Committee	Finance, Business & Investment Committee

Risk Score 2023/2024							
Residual	Apr/May	Jun/Jul	Aug/Sept	Oct/Nov	Dec/Jan 24	Feb/Mar 24	Target
12	16 ↑	16 ↔					9

Context

- Previous work to embed an approach that focuses on culture and behaviour change in FV now well progressed; focus now on a system reset to delivering tangible savings that focus on value and quality, not purely on cost
- NHS focus on financial control and grip has introduced additional areas for review such as internal audit and agency ceilings

Gaps in Control or Assurance

- **G2 Developing a 'value improvement' culture:** Trust-wide staff engagement to include waste reduction, financial and environmental sustainability and benefits realisation
  G3 Embedding structured support to enable timely delivery of sustainable Directorate FV plans: Enhanced framework to include governance, monitoring, reporting, tools, templates and access to supportive expertise

Progress

What's going well inc future opportunities	What are the current challenges inc future risks	How are these challenges being managed
• Engaging staff in waste reduction initiatives • Higher proportion of identified schemes are service transformation/waste reduction • Higher proportion of identified schemes provide recurrent cost reduction • FV tracker now in place; directorates use as tool to manage schemes & provides FV PMO with live data/reporting • In person FV delivery session was helpful and will now take place three times a year • Continue to strengthen links between financial and environmental sustainability via Trust's green plan and Climate Network	• Addressing gap in 23/24 FV Programme • Fully developing identified schemes, with target dates, values and supporting documentation • Balancing the retention of our organisational treasures and overall approach to FV, with achieving significant cost reduction • Capacity required within FV PMO and sectors to deliver high value programme • Work undertaken to understand actual in-year scheme values forecasts a shortfall of up to £5m against target	• Directorates who continue to have a gap in plans being provided with additional support • FV delivery session provided protected time for Directorates scheme development • Additional resource to support FV delivery in specific areas is being considered at Exec level • Central non-recurrent measures will now be considered to support delivery of full year target • FV included in finance business partner directorate finance reporting • Weekly CFO/COO session to expedite directorate plan development • In person FV delivery session to finalise plans and address gap

Risk Score: Remains **Significant 16** (the impact being *major* 4 x likelihood of *major* 4) as the 2023/24 target is higher than 2022/23, there is a gap in plans and implementation is slow. Aim to reduce to target risk score by October 2023

BAF 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

Strategic Priority	**Improved value**
Review Date	1 July 2023
Executive Lead	Chief Digital Officer
Lead Committee	Finance, Business & Investment Committee

Risk Score 2022/2023							
Residual	**Apr/May**	**Jun/Jul**	**Aug/Sept**	**Oct/Nov**	**Dec/Jan 24**	**Feb/Mar 24**	**Target**
20	**20** ↔	**25** ↔					**8**

Context

- Digital and estates risks comprise: digital infrastructure, Cyber security, people skills, and benefits realisation
- Estates risks mirror the challenge to site resilience
- Trust-wide digital transformation programme requires significantly enhanced capacity and capability to manage change to allow ELFT to be a major player in the ICS and connect with shared care records
- Significant work to bring digital baseline up to required standards of performance, to support 'care delivery in any setting'
- Governance structure established to scope/manage digital innovation in a more structured/joined up way to support delivery and success, e.g. digital/estates
- A full assessment of digital infrastructure at all Trust sites completed by Doclan, an expert in this field. A 6 facet survey being undertaken for estates
- Cyber security risks continue to escalate which have significantly increased the activity required locally to address the risk and the number of immediate tasks and software patches that must be deployed in a very short timescale
- Implications for not meeting required NHS carbon emissions target not known; failure to deliver will have a detrimental impact on the Trust and its populations

Gaps in Control or Assurance

G6: No detailed understanding of infrastructure, both digital and structural, to support improvement programme or detailed costing exercise to fully assess, plan, prioritise and deliver the right specification

G7: Address areas of immediate concern found during sites survey including funding and capacity; addressed by digital and estates strategies; however, insufficient capital/ CDEL available to support necessary requirements

G8: Cyber Security response times and ability to meet the necessary immediate software fixes and changes to satisfy the enhanced requirements set by NHSE being addressed by the digital strategy; team expansion needed; the new tools described in the Cyber strategy are imperative to meet expectations centrally

G9: Workstream to encompass requirements for digital support for not site based areas

G10: A full benefits realisation plan needed

G11: Cloud data fully migrated to AWS; ongoing work iro on premises systems not hosted in previous cloud environment

G12: Log4j latest global cyber vulnerability has to be addressed immediately by Trust Cyber Team as NHSX Cyber Team continue to identify the depth of the challenge

Progress

What's going well inc future opportunities	What are the current challenges inc future risks	How are these challenges being managed
• Further development of the strategy to bring greater efficiencies to our staff and patients • Robust management and oversight of both the Cyber threat and cloud infrastructure architecture • Digital staff consultation: phase 1 recruitment completed in April 2023 and phase 2 June/July 2023 • Delivery of the estates strategy and the CPSG to oversee digital and estates capital spend	• Continued pressure on implementing anti-cyber responses and reporting centrally • Continual growth in digital dependency and appetite set against a finite digital resource and funding stream • Fragility of some current infrastructure and ensuring we can continue to operate whilst delivering new technology • Recruiting and retaining staff remains challenging due to growth in digital services globally • Volatile nature of the market place, post Covid increase in cyber activity and the Ukrainian/Russian conflict pushing up the risk of a potential cyber-crime • Various estates challenged areas noted by the CQC need to be urgently resolved with more funding allocated	• Digital staff development and training plan developed to support succession planning • Digital Strategy Board monitors delivery of programme including benefits realisation, cyber security, and new risks that emerge • Remedial infrastructure plan scoped in line with strategic needs • Digital and estates strategies linked to ensure compliance • Solutions Board and DTOB ensures digital team priorities remain aligned to operational challenges and reprioritise where necessary • Infrastructure Programme Board monitors resilience and implementation of the new platforms and architecture • Fully engaged with national funding round; digital funding increase required to deliver digital maturity • Global cyber risk being tracked and managed

Risk score: Remains at **Significant 20**

BAF Risk 9	If the Trust does not effectively manage its **commissioning responsibilities** and associated risks as a lead provider or lead commissioner, this will impact on the quality and experience of care for service users and patients

Strategic Priority	**Improved population health outcomes**
Review Date	1 July 2023
Executive Lead	Executive Director of Commercial Development
Lead Committee	Integrated Care & Commissioning Committee

Risk Score 2023/2024

Residual	Apr/May	Jun/Jul	Aug/Sept	Oct/Nov	Dec/Jan 24	Feb/Mar 24	Target
12	16 ↑	16 ↔					8

Context

- NMC commissioning programme was established in Oct 2022 and is fairly new commissioning experience for the Trust to lead. The Trust is already part of the NMC process with partners for the last three years
- Development of the CAMHS NMC is a collaborative commissioned by NHSE with ELFT as the lead in Oct 2020 and is now established; the Perinatal NMC is starting its journey with a much higher financial and bed based risk profile
- Some successes in initial period; however, embedding a culture of partnership across various parts of the system takes time
- OD programme across providers in CAMHS has rolled out but is yet to be harnessed in Perinatal
- Central team is working with the various provider teams to ensure the risk profile of the service users is distributed so that workforce issues are considered and serve as a temporary mitigation. Work is ongoing with the private sector provider to address the clinical pathway and the length of stay of the service users in the pathway
- Development of coproduction in the commissioning processes is unique and is beyond what has been previously achieved. The leadership of service users has helped enormously in developing a unified strategy that focuses on outcomes and in ensuring a consistent approach across the patch and across various providers

Gaps in Control or Assurance

- **G1** Relationship with system partners
- **G4** Develop a unified pathway for low secure clients
- **G7** Ongoing work in OD for clinical team to develop a single vision
- **G9** New annual plan for the CAMHS collaborative
- **G10** Perinatal collaborative: business case development

Progress

What's going well inc future opportunities	What are the current challenges inc future risks	How are these challenges being managed
CAMHS collaborative: • Clear structures of accountability and operational management • Commissioning support unit established to ensure adequate management span for the process • Systems of assurance and engagement developed with partner commissioners and providers • Delivery of financial balance • Improved CQC rating for partners, better relationships and improved involvement of service users in commissioning process • Developing renewed clinical strategy • Strategic needs assessment commissioned for CAMHS pathway • Developing single plan across the system for service development • Central team being made resilient with additional roles **Perinatal collaborative:** business case written; initial risks identified; due diligence under way	• Embedding culture of commissioning in Trust • Embedding culture of partnership across partners • Resilience of units in operational delivery inc clinical leadership • Coproduction • Financial strategy underpinned by clinical strategy • Workforce resilience • Demand in the system • Change in the leadership and consequent impact on relationships • Changes in local leadership • Changes in ICS relationship • Vacancies in the units commissioned by NMC	• OD for clinical leaders in the system • Expert by Experience Leadership • Clinical strategy development • Strategic needs assessment • Reinvestment into the NMCs • Reinventing role of commissioner and ELFT • Clinical development sessions commissioned • Procurement of community eating disorder services • Investment into social care and voluntary sector • Investment into focussed work on variation in the outcomes of sectioning of BME adolescents • Work on the Perinatal collaborative yet to start so risk management is not as robust as the well-established CAMHS collaborative

Risk score: Significant 16 following the agreed increase in May 2023 reflecting the much higher financial and bed based risk profile for the perinatal NMC unlike the more established CAMHS collaborative

NHS Provider Licence Self-Certification 2022-2023
General Condition 6, Continuity of Service 7 and Condition FT4

NHS
East London
NHS Foundation Trust

The Board of Directors at its meeting on 27 July 2023 reviewed and agreed the NHS Provider Licence Self-Certification statements for 2022-2023:

General Condition 6: Systems for Compliance with Licence Conditions
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
In making the above declaration, the main factors taken into consideration include: • The Trust believes that the best service improvements are those where 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 annual governance statement in the Trust's annual report for 2022-2023 describes the Trust's capacity to manage risk, its 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' • The Board receives regular reports that allow it to assess compliance with the provider licence, including finance, performance, quality and compliance reports at each meeting. Individual reports address elements of risk, such as reports on safe staffing levels. This enables the Board to have clear oversight over the Trust's performance. The Board also receives regular assurance reports from the chairs of its standing committees following each committee meeting. There are clear reporting lines and accountabilities throughout the organisation that ensures quality and performance reporting requirements are mirrored from Board standing committee level to local level with information flowing both ways • 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 2022-2023. The Trust continues to account for the conditions of both in the delivery of its healthcare services • 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 • The Trust has a comprehensive programme of internal audit in place aligned to key areas of potential financial and operational risk • 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*"

Continuity of Service Condition 7: Availability of Resources
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
In making the above declaration, the main factors 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 • Budgetary and FV setting processes have been reviewed and strengthened during the year • 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 viability programme • Draft annual accounts for 2022-2023 submitted to NHSE in June 2023 as agreed by NHSE and as reported to Audit Committee • Although the Board is yet to sign off the annual accounts for 2022-2023 (due in November due to delay in LGPS audit), on initial review and following external audit the Audit Committee has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Trust continues to adopt the going concern basis in preparing the accounts. The view is supported by a cash balance of £134.5m as at 31 March 2023 • Due to the delay in the LGPS audit, the external auditors will not be able complete the audit of the Trust's annual report and accounts in line with NHSE issued timetable. However, NHSE are aware of the issue which is not within the Trust's control • Final annual report and accounts expected to be submitted in November 2023 • During 2022-2023 the Trust's financial performance (£1,899k surplus) was an integral part of ensuring the North East London ICS delivered financial balance • Confirmation from NHSE of the Trust being in segment 1 of the System Oversight Framework (no specific support needs identified) in Oct 2022.

Condition FT4: Corporate Governance Statement		
The Board of Directors confirmed compliance with Condition FT4: Corporate Governance Statement for 2021-2022 as set out in the table below *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	**CONFIRMED** • The Trust has in place effective corporate governance systems and controls which are updated according to changes in guidance/requirements • The Trust's governance systems are subject to both internal and external audit • 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 2022-2023 • 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* • The Trust's system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the Trust's strategic priorities • The Trust has carried out a comprehensive self-assessment against corporate governance related to this licence condition	**Risk 1:** If the Trust's governance framework and supporting structures are not fit for purpose adversely affecting good corporate governance and decision making **Mitigating Actions:** • Review of Board committee structure, terms of reference and information flow to and between committees and the Board completed to ensure it remains fit for purpose reflecting the changes to the Trust service provision and system working; review now on operational committees • Corporate governance development actions plan developed to bring together a range of actions from both internal and external inspections and assessments or those identified as being required to support/ enhance the systems/processes to ensure effective governance arrangements • Annual review of compliance with NHSE 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	**CONFIRMED** • Board is fully briefed as guidance becomes available • Regular updates provided by internal auditors at Audit Committee • Membership of NHS Providers and NHS Confederation	**Risk 2:** 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 horizon scan and are included on review groups and circulation lists including NHSE and NHS Providers, to provide contributions/influencing opportunities and early notification • Annual review of compliance with NHSE code of 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	**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 • The quality governance framework is critical to the Trust's safe and effective response to demands including the pandemic, winter pressures, etc	**Risk 3:** 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:** • As for para 1 above plus • Annual review Trust's SFIs and SoRD particularly reflecting Trust's responsibilities under Health & Care Act 2022 • Annual review of the Trust's BAF and risk appetite • Developing organisational structure charts to provide clarity on areas of responsibility and reporting lines
4. The Board is satisfied that the Trust has established and effectively implements systems and/or processes:	**CONFIRMED**	**Risk 4:** 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;

• To ensure compliance with the duty to operate efficiently, economically and effectively	• Para 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	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:** • As for para 3 above plus: • 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 • Review and strengthening of the Trust's budget setting and FV annual plans introduced for 2023-2024 • Delivery of the underpinning plans supporting delivery of the Trust's strategy, e.g. people plan, membership engagement plan, people participation priorities, quality priorities, etc • Executive oversight of legal requirements supported by relevant/expert teams including finance, MHA, legal and corporate governance teams • Legal advice sought when required
• 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, quality (including patient safety) and people, 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	
• 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 • CQC preparedness programme in place • 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 and triangulation of learning • 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 and 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 2022-2023 and in response to the requirements of system working • The Trust's SoRD and SFIs provide clear limits on financial decision making including when Board approval is required for significant financial decisions • During 2022-2023, 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 remains in segment 1 of NHSE Oversight Framework	
• 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 • Two new platforms (PowerBi and InPhase) being introduced	

	• 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 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 completed annually	
• 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 (e.g. people plan) inc development of population health measures in 2023 • 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 • Trust has produced an annual plan collaboratively with NELFT and has contributed to NEL ICS submitting a break-even financial plan	
• 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	
5. The Board is satisfied that the systems and/or processes referred to in para 4 (above) should include but not be	**CONFIRMED** • Joint Chair with NELFT appointed 1 January 2023 • Annual performance reviews for Executive and NEDs including the Chair and CEO – focusing on both individual objectives and	**Risk 5.1:** 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

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 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	contributions as well as those as a unitary Board, and system working • Annual succession planning discussions at Board's Appointments & Remuneration Committee (RemCo) and Council's Nominations & Conduct Committee (NomCo). Decision during 2022 to appoint an additional NED with carer/lived experience • 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 meeting on quality improvement initiatives, people participation and patient stories • Quality assurance, quality improvement, clinical leadership and coproduction are an integral part of the Trust's strategy (our organisational treasures) • 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 • Service users and carers, as well as the public and members' views are also represented by Governors • 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	**Mitigating Action 5.1:** Board composition and succession planning regularly reviewed by the Chair and RemCo to ensure skill mix and experience is appropriate and balanced **Risk 5.2:** 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 5.2:** 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

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	• Trust actively works with its providers, voluntary and third sector through formal and informal mechanisms to foster and enable integrated care • New membership engagement plan approved: coproduced and reflecting that at ELFT our members are our local community, service users, staff, stakeholders and the voluntary sector – connecting us to all we serve • Opportunity for staff to raise concerns through Freedom To Speak Up and Whistleblowing processes	
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. NEDs 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; one new NED appointed with carer/lived experience • RemCo and NomCo oversee the recruitment processes for Executive and NEDs respectively; two new NEDs appointed 2023 • 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	**Risk 6:** 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 6.1:** • 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 • Board and senior management succession planning overseen by RemCo and through appraisals

	• 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; during 2023 coproduced approach to Trust-wide review of leadership and culture undertaken for implementation in 2023-2024 • 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	

Training of Governors
The Board of Directors confirmed that, during the financial year most recently ended (2022-2023), 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
Chair
27 July 2023

Paul Calaminus
Chief Executive
27 July 2023

East London
NHS Foundation Trust

Modern Slavery and Human Trafficking Statement 2023

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 2023. 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 2023.

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

ELFT has a zero tolerance approach to any form of modern slavery or human trafficking in any part of our business activity. 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. Our overall approach will be governed by compliance with legislative and regulatory requirements and we aim to follow good practice and take all reasonable steps to prevent modern 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 in so far as possible and require our suppliers to hold similar ethos, again in so far as possible
- 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 modern 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.

Governance and policies

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
- All our people, procurement and commercial policies are equality impact assessed to ensure that colleagues are always treated fairly.

Working with Suppliers

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
- Encouraging suppliers and contractors to take their own action and understand their obligations in their processes
- Upholding professional codes of conduct and practice relating to procurement and supply
- Trust staff must contact and work with the procurement team 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 modern 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
Chair
27 July 2023

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

NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
27 July 2023

Title	Quality Assurance Committee (QAC) on 26 June and 4 July 2023 – Committee Chair's Report
Committee Chair	Prof Dame Donna Kinnair, Non-Executive Director, Chair of the 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) on 26 June and 4 July 2023.

Key messages

Quality Assurance Committee meeting held on 4 July 2023

Emerging Issues

- **Industrial action:**
  - The Trust has been particularly affected by the junior doctors' strikes having considerable impact on the provision of services including the requirement to cancel and re-book some appointments. Mitigations put in place ensured there were no incidents during this period and that appropriate cover was in place. Safety was prioritised with a focus on the acute and crisis pathways. Although there was some disruption there was no serious impact
  - Plans are in place for any further planned industrial action by both junior doctors and consultants
  - Further industrial action will have an impact on waiting times and lists across the Trust, and both local and system solutions are being identified
- **Right Care Right Person:** The Trust is engaged in ICS level work with East London Metropolitan Police Borough Commanders in response to correspondence from the Metropolitan Police Commissioner relating to the implement of Right Care Right Person across London
- **Prevention of Future Deaths:** An update on two PFDs issued since the committee's meeting in May was provided both of which have been reported to the Board. All issues being raised by the Coroner within each report are being carefully reviewed to identify further actions and learning.

Quality and Safety Report: Tower Hamlets and Newham Adult Community Health Services

- Overview of services: comprise of district nurses, therapists, rapid response and extended primary care teams (EPCT) as well as some specialists services nursing teams, such as continence services and foot health
- Achievements: external peer reviews which have been helpful to support CQC readiness; range of clinically led QI projects including continence pathways and discharge processes; service user led accreditation with 10 teams awarded 'gold' and three 'silver'; awards won by the tissue viability team and EPCT safety huddle approach for supporting safeguarding of vulnerable people shortlisted for an HSJ award; implementation of a scorecard system has helped the collection of useful quality and safety data; fifteen international nurses have been recruited; GP podcasts developed to enhance communication between CHS and GPs; reduction in pressure ulcers
- Variations: working group now established to support the design, testing and implementation of PowerBi following a delay; no formally agreed process for raising incidents with external partners; people participation worker role being explored; volunteer opportunities identified;
- Challenges and mitigating actions: identified areas for improvement and working on improving response rates for staff survey through listening events and focused support for staff; recruitment and vacancy gap – opportunity to review roles and career development pathways; recovery plans in place to address the longer waiting lists.

Quality and Safety Report: Bedfordshire Adult Community Health Services

- **Overview of services:** directorate covers community nursing in people's homes, urgent care response including rapid response, integrated falls, intermediate care, support for Discharge 2 Assess, care home support, specialist nursing and therapy including long term condition management, remote monitoring/development of virtual ward pathways and end of life care. Pathways across Bedfordshire remain complex due to two acute hospitals, two local authorities, multiple boundaries and historical commissioning behaviour
- **Achievements:** care home joint training initiative involving upskilling care home staff; urgent community response work with partners to provide rapid response and reduce unnecessary conveyance; integrated falls collaboration with the ambulance and fire brigade services reducing conveyance to hospital by 55%; Admiral nurse recruitment; a therapy pilot for spot beds has reduced length of stay; podiatry service review and redesign has been used by NHS England as an exemplar; ACP and nurse consultant roles development; workforce pipelines include school engagement activity to attract young people into health careers early and increasing apprenticeships
- **Variations:** working to improve data to ensure it is relevant and useful; there are some inconsistencies on the system pathways and models of care; and working to share learning and bringing fresh approaches to transformation to ICS work
- Learning: various methods of sharing learning are actively used; people participation activity has been embedded; QI work is used in response to issues and challenges
- **Challenges:** include workforce availability and collaborative planning; system risk ownership; increased demand in existing services versus capacity and acuity; digital transformation and keeping up with change, digital governance and cross boundary complexity.

Board Assurance Framework: Improved patient experience - Risk 4: *If essential standards of quality and safety are not maintained, this may result in the provision of sub-optimal care and increase the risk of harm*.

- **PFDs:** Two recently received PFDs; all issues identified in each PFD are currently being carefully considered
- **CQC:** Report received and published following four unannounced inspections in February 2023 which focused on SI of self-harm and deaths of patients who are detained under the MHA particularly on the aspects of the safe and well-led domains. Trust's rating went from 'good' to 'requires improvement' for safe; however, overall service remains 'outstanding'. Range of positive feedback as well as a number of areas for improvement including 'MUST' do actions (to comply with legal obligations); and 'SHOULD' take actions to prevent non-compliance with legal requirements in the future or to improve services. The report can be found here
- **Demand:** Remains high in crisis services and bed occupancy consistently high above 90%. Growing waiting list with adult ADHD and adult autism specifically affected
- **ED delays:** Remains a challenge; work completed on standardising data and availability across the system. Case note audit undertaken to identify bottlenecks within each NEL ED pathway and shared with teams
- The Committee agreed there were no changes to the risk score and that appropriate controls are in place and operating effectively.

Internal Audit: Good progress has been made with no overdue management actions.

Quality Assurance Committee meeting held on 26 June 2023

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 meeting presented at each Audit Committee meeting and are available on request by Board Directors from the Director of Corporate Governance.

Appendix 1: Meeting held on 26 June 2023 to receive quality and safety related annual reports

Annual Report 2022-2023	Matters of Concern/ Improvements	Key Points	Positive Assurance
Annual Quality Report	• No concerns raised • Consideration to be given to combining the Quality Report and Quality Account report to avoid repetition • Consideration to be given to the inclusion of feedback from the NED visits	Quality Improvement: • Optimising flow: East London Children's Eating Disorder Service (CEDS) has reduced long wait times for young people to receive an assessment after being referred to the service from an average wait time of 17 weeks to 5.4 weeks • Equity: Community forensics service has more than doubled the number of service users attending the BAME group where they discuss issues about race • Quality plan for 2023-24 highlights how quality improvement projects across the Trust link to ELFT's key strategic priorities and the annual plan for 2023-24, with a focus on pursuing equity, inpatient quality and safety, capability and sustainability and value Quality Assurance: • Thriving service user led accreditation programme; review of standards led to the development of a platinum award aimed at recognising excellence in delivering what matters most to our service users • Workplan for 2023-24 focuses on improving the experience and impact of the team and workstreams as well as the implementation of an integrated online system for quality assurance and risk management, and the development of a stakeholder-led accreditation programme for corporate services	• Progress made with improving services as part of the focus on optimising flow and pursuing equity • Continued roll out of the service user led accreditation programme • The Committee noted the annual report
Annual Quality Account	• No concerns raised • Consideration to be given to combining the Quality Report and Quality Account report to avoid repetition	• Quality Accounts now complete with the exception of the statement from NEL ICS, and reflects the feedback from the Committee where possible	• Quality Accounts will be finalised and ready for publication on the Trust's website by 30 June 2023 deadline • The Committee approved the annual report
Annual Integrated Safety Report	• No concerns raised	• Softer safety intelligence being monitored through surveying staff and service users along with reviewing data in a triangulated way	• The report provides assurance on the work undertaken to continuously improve safety management, learning and

Annual Report 2022-2023	Matters of Concern/ Improvements	Key Points	Positive Assurance
		• Ongoing challenges named by staff include staffing issues, violence and aggression, self-harm and access; service users have named involvement of families, communication and staff training as key areas • Triangulation of themes from SIs, complaints, incidents, 48 hour reports and from service users and staff being incorporated into the priority setting for the year ahead • Triangulation of learning from safety has been improved by including learning from LeDeR, inquests, Freedom to Speak Up, Care Opinion and PALS both in safety reporting and in the Patient Safety Forum • There has been an increase in the number of expected deaths this year, reflecting the national figures. Unexpected deaths have reduced which is due to improved accuracy of data capture and categorisation • Trust received five PFD notices, many related to care from 2018; a new strengthened PFD oversight system has been introduced • There are improvements in timeliness and allocation of our SIs and notable practice identified which is being used for learning • Safety has taken centre stage for improvement work across the Trust with the launch of a new in-patient safety programme; there is new work to improve safety culture for our in-patient wards and learning from safety • Good progress being made on the safety plan including transformation of our SI approach; two patient safety partners recruited, which is a new service user role dedicated to safety	culture within the Trust, and the progress made against achieving year one objectives of the Trust's new safety plan • There is a continued healthy safety reporting culture • The Committee approved the annual report
Safeguarding Annual Report (for Adults and Children)	• No concerns raised • Recommended the adult safeguarding action plan rating is reviewed • Recommended the children's safeguarding work plan is more specific to provide clarity on	• 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 been a challenge due to the lack of availability of compliance data; however, an action plan is in place to address the issues and compliance has improved • QI project to increase levels of recording as there have been issues with correctly recording referrals	• The report provides assurance of the progress with regard to the Trusts 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 adults and children is a Trust priority

Annual Report 2022-2023	Matters of Concern/ Improvements	Key Points	Positive Assurance
	whether goals are met	• Safeguarding supervision has commenced with teams and where complex cases are discussed; themes covered include parent capacity, self-harm and domestic abuse • Trust is involved in a significant number of children's case reviews where named professionals are involved in action planning and dissemination of learning • Plans for next year include prioritising domestic abuse practice including additional training for staff as well as cascading the learning from the domestic homicide reviews; intention to co-produce the Level 3 training to ensure patient experience is included; aiming to bring trauma informed care into supervision to improve the quality of support	• The Committee approved the annual report
Infection, Prevention and Control Annual Report	• No concerns raised • Recommended that future reports are edited to remove the significant amount of data analysis	• The pandemic increased awareness of infection control across the Trust • Policies and guidance have been rapidly changing and have kept on top of these • Management of outbreaks has been improved and root cause analysis undertaken after each • Communication has improved both internally and externally, working closely with IPC guidance • Due to improvement and knowledge of IPC, other infections have been managed quickly and efficiently • The team is now more involved in QI projects such as sustainability, improving cleanliness and ventilation • Challenges include high levels of staff absence, although some new posts have now been recruited; the geography of the organisation and the older environment, particularly as ventilation is a new area to be monitored and improved to reduce the risk of patient infections • Future plans involve going back to business as usual, such as undertaking audits; also reviewing how to involve patient participation	• The report demonstrated the actions taken to ensure high standards of infection prevention and control have been maintained within the Trust during the past year • The Committee approved the annual report
Guardian of Safe Working Annual Report	• No concerns raised	• There have been 158 exception reports over the past year, similar number to the previous year; most exception reports relate to small changes to working hours and difficulty with accessing breaks, and are for working one or two hours over the rostered hours • Where there have been breaches, the issues have been addressed	• Junior doctor work schedules are compliant with the junior doctor contract

Annual Report 2022-2023	Matters of Concern/ Improvements	Key Points	Positive Assurance
		• There is a good spread of reporting across all geographies and grades • There are low rates of reporting by FY1 Doctors who generally do not work out of hours and within CAMHS trainees where work is continuing to remind them of the importance of exception reporting	• The Committee noted the annual report
Freedom to Speak Up Annual Report	• No concerns raised	• Although FTSU was set up for patient safety concerns, the majority of concerns raised are in relation to HR processes and relationships which can have an indirect impact on patient safety • There was an increase of about 54% in the number of issues raised this year compared with the previous year • Themes with the highest increases are patient safety, quality of care and staff wellbeing. A new area is 'other inappropriate attitudes or behaviours', i.e. incivility and behaviour not in line with Trust values • The professional groups raising most concerns were nursing and midwifery and administrative and clerical • Despite the increase in the number of concerns being raised, the NHS staff survey responses suggests staff are still reticent to raise concerns • Future plans include using the Freedom to Speak Up and staff survey data to identify those localities that may need more support and develop a supporting plan; also to work with People & Culture to develop an expectations document of timeliness for responses and resolution of concerns raised	• The Committee noted the annual report
Complaints, PALS and Compliments Annual Report	• No concerns raised • Future reports to include information on Ombudsman investigations including conclusions/findings, and the Trust's response	• Number of formal complaints decreased by 14% from previous year • Closing complaints remains a challenge partly due to the need to improve systems, complexity of complaints and unrealistic timescales • Increases in PALs enquiries and compliments formally recorded on the previous year • Top themes for complaints were attitude of staff, communications and clinical management of mental health; for PALS it was attitude of staff, communications and appointment delays • Learning lessons seminar are held looking at themes and changes to practice. Bi-monthly meetings introduced with governance co-ordinators to discuss themes, trends and any concerns. QI projects also in place, e.g. to improve the experience of carers with Luton	• Under complaints regulations all formal complaints must be acknowledged within three working days and this has been achieved • The Committee approved the annual report

Annual Report 2022-2023	Matters of Concern/ Improvements	Key Points	Positive Assurance
		CMHT; providing training to improve confidence levels of staff dealing with complaints • Some items on last year's workplan were not achieved due to staffing issues, this is now much improved • Future plans include development of a framework based on risk and complexity, allowing more time for complex complaints, and to support primary care with their complaints process	
SIRO Annual Report	• No concerns raised	• The report encompasses information governance, digital and cyber security • The Trust received a fully compliant rating across all assertions for the Data Security & Protection Toolkit • FOI activity remained high during the year with a 35% increase in requests over the last three years; a backlog is currently being addressed through an action plan • The number of Access to Records and SAR requests are similar to previous years but complexity is increasing • Although cyber remains a key threat to the Trust, significant focus and activity has resulted in the prevention of cyber security breaches	• The report provided assurance about the progress and practice on information risk management and the security arrangements for information sharing which has strengthened the Trust's position • The Committee approved the annual report
Emergency, Preparedness, Resilience and Response Annual Report	• No concerns raised	• Report summarises how the Trust has responded to the major events of 2022-23 including the pandemic and recent industrial action • Live exercises taken place throughout the year from which lessons have been learned; no significant gaps identified • Trust-wide exercise conducted recently where feedback has been incorporated in the work plan • Next year will look at the key risks the Trust faces, such as heatwaves, cyber attacks and utility failure. The team is working closely with IT and estates on disaster recovery plans.	• 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; the Trust's major incident plan is now included on a national database as best practice

Annual Report 2022-2023	Matters of Concern/ Improvements	Key Points	Positive Assurance
			• NHSE observed the Trust-wide workshop and provided positive feedback • The Committee approved the annual report
Health, Safety and Security Annual Report	• No concerns raised	• Health, Safety & Security Committee now includes service user input and a service user sub-group is being formed • There was a reduction in RIDDORS (reports of injuries to staff) and in physical violence against staff compared to previous year • Significant decrease in the number of violence and aggression incidents reported to the police compared to the previous year; the intention is to implement Operation Cavell to address this • Police liaison continues to be an area ELFT can be proud of • A protocol to ensure the safety of individuals put on Section 136 as well as that of staff introduced • Variation with staff accessing the people safe lone working app; a full implementation and training programme, and a series of webinars have taken place to improve compliance and raise awareness • ELFT is the first NHS Trust to have their health and safety learning programme endorsed by NEBOSH (the National Examination Board in Occupational Safety & Health) • Main focus in the future is around musculoskeletal conditions which more staff are suffering from and also the violence and aggression which staff are faced with	• The report demonstrated the Trust is meeting its obligations under the Health & Safety at Work Act 1974 • The Committee approved the annual report
Mental Health Law Annual Report	• No concerns raised	• Significant improvement in compliance with Tribunal Rule 32 (Tribunal report timeliness) since November 2022 • Action plans have been developed to address issues around compliance with consent to treatment/admission provisions, and Section 132/132A MHA (statutory duty to inform patients of their rights) • A new end to end digital MHA solution being implemented; this will free up staff time in our services by reducing administrative tasks and ensuring safer, more efficient MHA administration • An extensive programme of work developed including a training programme, reviewing recording tools and developing online resources	• The report provided assurance that the Trust discharges its statutory duties and responsibilities under the Mental Health Act (MHA) 1983 and the Mental Capacity Act (MA) 2005 • The Committee approved the annual report

Annual Report 2022-2023	Matters of Concern/ Improvements	Key Points	Positive Assurance
		to address issues highlighted following recent reviews in particular around consent to admission and treatment • In terms of legal developments, work had taken place to prepare for the implementation of the Mental Capacity (Amendment) Act 2019 and the new Liberty Protection Safeguards, which were expected to replace DoLS in 2023-24; however, the implementation has now been postponed indefinitely. There is also no certainty as to what will happen with the MHA reform	
Medical Education Annual Report	• No concerns raised	• Achievements include supporting the first cohort of international students; progressing the employment of and support for Physician Associates (PAs) placements • Continued strong focus on service user involvement being embedded in medical education: the Academy of Lived Experience (ALE) expands on the Trust's innovative work to strengthen partnership collaboration and develop work across all services and professional groups – currently working to fully embed this is in all learning to involve service users across all teaching • Challenges include the programme on addressing health inequalities by re-distributing training posts to the areas of greatest need across the UK which will have a significant impact on Trust services and the reduction of training opportunities available in London. Mitigating impact by working with clinical leads to explore the impacts and reviewing job roles within teams to see how they can be managed differently; the additional workforce of PAs can help with this • Future plans include the further development of the additional PAs across the Trust; developing the Trust's definition of simulation and how to incorporate in MDT settings; further development and innovation training in collaboration with ALE; supporting international medical graduates; identifying required support for primary and community care medical staff	• 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 • 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
Research and Innovation Annual Report	• No concerns raised	• Research activity is correlated with better health, better care and better CQC ratings • One of the core ambitions is to maximise opportunities to participate in relevant research	• In 2023 ELFT was the highest recruiting and most productive community and mental health trust in the north Thames region in

Annual Report 2022-2023	Matters of Concern/ Improvements	Key Points	Positive Assurance
		• There is a need to address the imbalance between the proportion of research related to mental rather than community health. The first study in over 15 years in partnership with industry is due to go live in our tissue viability service, which is positive in rebalancing the trend. A partnership has been created with the University of Cambridge to establish a new hub for health research which should also help to redress this imbalance, this is a significant and long-term investment • Aim is to broaden the spectrum of research to include service evaluations, case studies and quality improvement • Integrating routine clinical data sets to use them for research and evaluation purposes is a challenge • The annual research & evaluation conference planned for 1 November	respect of respect of participating in relevant research • The Committee noted the annual report
Legal Claims Annual Report	• No concerns raised	• Number of claims have remained stable and not significantly different to previous two years • Clinical negligence (CNST) claim values have significantly reduced; however, the Liability to Third Party (LTPS) claims have increased partly as a consequence of the Covid backlog and settlements were made prior to inquests which decreased costs. Intention is to use the lessons learnt from this to encourage future early settlement processes • Focus in the coming year on meeting the 30 day deadline to reduce costs; deadlines were not always met this year due to staff limitations • Information governance claims has been a new feature under LTPS in the last two years, with a further four settled in 2023-24 • Opportunities for learning identified with the aim of developing robust systems for sharing the information and learning from claims with the Director of Patient Safety and the Risk & Governance Team to better inform their planning	• The Committee noted the annual report

East London NHS Foundation Trust

Quality Assurance Committee Meeting

Monday 26 June 2023 from 14:00 to 17:00
By MS Teams

AGENDA

1	Welcome and Apologies for Absence	Note	Donna Kinnair	14:00
2	Declaration of Interests on Items on the Agenda	Assurance	All	14:05
3	Quality Workplan Report and Quality Accounts 2022-2023	Assurance	Amar Shah	14:15
4	Annual Integrated Safety Report	Assurance	David Bridle	14:30
5	Safeguarding Annual Report	Assurance	Lorraine Sunduza / Claire McKenna	14:45
6	Infection, Prevention and Control Annual Report	Assurance	Lorraine Sunduza	14:55
7	Mental Health Law Annual Report	Assurance	David Bridle	15:05
8	Emergency, Preparedness, Resilience and Response Annual Report	Assurance	Edwin Ndlovu	15:15
9	Health, Safety and Security Annual Report	Assurance	Lorraine Sunduza	15:25
10	5 Minute Break			15:35
11	SIRO Annual Report	Assurance	Amar Shah	15:40
12	Guardian of Safe Working Annual Report	Assurance	David Bridle	15:50
13	Freedom To Speak Up Annual Report	Assurance	Lorraine Sunduza	16:00
14	Complaints, PALS and Compliments Annual Report	Assurance	Lorraine Sunduza	16:10
15	Legal Claims Annual Report	Assurance	David Bridle	16:20
16	Medical Education Annual Report	Assurance	David Bridle	16:30
17	Research and Innovation Report	Assurance	David Bridle	16:40
18	Any Other Business	Note	All	16:50
19	Issues to be brought to the Board's attention	Note	Donna Kinnair	

20 Dates of Future Meetings

- Tuesday 4 July 2023 14:00-16:30
- Monday 11 September 2023 14:00-16:30
- Monday 13 November 2023 14:00-16:30
- Monday 8 January 2024 14:00-16:30
- Monday 4 March 2024 14:00-16:30

*Until further notice all meetings will be held by video conference from 14:00 – 16:30 unless otherwise indicated above

Professor Dame Donna Kinnair DBE
Non-Executive Director
Chair of the Quality Assurance Committee

East London
NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE
26 JUNE 2023

Title	Quality Report
Author/Role	Duncan Gilbert, Head of Quality Assurance Ellie Parker, Deputy Head of Quality Assurance Katherine Brittin, Associate Director of Quality Improvement Auzewell Chitewe, Associate Director of Quality Improvement
Accountable Executive Director	Dr Amar Shah, Chief Quality Officer

Purpose of the report

To set out progress against the quality workplan for the past financial year, incorporating the two domains of assurance and improvement, and to set out the proposed workplan for the coming financial year.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Key messages

The Quality Improvement section of the report includes examples of how teams have improved services while part of the 'optimising flow' and 'pursuing equity' learning sessions in 2022/23. The East London Children's Eating Disorder Service (CEDS) were working on optimising flow and managed to reduce long wait times for young people to receive an assessment after being referred to the service, from an average wait time of 17 weeks to 5.4 weeks. In their equity work, the community forensics service was able to more than double the number of service users attending the BAME group where they discuss issues about race. The most attended QI training programmes, Pocket QI and the Improvement Leaders Programme received CPD (continuous professional development) accreditation from an external body.

The Quality plan for 2023/24 highlights how quality improvement projects across the Trusts link to the key strategic priorities for ELFT and the annual plan for 2023-24, with a focus on pursuing equity, inpatient quality and safety, capability and sustainability and value

The Quality Assurance section of the report sets out progress against last years workplan, with particular attention to the impact on the delivery of, engagement with, and impact of our core QA workstreams. The report provides some detail on the thriving service user led accreditation programme, and the review of standards undertaken with our service users that has led to some new standards for services, and the development of a platinum award aimed at recognising excellence in delivering what matters most to our service users. The year has been one of gradual change in regulatory approach and the team has been ensuring that this is reflected in our internal approach, more fundamental changes are anticipated in 2023/24 and inclusion of a dedicated CQC workplan in the report reflects this.

The QA workplan for 2023/24 is tightly focused on improving the experience and impact of the team and our workstreams. But alongside are some significant change projects in the implementation of INPHASE as an integrated online system for quality assurance and risk management, transition to a new provider for our PREM/FFT survey (Civica), and the development of a stakeholder-led accreditation programme for our Corporate services.

Strategic priorities this paper supports

Improved population health outcomes	☒	The information provided in the Quality Plan 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 understanding, assuring against and improving aspects related to these four objectives across the Trust.
Improved experience of care	☒	
Improved staff experience	☒	
Improved value	☒	

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 Background/Introduction

1.1 This report provides an update on the organisation's Quality Improvement (QI) plan and Quality Assurance (QA) plan for 2022-23, considering the priorities aimed at progressing the organisation's aim to improve the quality of life for all we serve.

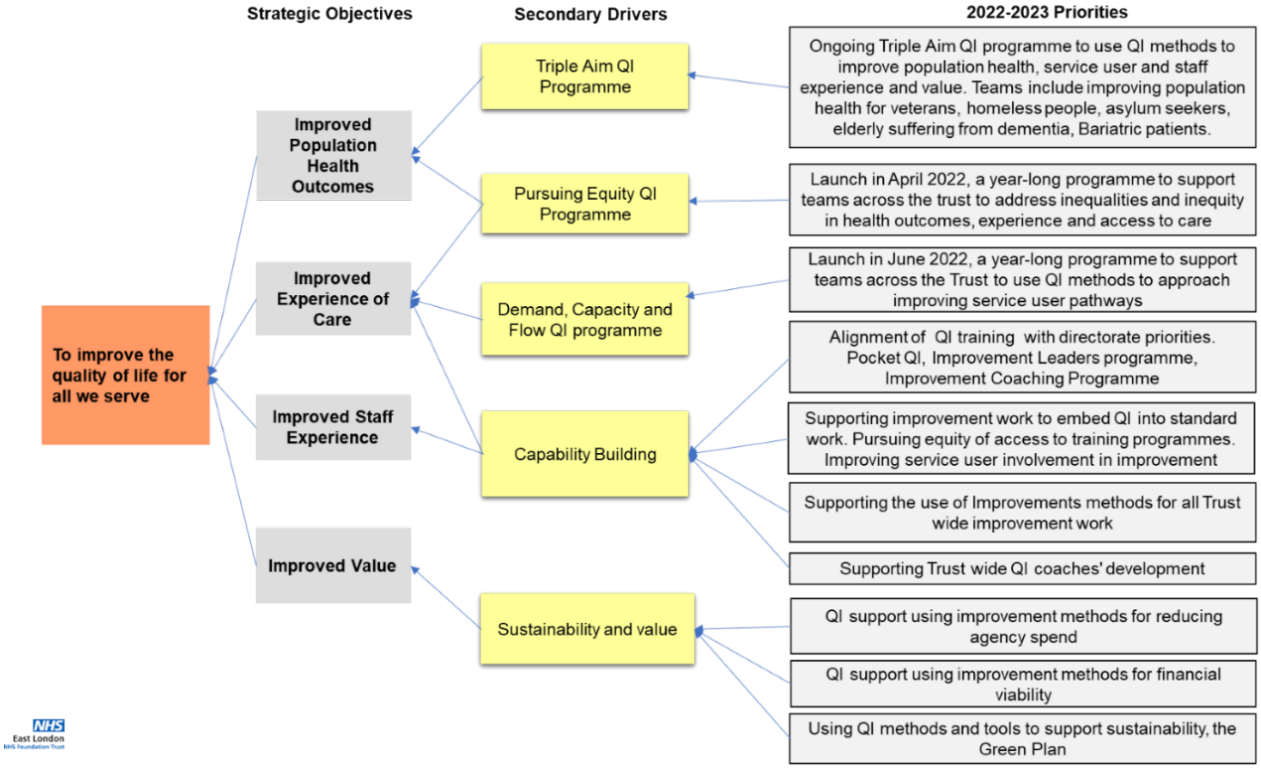
1.2 The Trust's quality improvement plan demonstrates the key priorities for 2022-23 with some stories from teams working on equity and flow, the ideas they are testing, and the results that are starting to emerge. This is followed by an overview of the plan for 2023-24.

2.0 Quality Improvement

2.1 The QI plan for 2022-23 focused on the following priorities aimed at progressing our aim to improve the quality of life for all we serve.

- Triple Aim QI Programme
- Pursuing Equity QI Programme
- Demand, Capacity and Flow QI Programme
- Capability Building
- Value

2.2 The Trust's quality improvement plan (below) demonstrates how Quality Improvement (QI) work across the Trust was organised to support delivery of the Trust's annual plan. This section of the report summarises progress in delivering the 2022-23 plan. The two large-scale improvement programmes, on equity and flow, were successfully delivered and are starting to see results.



Trust annual quality improvement plan for 2022-23

2.3 **Improving Population Health**

2.4 *Triple Aim:*

2.5 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. The 'Triple Aim' learning system continued in 2022/23 after it was restarted in June 2021. Seven teams across the organisation worked on improving population health using the triple aim approach, working across organisational boundaries to simultaneously improve outcomes, experience and value. The teams worked on different populations including veterans, asylum seekers, homeless people, children, people who frequently present to crisis mental health services and people with long-term conditions accessing talking therapies.

2.6 One of the project teams from Newham adult mental health have been focusing on frequent users of the crisis pathway to help them thrive, be socially connected and receive the right support at the right time. They are now testing offering 1:1 support from community connectors to help service users access the Crisis Café to reduce social isolation and loneliness, and increase connection with the local community. This will also provide out-of-hours support at high-risk times for crisis presentations.

2.7 *Marmot Trust:*

2.8 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. ELFT partnered with the Institute of Health Equity, to work towards becoming the first NHS Marmot Trust. The Trust has been applying the QI method in this area, using the Triple Aim approach to this work in Luton and Newham.

2.9 In Luton, colleagues from human resources, public health, the local authority, a facilities management service and peer support workers are working together to support local vulnerable people into employment. The project team which involves partners from ELFT, the local authority, council and other system partners have agreed the portfolio of work that will help them achieve their aim "to support ELFT service users and the general population in Luton to gain and retain employment and skills". This involves a task and finish group to Understand & address financial exclusion, as a major barrier to employment for people in vulnerable groups. Several QI projects to improve the accessibility of recruitment processes; Promote opportunities more effectively and in a more targeted way; Provide pre-employment opportunities; Provide in-work support for new recruits and Provide support for managers & clinical teams to recruit from service users and other disadvantaged groups. The team have started to collect data related to their testing and have recruited 5 service users from the population into Health Care Support Worker roles in Luton.

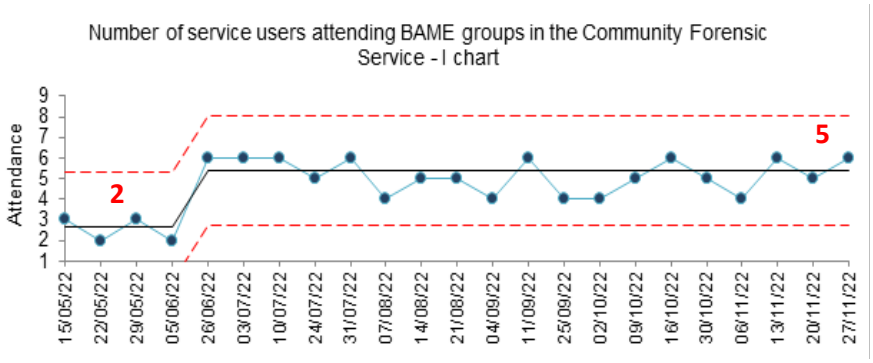
2.10 In Newham, the work received funding from the ELFT charity to support some of their work to improve the wellbeing of children and young people in Newham by focusing on two principles, 'giving every child the best start in life' and to 'enable all children, young people and adults to maximise their capabilities and have control over their lives'. The project has agreed on two interventions to look at (1) Healthier Wealthier family's pilot – placing financial advisors into community children's centres and specialist children's clinical services. The team are working with University College London department of Population Health. (2) Family Literacy Project – Partnership with the bank HSBC and East London Business Alliance to offer health literacy courses to Specialist Children and Young Peoples Service (SCYPS) and Child and Adolescents Mental Health Service (CAMHS) families in Newham.

2.11 **Improving Experience of Care**

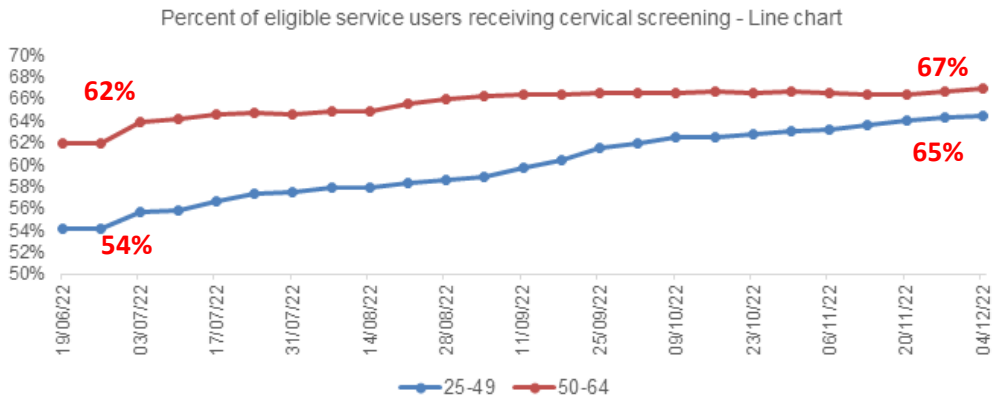
2.12 *Addressing Inequalities:*

2.13 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 has been supporting teams to understand what contributes to inequity within the populations they serve, use improvement methods to test meaningful change ideas and develop measurement plans to know if they are making an improvement. Currently thirteen teams are part of the programme. Since the programme launched, 11 of the teams are testing change ideas, with four having seen an improvement. 4 teams are developing driver diagrams to construct their change theory and are receiving coaching support to help them begin testing change ideas. All teams are developing change ideas, with 10 teams actively testing.

2.14 Several teams have been working to improve outcomes, access, and experience for Black, Asian, and Minority Ethnic (BAME) service users. Tower Hamlets Early Intervention Service saw a 27% increase in the number of BAME service users receiving treatment because of prioritising service users who had recently been discharged from wards, and by introducing family-based therapy. Meanwhile, the community forensic team have been testing a weekly service user group welcome to anyone to discuss issues around race. Attendance at the group has increased over time as a result of offering a virtual option (chart below). One service user reflected "the group has been constructive and people that come here get energy from it and that it starts off the week, it's a time for reflection... I find it innovative".



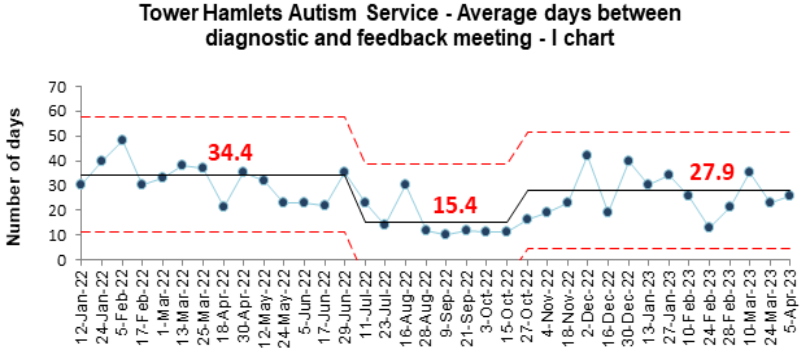
2.15 Cauldwell medical centre based in Bedford have been working to increase the percentage of eligible women receiving cervical screening. They identified that only 55% of women between 25-49 received screening compared with 63% of women over the age of 50. The team have tested a range of change ideas including text message reminders, changing the language of letters and outreach events, and have managed to increase overall screening rates and reduce the equity gap between women under and over the age of 50. The percentage of women aged 25-49 receiving cervical screening has increased from 55% to 63%. The percentage of women aged 50-64 receiving screening has increased from 63% to 66% (chart below).



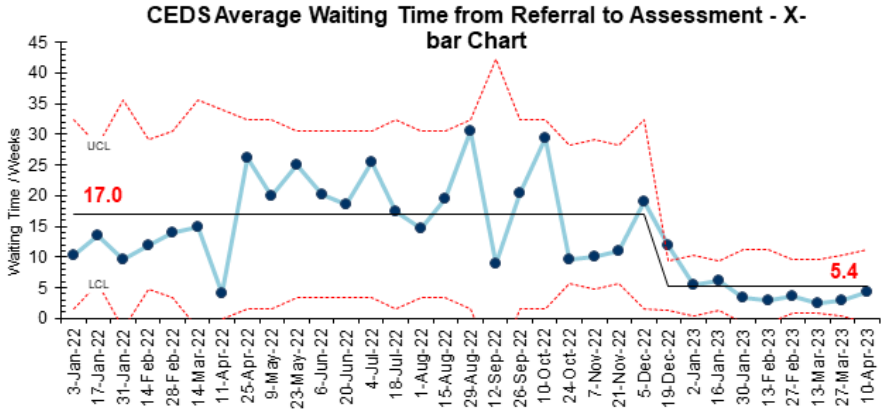
2.16 *Optimising Flow programme:*

2.17 Since June 2022, 19 teams have been coming together to share ideas and apply QI to optimise flow through patient pathways in their services. A mid-programme evaluation demonstrated improved service user involvement in the work and that the programme has helped accelerate team progress. Of the teams on the programme, 16 progressed to the point of testing change ideas, with five teams showing improvement. Two teams were developing their change strategy and one team is in the implementation phase.

2.18 Tower Hamlets Autism Service: their aim was to reduce the wait time from referral to assessment by 50% in one year. Ideas tested include a referrals pack to streamline the process, this resulted in a 38% reduction in the wait time from referral to the active list (chart below). Additionally, increasing the time of their weekly assessment meeting by one hour meant they could discuss more cases and reduce the time a diagnosis is received by one week.



2.19 The East London Children's Eating Disorder Service (CEDS) identified that there are long wait times for young people to receive an assessment after referral to the service. The aim of the project was to reduce their wait times and improve patient experience. They developed a process map to better understand where there were inefficiencies and bottlenecks in the system. Their change ideas included discontinuing the triage process, introducing a single assessor, and updating the referral form. After testing these ideas for a few months, the team saw a reduction in the average wait time of 17 weeks to 5.4 weeks (chart below).



2.20 **Improving Staff Experience**

2.21 *Capability Building:*

2.22 Pocket QI, the Trusts one-day foundational QI training is accessible to all staff and service users which means they will be able to apply QI methods to complex issues that require improvement in their area. The training is in both London and Bedfordshire and is consistently well attended. During the year, this training also received CPD (continuous professional development) accreditation after being scrutinised by an external accreditation organisation to ensure integrity and quality compatible with global CPD requirements. Efforts to align capability building for quality improvement into directorate annual planning has contributed to an increase in staff attending all QI training programmes. Pocket QI has seen a 150% increase in graduates in the past 10 months with a current average of 65 graduates per workshop. To meet the increased demand, the number of London training sessions has been doubled to one every month.

2.23 Building capability in QI skills is an important part of developing and maintaining a culture of Quality Improvement across the Trust. In March 2023, 167 staff and service users graduated from the six-month long Improvements Leaders Programme (ILP) to lead and support teams to progress with their improvement work in their areas. During the year, the programme was received CPD accreditation. Over a hundred teams displayed their improvement work to celebrate their progress. One senior leader graduate has now requested all the management team members in his area to attend the next wave of ILP, to embed the improvement culture in his area and the projects he is a sponsor for. A service user attending from Tower Hamlets mental health services reported that the ILP made her understand why her part in a project was so important and felt motivated to do more. The number of active QI projects has returned to pre pandemic levels throughout 2022 with a notable increase in November as a result of the onset of the current Improvement Leaders Programme.

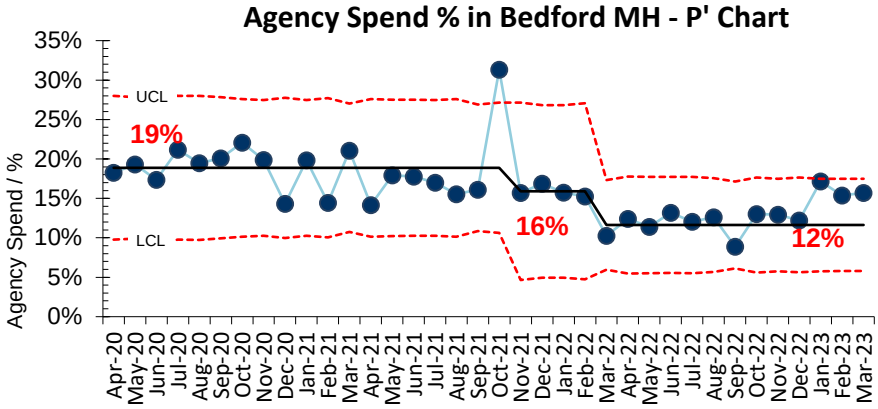
2.24 Also in March, 55 staff and one service user graduated from the Improvement Coaching Programme (ICP), a seven-day course over six months equipping QI coaches with a deeper knowledge in improvement science so that they can support and guide teams working on QI projects. One of the many stories of how staff are benefiting from QI training, in addition to helping improve services, is from a QI coach on the current ICP. They work as a Life Skills Recovery Worker which involves supporting nurses and healthcare assistants with their care roles and facilitating activities and events on the ward for and with service users. They were encouraged by their manager to go on the Improvement Leaders Programme. They have been using the plan-do-study-act approach regularly in their job and even in their personal life and business. They were involved in a QI project that improved service user satisfaction with the quality of 1:1s

from 65% to 93%, and staff reported that they felt more confident in facilitating 1:1s as a result of the project. The skills and experience they obtained from this work has built their confidence to speak and lead a team. They even had the confidence to present the work at a QI conference at the Royal College of Psychiatrists. This has given them the confidence to become a QI coach and support others with their QI projects.

2.25 **Improving Value**

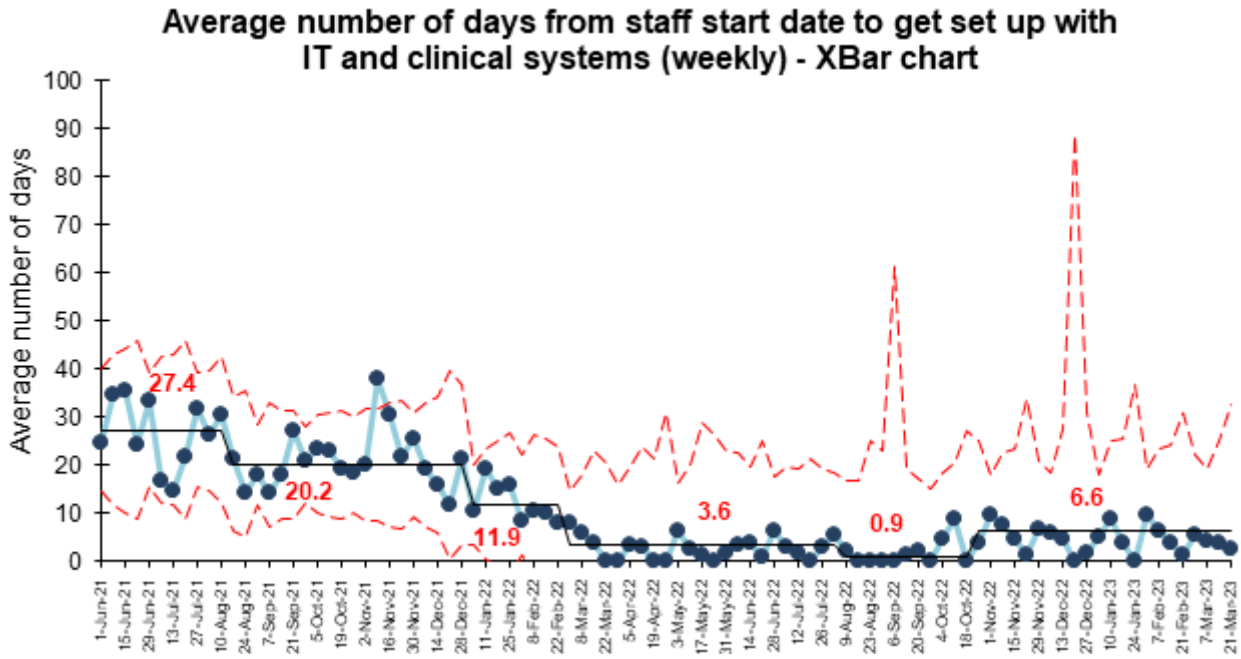
2.26 *Agency spend project:*

2.27 The trust wide project on staff agency spend reduction has seen a reduction in percentage of agency spend in six areas across the Trust. Of particular interest is in Bedford Mental Health where the project team primarily focussed their tests of change. They were able to reduce the percentage of agency spend from 19% to 14% and have sustained this for more than a year (chart below). Some of the change ideas from this work were applied across the organisation, trust wide data remains unchanged with an average of 7.7% of total staffing costs being spent on agency staffing. Change ideas that have been implemented into business as usual include redesigned job descriptions; internal process for agency pay rate limit and approval; finance business partner approving and coaching budget holders; appointment of a medical resourcing manager; an incentive scheme to encourage staff to take on staff bank shifts instead of filling those through an agency; changing to a direct engagement supplier whereby the trust saved on VAT by paying agency staff directly or a 3rd party instead of by their agency. A recommendation from the work was to develop a central structure for managing temporary staff which is now established.



2.28 *New Starter Project:*

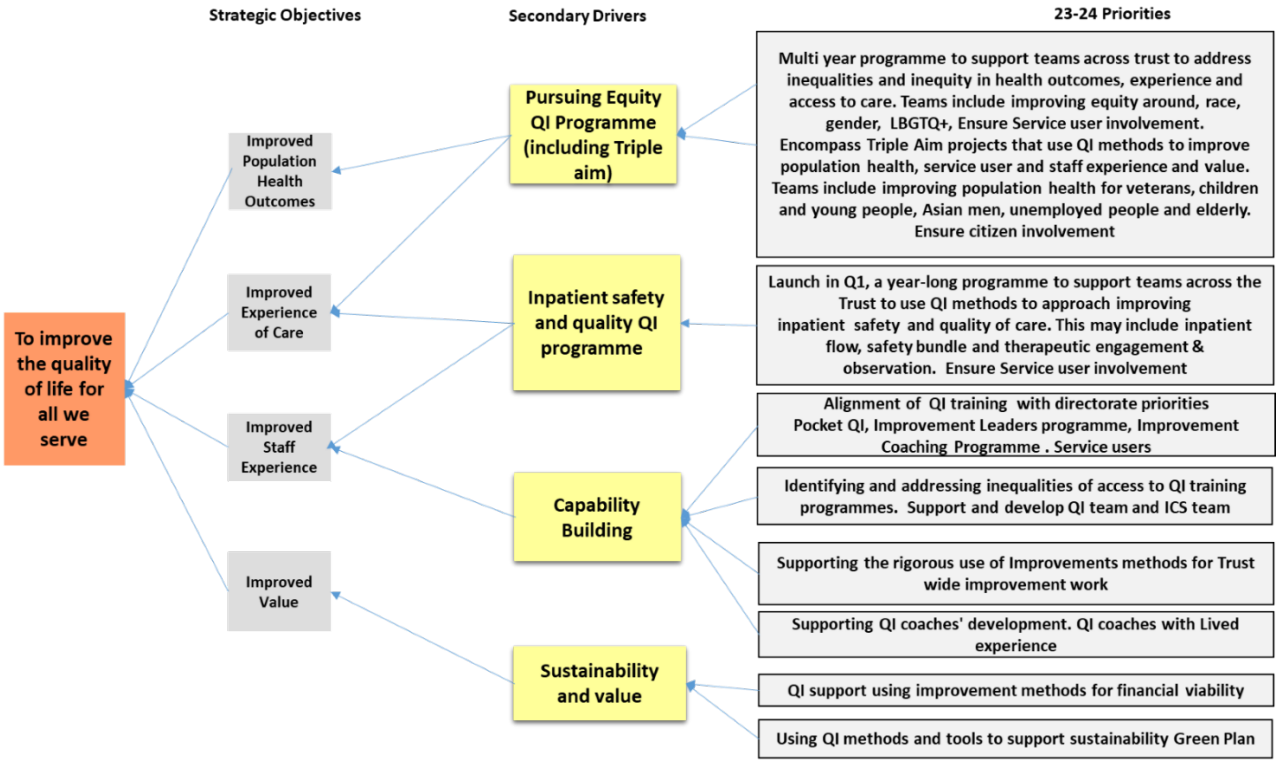
2.29 A team consisting of team members from the people and culture, IT helpdesk and digital departments have been working towards improving the experience of new staff starting at ELFT. Their aim is that all staff on day one are in possession of their 'smartcard', a card that enables access to NHS systems, and that they are able to access clinical IT systems within one week of their start date. Access ensures clinical staff are equipped with essential patient information, a key factor in patient safety. Improving data quality and internal process change has resulted in clinical staff accessing clinical systems within seven days (chart below).



3.0 Quality Priorities for 2023/24

3.1 *Quality Improvement:*

3.2 The driver diagram below sets out our QI 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 2023-24. Capability building and sustainability and value continue to be priorities in the QI plan. A trust wide scoping exercise was undertaken with all directorates to identify equity work that they want to support in 2023/2024. Teams looking to use QI to approach an equity issue will be recruited into the 'Pursuing Equity' programme to help accelerate their progress my sharing their learning and bringing in expert faculty as needed. Clinical directorates with inpatient wards were consulted on their priorities and complex problems for the coming year. As a result, a new programme on 'Inpatient Quality and Safety' will support application of the safety bundle for reducing violence on mental health inpatient wards and improving therapeutic engagement and observations. This will bring teams together regularly to learn, share and test ideas together with local QI coaching to support projects. This programme will be different to the equity programme because the inpatient units will have a shared aim, change ideas will focus on rapid scale-up and implementation of successful ideas into business as usual and quality control.



4.0 Quality Assurance

4.1 This section describes progress against the Quality Assurance workplan 2022/23, and sets out the workplan for 2023/24.

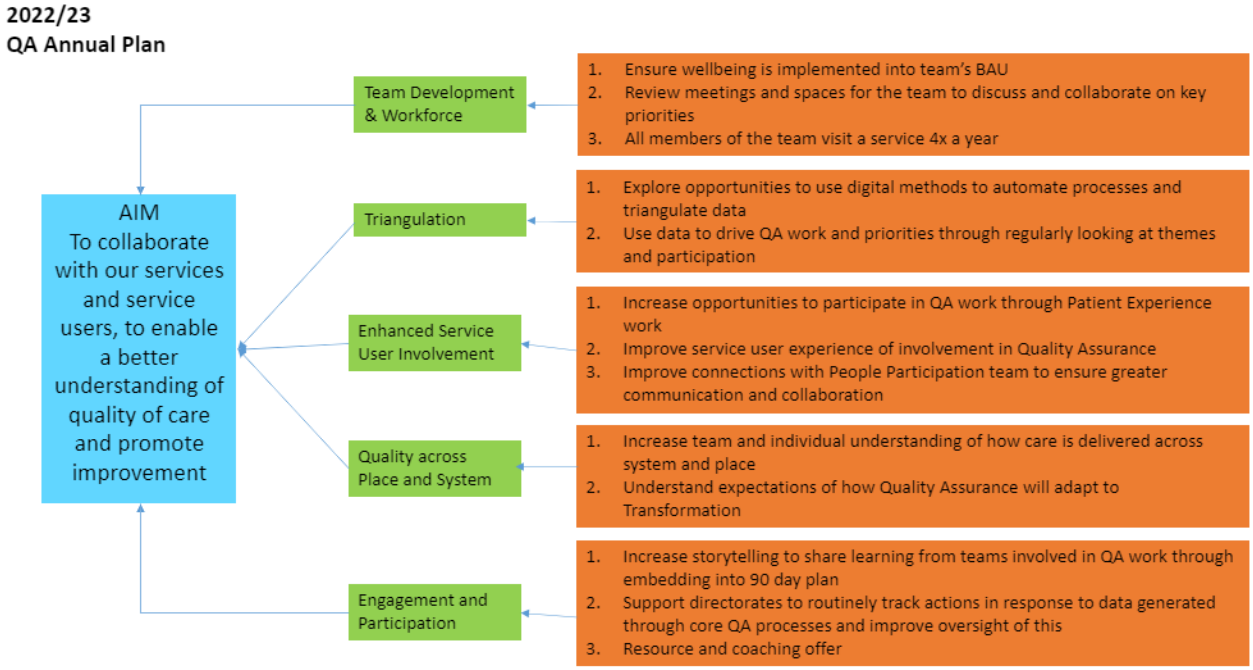
4.2 Quality Assurance is the range of methods by which the organisation ensures that it is doing what it should be doing, and to the required standards. Quality Assurance at ELFT forms part of a wider quality system that also includes planning, improvement and control. It is the aim of the Quality Assurance Team (QA) to contribute to the development of this system, and to support the organisation in delivering the highest quality care, and meeting its strategic objectives.

4.3 In practice, effective quality assurance processes support regulatory compliance and are crucial to inspection readiness and sustaining an outstanding rating, as well as supporting and promoting learning and improvement.

4.4 The ethos of the QA team is rooted in openness, collaboration and continuous improvement. Engagement and capability building are at the heart of the Trust quality assurance model. The team positions itself as a hub for quality assurance activity, and a source of expertise in relation to quality assurance, enabling teams to understand the quality of service they provide.

4.5 The work plan for the past year is set out below and was focused on 5 priority areas:

- Team development
- Efficiency and value
- Enhanced service user involvement
- Understanding and contributing to quality across system and place
- Enabling and monitoring action, learning and improvement



5.0 Effective delivery of core quality assurance processes

5.1 Across the workplan for 22/23 is the ambition to improve what we do, and the experience of our stakeholders. The report starts by setting out the activity and impact of our core workstreams.

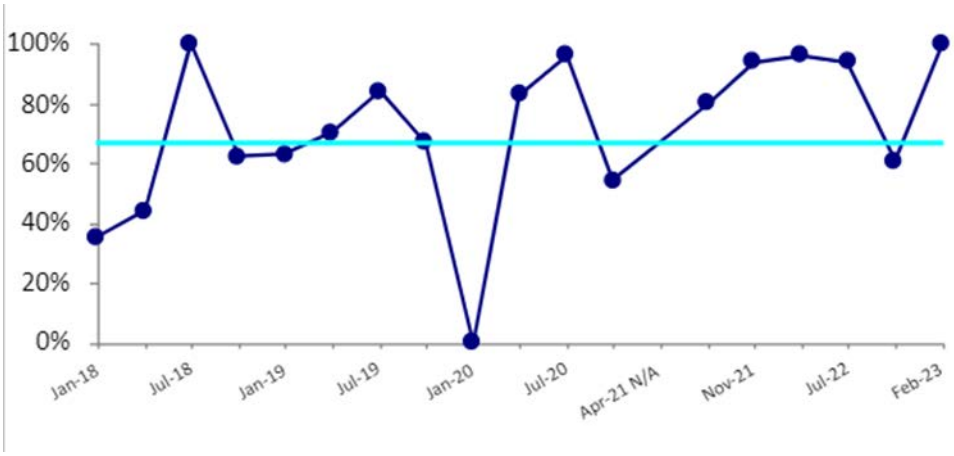
6.0 CQC@ELFT – supporting regulatory compliance and inspection readiness

6.1 This workstream involves all clinical services undertaking an annual self-assessment against core regulatory standards. Directorate management teams review the findings on a summary report produced by the Quality Assurance team. Along with the range of other intelligence DMT have, they choose a selection of their services to take part in a peer-to-peer review of the service, which looks at evidence to support the self-assessment, provides objective judgement of compliance, identifies areas of strength and opportunities for improvement. The peer-to-peer review simulates a CQC inspection and facilitates sharing of learning and good practice across services.

6.2 Throughout the financial year 2022/23, self-assessments have been completed by Newham Mental Health, Tower Hamlets Mental Health, City & Hackney Mental Health, Bedfordshire & Luton Mental Health, Specialist Services (Talking Therapies, CAMHS, Addictions, SCYPS, Forensics) and Primary Care.

6.3 Participation in the self-assessment process is monitored by the Quality Assurance Team and reported regularly to the Quality Committee. Participation over the 2022/23 year is set out below.

Percentage of internal CQC Self-Assessment surveys completed by quarter



6.4 The QA team provides a summary report to relevant Directorate Management Teams after each round of self-assessment, setting out participation and overall compliance with standards. Each self-assessment undertaken is expected to include an action plan to address any identified areas of non-compliance. DMTs are asked to follow up with any teams who have not participated within the prescribed time frame to ensure self-assessment is completed and that they and the organization have the assurance they required regarding regulatory compliance.

6.5 Following from CQC Report dated January 2022, a key priority was to update and strengthen the CQC@ELFT programme for 2022/23 in light of the identified areas for improvement. As a result, 5 new standards were added to the self-assessment tool. These standards and the correspondent key line of enquiry are listed below.

- Safe: Physical health is assessed as part of the initial assessment / on admission and reviewed regularly (for Mental Health Services only)
- Caring: The service keeps families and carers informed of their loved one's care, where appropriate
- Well-led: There are initiatives to ensure and promote staff Wellbeing
- Well-led: IT systems are effective to monitor and improve quality of care
- Well-led: Local broadband and connectivity is of the required standard to ensure the service can go about its business

6.6 As part of the Trust's patient safety plan, we introduced a Patient Safety Culture tool for Inpatient services. The tool will enable teams to understand better and, where necessary, improve their safety culture. All ward staff are expected to complete an online survey and, later on, reflect collectively on the team's results and agree on the next steps to strengthen their safety culture. The summary report, produced by Quality Assurance Team, provides resources to support the conversations.

6.7 The Care Quality Commission (CQC) has announced that is launching a new regulatory model later this year. Once more details are published, CQC@ELFT will adapt to these changes to ensure the process remains a current and meaningful way of reviewing the quality of care we are delivering.

7.0 Patient Experience

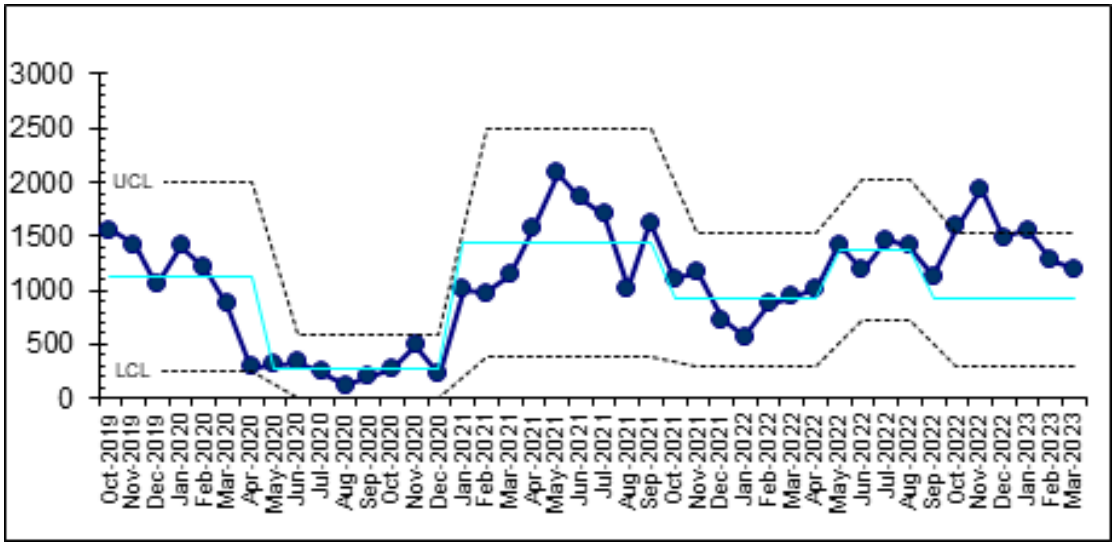
7.1 The Trust uses the Patient Reported Experience Measure (PREM) feedback system to measure service users' and carers' experience of care. The friends and family test

questions are the core component of the system. The Trust also uses Care Opinion to collect service users' and carers' experience of care.

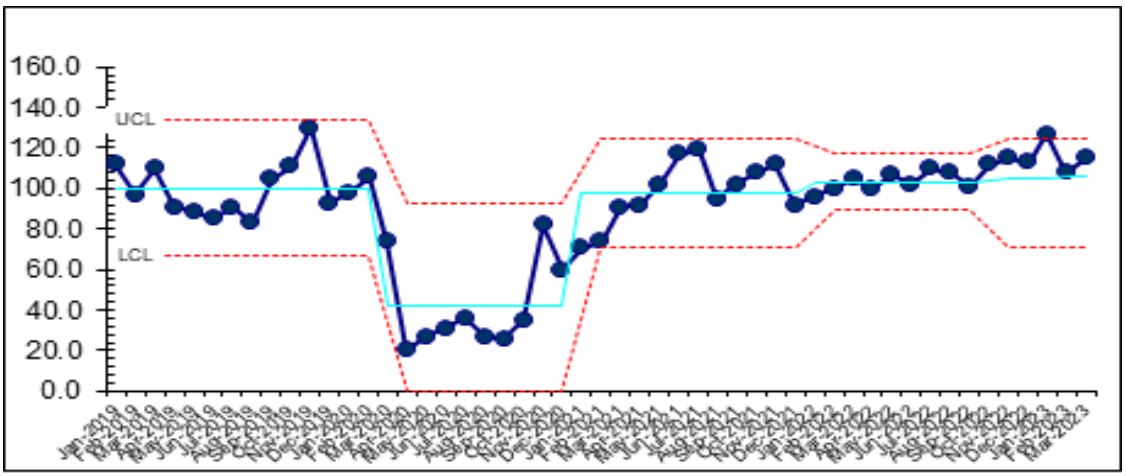
7.2 For the PREM survey, the Quality Assurance Team monitors the volume of feedback the Trust receives and reports it regularly to the Quality Committee. The number of responses received as well as the number of teams receiving their feedback via the platform between April 2022 and March 2023 remain fairly consistent.

7.3 The number of PREM responses received over time, the number of teams receiving regular feedback and the % of responses of service users and carers that report having good and very good experience of our services can be seen in the charts below. Overall, most service users and carers report having good and very good experience of our services.

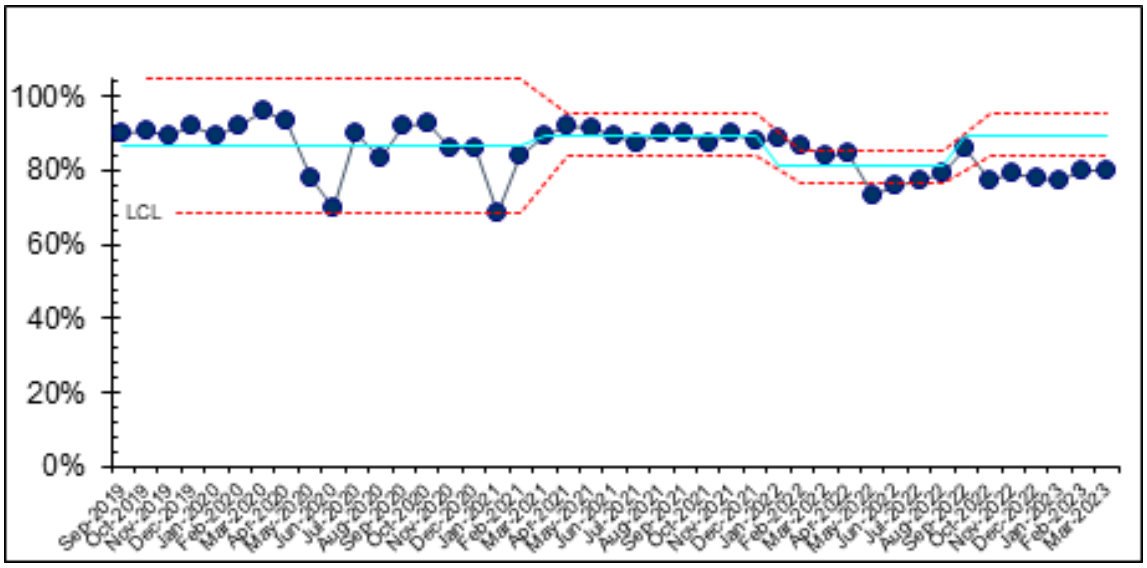
PREM survey - Responses Trustwide



PREM survey - Number of teams receiving feedback



PREM - FFT - Percentage of people answering 'Very good' or 'Good' in response to the question 'Overall, how was your experience of care?'



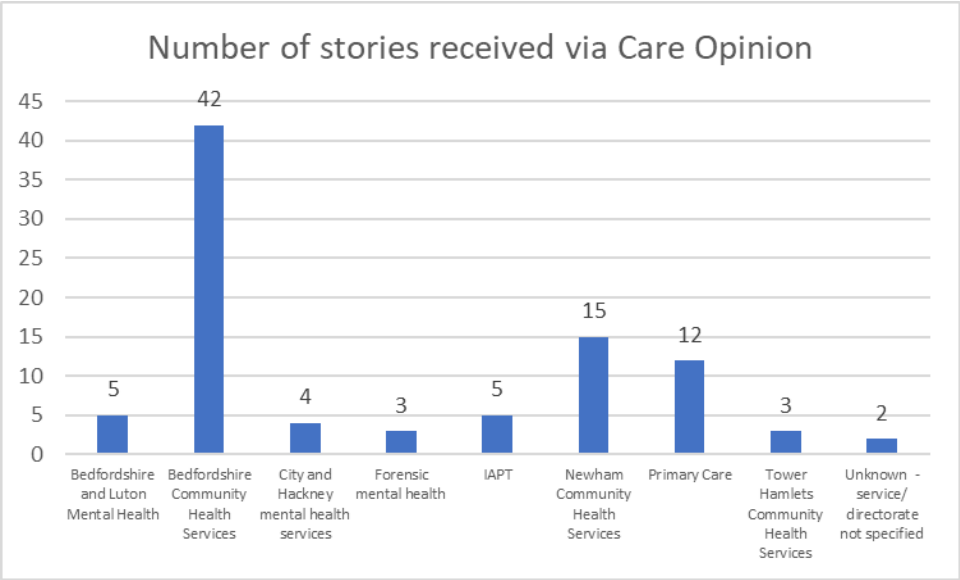
7.4 All services are asked to review their feedback on a regular basis, in order to recognise and share good practice, but also identify and address areas for improvement. Directorates have developed effective systems, supported by their quality and governance leads, to oversee this and facilitate sharing of actions and ideas.

7.5 A good example of this is in Tower Hamlets Mental Health Services where they identify issues for action centrally in performance and governance meetings, and look back at the issues from the previous month to check on progress. From this outset this helped bring about improvements, and in the first couple of months of the system being in place the inpatient teams had identified the following issues:

- Need to fix the buzzer on Bricklane Ward
- Have more snacks and better food – unit wide
- More activities on the ward wanted

By the following month the buzzer has been fixed, there is a new catering provider at Mile End who has been invited to ward community meetings which are attended by patients and will give service users the opportunity to discuss the menu. And a new OT was recruited who will take forward the issue with activities. Teams are then encouraged to share these actions with their service users and carers via their local 'you said we did' boards.

7.6 During the 2022/23 financial year, the Quality Assurance team has been testing the Care Opinion platform to establish if it is a useful platform to use in addition to the PREM feedback system. Care Opinion is an online public platform where anyone who comes into contact with health or care services can share their experience. Any feedback submitted to Care Opinion is moderated by the Care Opinion team. Services that receive feedback can respond. The QA team worked with teams that volunteered to use the platform and have worked with them to implement it. 17 teams from across the Trust, and two directorates have started using the platform. Our Trust has received 91 stories. 77% (70/91) of the stories received were positive. The breakdown of the number of stories received between 1 April 2022 and 31 March 2023 by each directorate can be seen in the chart below.



7.7 During the 2022/23 financial year, the Quality Assurance team has also supported the creation of the Patient and Carer Experience Forum. The purpose of the Patient and Carer Experience Forum is to provide a platform for discussion and review of patient and carer experience data with the aim of learning and, ultimately, improvement of patient experience within the organisation. The forum met 3 times since the first meeting in September, and 4 Directorates have shared their priorities and recent improvement work.

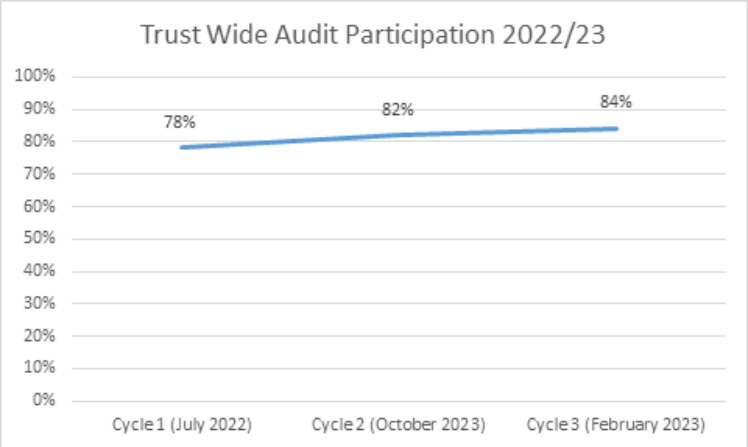
8.0 Trust Clinical Audit Activity

8.1 The Quality Assurance team manages the trust wide clinical audit programme. Clinical services undertake audits against both mandatory Trustwide standards and locally determined standards. From 2022/23 clinical audit cycles take place 3 times per year, in June, October and February.

8.2 This does not apply for three medicines audit, Controlled Drugs and Safe and Secure handling of Medication. Controlled Drugs audit is audited 4 times per year, at the start of each quarter. Safe and Secure handling of Medication is audited twice per year so that teams can monitor progress and changes within the same calendar year. Transcribing audit is completed annually.

8.3 The Quality Assurance team measures the participation in clinical audit and reports it to Directorate Management teams and centrally to the Quality Committee. Medication Audits and Infection Control Audit are reported to Medicines Committee and Infection Committee.

Percentage of the Trusts overall Participation



8.4 During 2022/23 Bedfordshire and Luton Community Mental Health Directorate designed their Directorate audit.

8.5 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.

8.6 Agreed priorities and associated actions are expected to be logged on an audit action tracker. Each action has an allocated owner who is responsible for completing the action and update the tracker accordingly.

8.7 An example of this is the Tower Hamlets Mental Health directorate. In this directorate all teams review results and discuss actions at local meetings with the Tower Hamlets Clinical Governance Coordinator. These actions are recorded on a Governance Tracker and progress against actions is monitored by the Clinical Governance Coordinator.

8.8 Notable successes in bringing about improvement include IAPT increasing their recording of Anxiety Disorder Specific Measures (ADSM) scores from around 30% to over 70%. And community teams in City and Hackney Mental Health Services increasing their informing of service users of the outcome of referrals from 60% to over 80%.

9.0 Service User Led Accreditation

9.1 The Service User Led Accreditation programme, launched in 2019, has continued in 2022/23. 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 award. Services who 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.

9.2 The programme has successfully transitioned back to being conducted in person after being moved virtually due to the Covid-19 pandemic. This has enabled a better experience for both services users involved and clinical teams. This programme is a crucial aspect of our commitment to providing high-quality services that are responsive to the needs and

preferences of our service users. All visits include a Quality Assurance member who supports the assessors and ensures the process is as smooth as possible for the service involved.

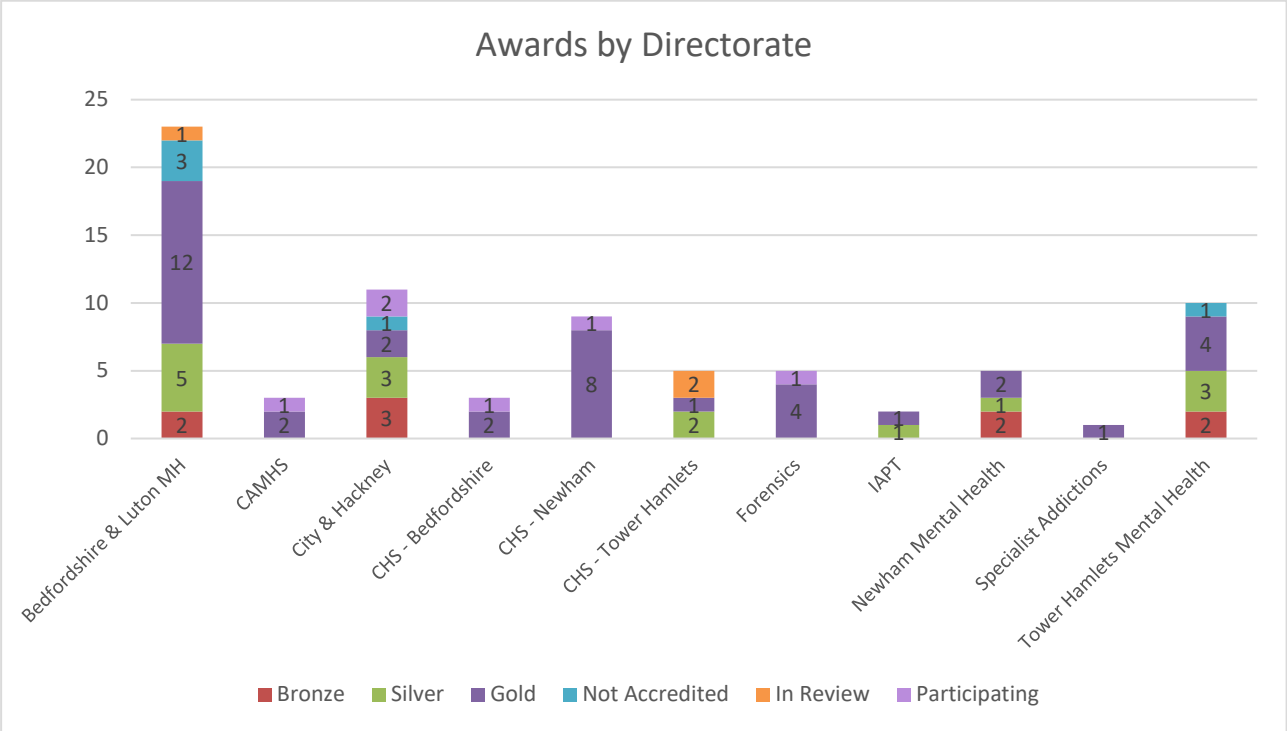
9.3 In the past year, 13 clinical teams have registered to take part. Out of these, 5 teams have completed their assessment and visit, 2 teams have dropped out of the process before its conclusion, 1 team has requested to defer starting the process until summer 2023. Four teams are due to commence the programme in the next few months. Lastly, we are working with one of our Primary Care services to understand how the accreditation programme can work for them. Hopefully, this will inspire other teams to join our programme.

9.4 A total of 84 clinical teams have participated since the start of the programme.

9.5 The QA team and a service user have started a project to increase the number of registrations by two per month by May 2023. The project aims to encourage more services to participate in the programme and increase the uptake, ensuring that service users continue to be involved in developing and improving the services they use. As part of the project, we have also introduced Q&A sessions which provide an opportunity for services to ask questions and learn more about the accreditation process. By facilitating these sessions, we aim to increase understanding and awareness of the programme.

9.6 The QA team are also working with Service Users to introduce a developmental offer to services, which will aim to support services who do not yet feel ready to be accredited.

9.7 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 further assessment.



9.8 As part of the accreditation process, feedback is routinely collected from the clinical teams and assessors involved. In addition, feedback is discussed weekly at team meetings. Feedback collected from clinical services showed that all would recommend other

services to take part and rated the experience as valuable. An example of some of the feedback is below:

"That outside view on things from experts by experience is invaluable. And at the end its great reward for hard work – for us it was a real morale boost after working through some significant challenges."
(Maham Shahzad, Service Manager, Brett Ward)

"The whole experience was a great opportunity to understand what matters to our service users and about what we do well as a service. It has really made us appreciate the value of getting input from service users and we have now started looking at how we can source that more actively as a team."
(Laura Shrieves – Bedfordshire Early Intervention Service)

"I appreciated the fact that I was talked through my expected experience step by step, and the process that followed was pretty much what was expected. However, the best bit of our experience on Joshua ward was receiving such positive feedback from the assessors, who were very complimentary with their feedback. My staff also really appreciated the feedback, and we spent a whole away day going through the report bit by bit and reflecting on it. Joshua ward staff were very proud about the fact that their hard work was being acknowledged, and we also made an action plan as a team as to how we could achieve a gold standard in our next assessment. This proved to be a very positive day and was very much needed after a very tough couple of years, where the ward and the team have been under a lot of pressure, much like the rest of the mental health services."
(Koray D'Jafer – Joshua ward City and Hackney)

9.8 The impact of the programme has further been explored via storytelling. So far, 2 clinical teams have been interviewed to share what participating meant. Sharing these stories will encourage other teams to participate.

9.9 We have continued to host regular 'Assessors together' sessions with our assessors. This provides a space for shared learning and connections between assessors. Our QA Service User Lead also produces newsletters designed to provide updates and information on upcoming visits and other opportunities for our service users to get involved in the programme. produces newsletters designed to provide updates and information on upcoming visits and other opportunities for our service users to get involved in the programme.

9.10 To further involve our service users in the programme, we hold quarterly service user panels where service users can provide feedback and suggestions on reports from services going through the process. We also invite service users to deliver certificates to teams that have been accredited, recognising their contribution to the programme.

9.11 Overall, our approach to QA prioritises collaboration and engagement with our service users, ensuring that their perspectives and experiences are incorporated into our processes and decisions. We believe this approach will improve outcomes for everyone involved in our programme.

9.12 We are continuously improving and developing the programme, which is a main QA priority for the 2023/24 year. In May 2023 we will be launching the Platinum Award. The standards for the Platinum Award were designed in co-production with service users from across the Trust. Service users were asked to reflect on experiences of exceptional service and care and, using the Trust's values and current domains of the Accreditation as lenses, discuss what would need to happen make the services they access to be

providing the same level of service. Following this exercise, the feedback was collated and analysed and refined into three new 'Platinum Domains'; Place-Based Partnerships and Population Health, Peer-Support and Flexibility, Staff Wellbeing.

10.0 Implementation of National Institute for Health and Care Excellence (NICE) guidance

10.1 The team manages the process by which new and updated guidance is received into the Trust, its relevance assessed, the guidance disseminated to relevant services for review, and where necessary detailed baseline assessment undertaken.

10.2 During the financial year 2022/23, NICE published 200 new or updated guidelines. Since the second half of the financial year, the guidance hasn't been consistently reviewed by the allocated clinical leads.

10.3 The Quality Assurance team has been working with Medical Directors on the recovery plan to ensure that all the new or updated guidelines is reviewed by the relevant services. The Medical Director for Luton and Bedfordshire Mental Health Services has blocked time in her diary to review new guidance as they are circulated. Reviewing the guidance yet to be triaged has been delegated to Consultant Psychiatrist. The Medical Director for Community Health Services has met with the QA team and confirmed his understanding of the process. There is a clear commitment to reviewing the backlog, and a more detailed plan to deliver this is currently being developed.

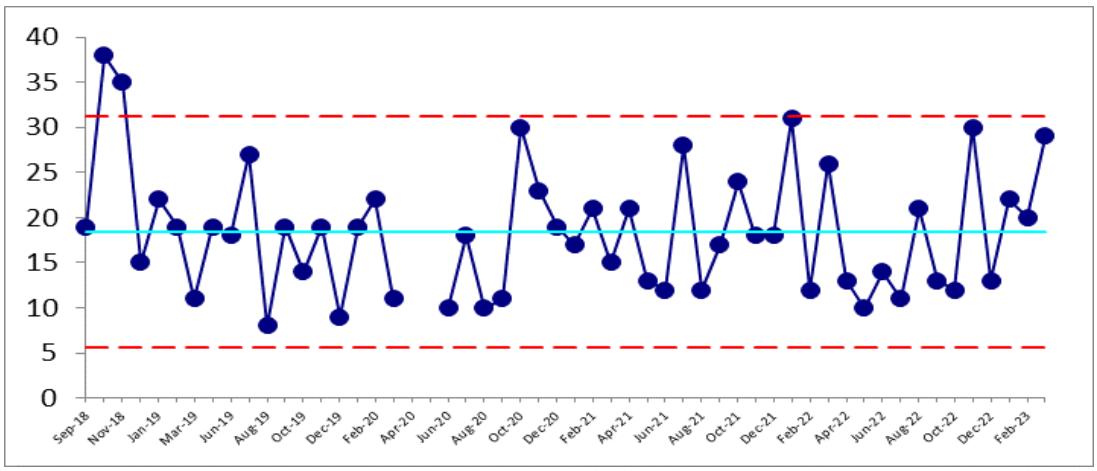
10.4 A meeting took place in May 2023 to discuss the current process and ways of streamlining. A proposal for how the process can be improved will be introduced in 2023.

11.0 Executive Walkrounds

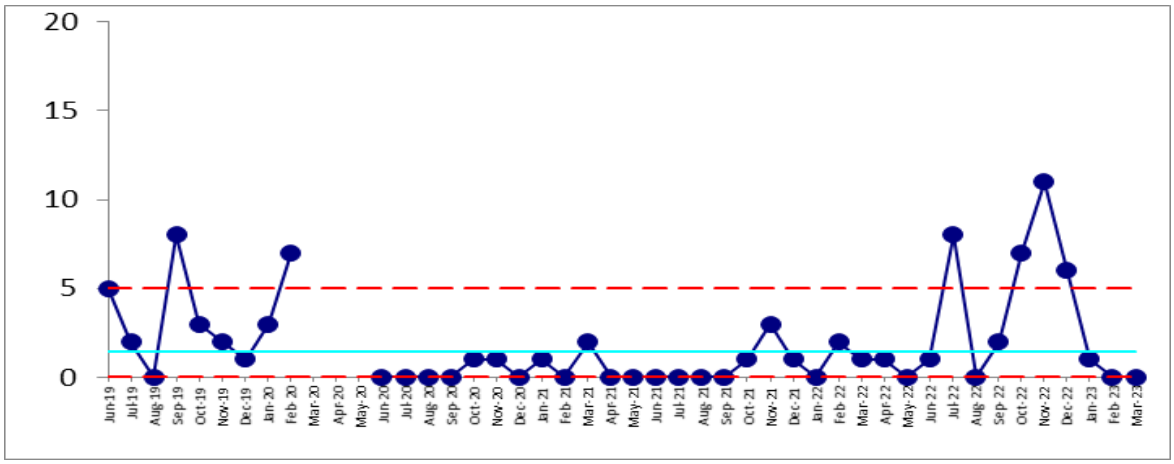
11.1 The Quality Assurance team continues to coordinate a programme of Executive Walkrounds. Each team within the Trust gets visited by one of our Executive Directors annually. The Executive Directors use a standard set of questions that capture both what the team is proud of, and what could be improved.

11.2 The Quality Assurance team work with the Executive Assistants to arrange all the visits that take place. All arrangements are logged on a live tracker monitored by Quality Assurance. The number of visits taking place monthly, and the number of cancellations within 7 days of the scheduled visit are reported monthly to the Quality Committee.

Number of walkrounds scheduled



Number of identified late cancellations



11.3 Feedback and key discussion topics from each executive walkround are recorded and shared back with Directorate Management Teams. DMTs are asked to take action to recognise services' successes, but also to support them in addressing issues and concerns raised.

11.4 It is expected that these actions are tracked and reported on at their local DMT meetings.

11.5 The records are also periodically used to examine wider themes, often triangulated with other sources of feedback, to help provide greater understanding and assurance around aspects of staff experience. Some of the more prominent themes from walkrounds during the past year are set out below.

Positive

- Many teams were proud of their teams' cultures. Teams described working well together, having supportive and hardworking colleagues, and being supported from their managers.
- Teams have also mentioned successfully improving internal processes, improving the environment of their services, being more efficient, bringing innovation to their services, and successfully managing services' transformation.
- Many teams have strong links with other ELFT teams, and with local services.

Negative

- Teams reported having a shortage of staff, and problems with recruitment and retention, which has been exacerbated by the increase in cost of living. Local authorities and organisations our teams work with have also similar problems and it negatively affects ELFT teams' ability to work effectively together.
- Many teams experience problems with devices (e.g. slow computers, not receiving devices on time) and slow internet that impact their work negatively. Many reported having to work from home to use their own internet and personal devices.
- In addition, teams reported problems with buildings, e.g. buildings not regulating heat and cold very well resulting in a very hot temperature in summer and cold in winter, not having enough space for internal meetings or meetings with service users.

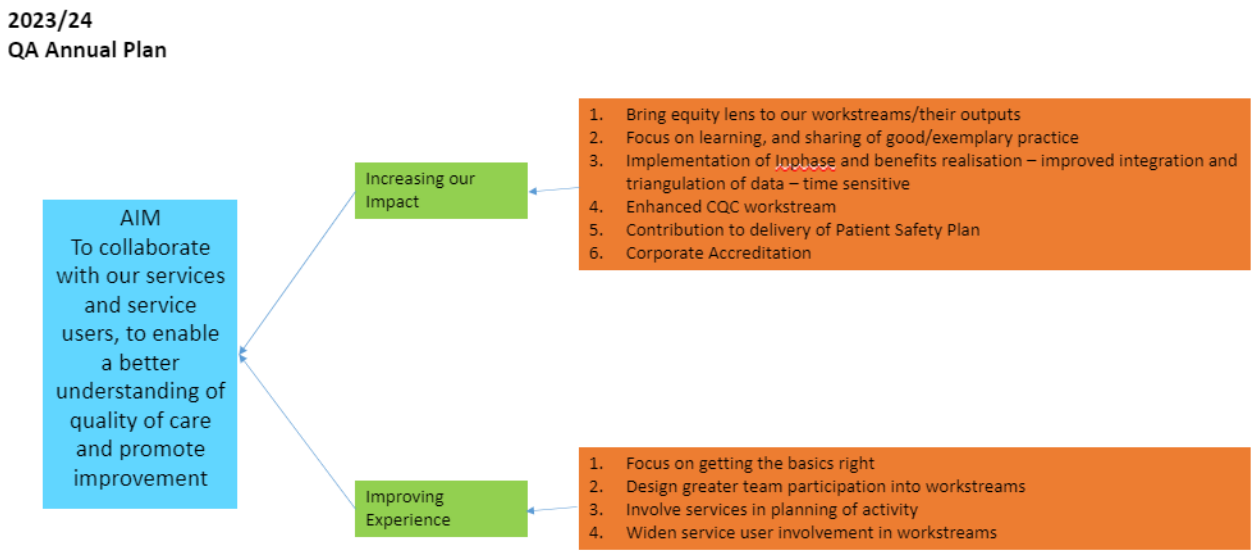
11.6 The trust expects that teams participate in our internal quality assurance programmes, that good practice identified is recognised and shared, and that any areas for improvement are acted upon, and that those actions are tracked by the Directorate Management Team.

11.7 The QA team tracks participation of each service in each of our workstreams throughout the year, and reports back to DMTs every 6 months. DMTs are asked to take action to improve participation in QA workstreams across their Directorate.

11.8 The QA team also monitor and share back with DMTs their services participation in external accreditation programmes. All services are encouraged to consider participation in such programmes to strengthen assurance and their understanding of the quality of the service they are providing, to recognised good practice and support improvement, and facilitate learning and work across services and organisations.

12.0 Annual Plan for 2023/24

12.1 The work plan for 2023/24 is set out below and focused on 2 priority areas: increasing the impact of our work and improving the experience of our work for clinical services and service users.



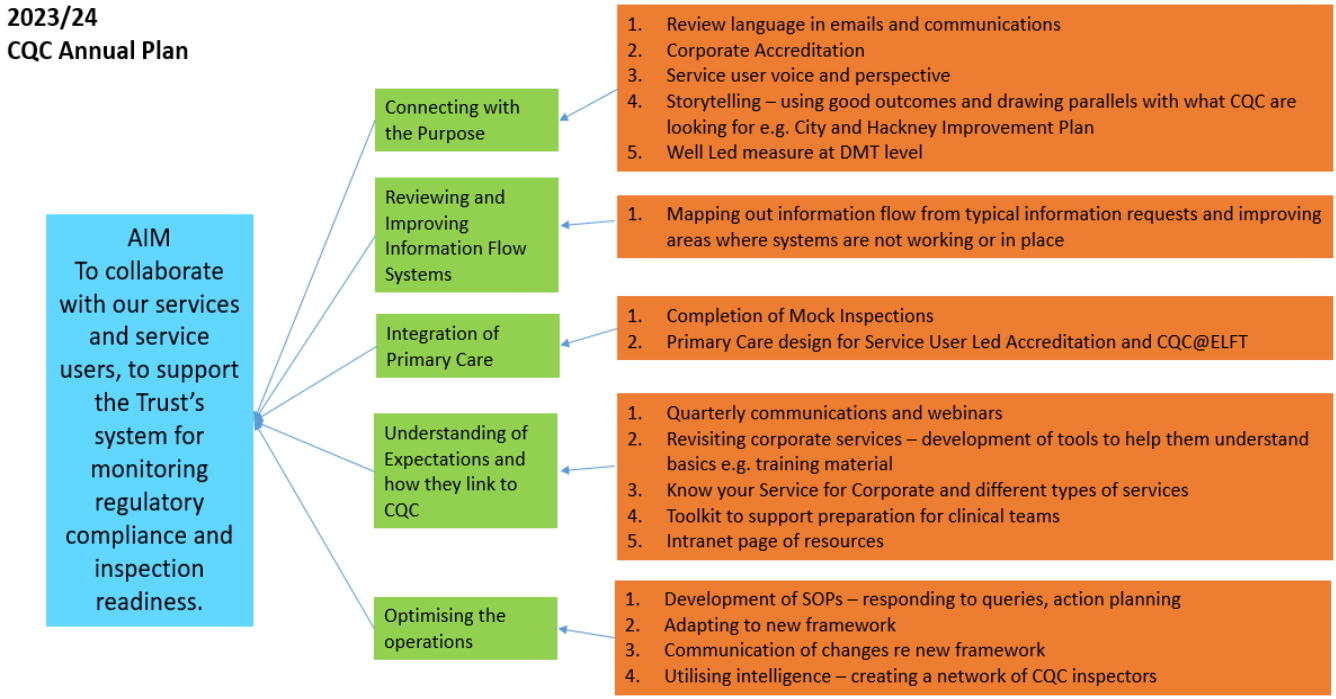
12.2 This workplan aims to help us focus on what is important for our key stakeholders: clinical services and service users. Over the next financial year we will be introducing digital systems, and broadening our QA offer to corporate services in order to increase our impact. We'll also be aiming to contribute to the Trust's equity and patient safety priorities. To improve stakeholder's experience of our work, we'll be focusing on getting the basics right with regard to customer service, and involving clinical services in the planning of work across the year. We'll also be identifying more opportunities for service users to participate in Quality Assurance work.

13.0 Annual Plan for monitoring regulatory compliance and inspection readiness 2022/23

13.1 A programme of work will be developed in 2023/24 to build and learn from the previous inspections. This will include:

- A Service User Led Accreditation process to support Corporate services and ensure we are connected to our purpose and meeting needs of clinical services

- Reviewing and Improving Information Flow systems, particularly where information is likely to be required as evidence for CQC
- Integrating Primary Care services into Trust Quality Assurance processes for monitoring CQC compliance and also Service User Led Accreditation
- Adapting Trust self-assessments and peer review documentation to CQC's New Framework, expected later in 2023



14.0 InPhase and Civica Implementation

14.1 During 2023/24 the Quality Assurance team will be introducing 2 new systems to support Quality Assurance work. We will be introducing Civica to support the collection of Patient Experience feedback in Autumn 2023. Civica will offer the Trust ways to make our surveys more inclusive to service users who have a learning disability, dementia, are children or do not speak English as a first language. This will help us collect feedback from a wider group of people and ensure it is more representative of the local population. A programme of work is starting to ensure services are aware of the change.

14.2 The Trust is also introducing InPhase which will be replacing systems for various quality and governance processes this year. We will be using InPhase for multiple Quality Assurance modules including audit, CQC@ELFT, Accreditation and NICE. The system will enable services to have greater oversight of their quality activity and actions that result from it. We aim to have all modules on InPhase by the end of the financial year.

15.0 Action Being Requested

15.1 The Board/Committee is asked to RECEIVE and NOTE the report.

East London
NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE
26 JUNE 2023

Title	2022/23 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 2023 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 19th 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.

NHS
East London
NHS Foundation Trust

QUALITY ACCOUNTS 2022/23

East London NHS Foundation Trust

Contents

If you require any further information about the 2022/23 Quality Accounts please contact: ELFT Communications Team on 0207 655 4000

Our Services

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 £640 million. The Trust provides Mental Health, Community Health and Primary Care services.

East London NHS Foundation Trust (ELFT) provides local services to an East London population of 950,000 and to a Bedfordshire and Luton population of 820,000.

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. 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.

A new acute mental health inpatient unit for children and young people in Bedfordshire, Luton and Milton Keynes opened to admissions in February2023. The unit consists of 8 beds. The service will provide specialist, short-term care for young people aged 13-17 with severe or complex mental health difficulties. The unit is a partnership between ELFT, Central and North West London Foundation Trust (CNWL) and Bedfordshire, Luton and Milton Keynes Clinical Integrated Care Board.

This unit is based at the Luton Centre for Mental Health, part of the Luton & Dunstable Hospital site. It was developed in partnership with service users and carers, who chose the name ‘Evergreen’ for the unit. Coproduction has been at the heart of the development of Evergreen. An engagement group consisting of young people who have all had experience of inpatient admission have supported the team with recruitment, the selection of furniture/fittings, the unit’s layout, policies, and will also be delivering training to new starters.

Increasing integration of services, and greater partnership working, has continued apace. The Trust is part of a CAMHS Provider Collaborative involving a partnership with Barnet, Enfield & Haringey Mental Health NHS Trust (BEH), NELFT, The Tavistock & Portman NHS Trust and The Whittington Health NHS Trust. We also work closely with NELFT to make optimum use of adult health care resources to ensure that people can be cared for locally where possible.

With the greater emphasis on Integrated Care Systems (ICSs), much of the Trust's work and the way services are provided is in collaboration with partner organisations such as fellow NHS trusts, local authorities, other public bodies and the voluntary sector.

In our 2021/22 Quality Accounts we spoke about the example of the Mental Health Community Transformation programme taking place across East London and Bedfordshire that aimed to deliver:

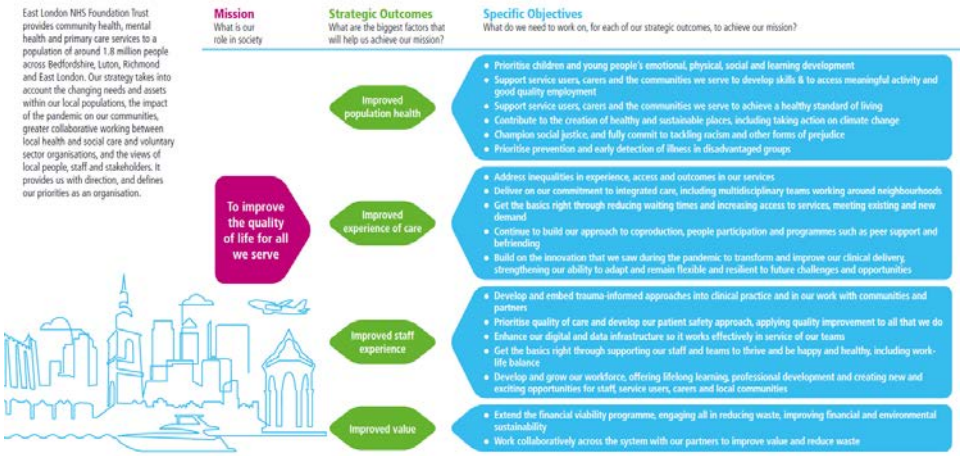
- More joined-up care
- Care closer to home
- Reduced inequalities
- Greater Coproduction

This transformation is now embedded across East London services and starting to deliver real impact. Since the very start of the work in 2019 the experience of people using services has changed.

The repercussions of the Covid pandemic, and latterly the increasing cost of living, have, of course, continued to provide a challenging context within which to deliver high quality care. Huge efforts, summarised in the report, continue to be made to improve patient flow and timely access to assessment and treatment.

Our Trust Strategy

The ELFT Board commissioned a refresh of the Trust strategy in early 2021. Building on the previous strategy, and retaining the mission to improve the quality of life for all we serve, the latest Trust strategy for 2021-2026 is set out below.



The Trust has strengthened its annual planning process to support implementation of the strategy, and align priorities with system partners, and are working in collaboration with our communities and partners, always striving towards continuous improvements in everything we do in order to deliver our strategy, and in support of wider Integrated Care Systems strategic objectives.

Integrated care systems (ICSs) are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population.

The central aim of an ICS is to integrate care across different organisations and settings, joining up hospital and community-based services, physical and mental health, and health and social care. Integrated care systems (ICSs) have been tasked with four main objectives:

1 To improve **outcomes in population health** and healthcare
2 To tackle **inequalities** in outcomes, experience and access
3 To enhance **productivity** and value for money
4 To help the NHS support broader **social and economic development.**

ELFT is a member of two ICSs, North East London (NEL), and Bedfordshire, Luton and Milton Keynes (BLMK). Each ICS has an established set of strategic priorities.

NEL

Our purpose:
"We will work with and for all the people of North East London to create meaningful improvements in health, wellbeing and equity."

Our flagship priorities:

Children &young people	Mental health	Employment & workforce	Long-term conditions
• to make NEL the best place to grow up	• to improve the mental health and well being of the people of NEL	• to create meaningful work opportunities for people in NEL	• to support everyone living with a long-term condition in NEL to live a longer, healthier life

Our operating principles:
- Improving quality and outcomes
- Securing greater equity
- Creating value
- Deepening collaboration

BLMK

Part 1 – Statements on Quality

1.1 Statement on Quality from Paul Calaminus - Chief Executive

Alongside the continued importance of Quality Improvement methodology, co-production and clinical leadership, our Quality Accounts this year reflect the steps that have been taken over the year to improve the availability and use of data to try and improve services. This has led to real improvements in information available to teams, that can be used alongside our own observations, and the experience of our service users. It has been pleasing to see the growing appetite in the Trust to use this information for improvement, bringing some exciting innovation and improvement in outcomes.

Our Quality Accounts report also reflects our move to understand the broader issues our communities face and our efforts to provide our services in a way that is coherent and effective. Service users, patients and carers are key in helping us to get it right, to understand and accept when something isn't working, and seek to do better.

I want to thank everyone who has been, and continues to be, involved in the work reflected in this report, both those who provide services, and those who receive them as we continue to work to improve our provision of safe and effective care.

Paul Calaminus
Chief Executive

1.2 Statement on Quality from Dr Amar Shah - Chief Quality Officer

I am pleased to introduce the Quality Accounts for East London NHS Foundation Trust for 2022/23.

The report summarises our work to provide assurance about quality of care – through a variety of mechanisms, such as clinical audit, service user-led accreditation, service user feedback, external accreditation schemes and feedback from CQC inspection. The report also outlines the work of our teams to continue improving the quality of care they are providing, through the application of quality improvement (QI) on areas such as population health, equity and access. The last decade of focus on quality at ELFT has helped develop a structured and systematic approach, with greater autonomy and ownership of teams to understand and improve quality of care, together with greater service user involvement and leadership.

Some of the work contained in this report is truly ground-breaking, such as the application of quality improvement at scale to tackle the immense challenge of waiting lists and high demand in the wake of the pandemic, across 50 of our community-based teams. The examples of teams applying their QI skills to identify and tackle equity issues is also right at the forefront of this field globally, and the report contains some outstanding results that have been achieved so far.

The availability and accessibility of data and information at all levels of the organisation, from individual clinicians, teams, directorates and the Trust board, enables a system of quality control – allowing each level of the organisation to pay close attention to variation, understand and investigate causes of unusual variation and respond appropriately. The performance report to the Trust board includes a system-level dashboard of key quality metrics, together with narrative, to ensure we are alert to the key quality indicators on a routine basis.

The organisation's approach to quality is characterised by the appetite to continuously learn. The report contains details of how the organisation is responding to findings from targeted CQC inspections, from significant safety incidents during 2022/23 and how we plan to approach safety differently in future. The year ahead includes ambitious plans to apply our quality improvement approach at scale, across all our inpatient wards, to focus on safety and quality, in light of a number of themes emerging from safety incidents. This work has already begun, and is starting to yield creative new ideas and interesting learning. Our work on equity continues, with a second phase of the Pursuing Equity programme that will start to apply the method to larger-scale projects across our teams and directorates. The continued vigilance, and preoccupation with safety and quality on a daily basis, is a hallmark of ELFT's commitment to learning and improvement.

Dr Amar Shah,
Chief Quality Officer

Part 2 – Priorities for Improvement and Statements of Assurance

This annual Quality Accounts provides the platform to share both our progress and achievements during 2022/23 and our plans and priorities for 2023/4.

In this section the Trust updates on progress on delivering our priorities for improvement for 2022/23, along with statements of assurance from our Trust Board.

During 2022/23 the Trust provided and/or sub-contracted 166 relevant health services. The Trust has reviewed all the data available to them on the quality of care in all 166 of these relevant health services. The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2022/23.

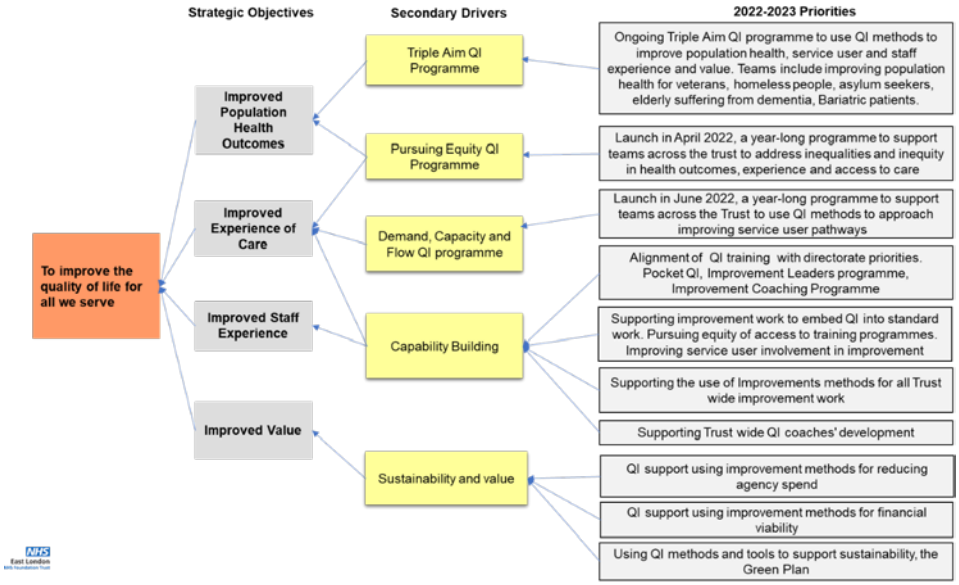
2.1 Reflections on 2022/23 – Progress Against Priorities

As set out in last year's report, our annual plan for 2022/23 focused on the following priorities aimed at progressing our aim to improve the quality of life for all we serve:

- *Triple Aim QI Programme*
- *Pursuing Equity QI Programme*
- *Demand, Capacity and Flow QI Programme*
- *Capability Building*
- *Value*

The Trust's quality improvement plan (below) demonstrates how Quality Improvement (QI) work across the Trust was organised to support delivery of the Trust's annual plan. This section of the report summarises progress in delivering the 2022/23 plan. The two large-scale improvement programmes, on equity and flow, were successfully delivered and are starting to see results. The report provides a number of stories from teams working on equity and flow, the ideas they are testing, and the results that are starting to emerge.

Trust annual quality improvement plan for 2022/23



Improving Population Health

Triple Aim:

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. Seven teams across the organisation worked on improving population health using the triple aim approach, working across organisational boundaries to simultaneously improve outcomes, experience and value. The teams worked on different populations including veterans, asylum seekers, homeless people, children, people who frequently present to crisis mental health services and people with long-term conditions accessing talking therapies.

One of the project teams from Newham adult mental health have been focusing on frequent users of the crisis pathway to help them thrive, be socially connected and receive the right support at the right time. The team have been testing and learning from the use of apps to reduce social isolation and loneliness. They have broadened their approach by seeking support from the Working Together Group for deeper service user involvement. They are now testing offering 1:1 support from community connectors to help service users access the Crisis Café to reduce social isolation and loneliness, and increase connection with the local community. This will also provide out-of-hours support at high-risk times for crisis presentations. The team will also be inviting stakeholders from the third sector to engage in this project.

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. ELFT partnered with the Institute of Health Equity, to work towards becoming the first NHS Marmot Trust. In February 2022 the Trust started applying the QI method using the Triple Aim approach and began offering QI support to this work in Luton and Newham.

In Luton, colleagues from human resources, public health, the local authority, a facilities management service and peer support workers are working together to support local vulnerable people into employment. The project team which involves partners from ELFT, the local authority, council and other system partners have agreed the portfolio of work that will help them achieve their aim "to support ELFT service users and the general population in Luton to gain and retain employment and skills". This involves a task and finish group to Understand & address financial exclusion, as a major barrier to employment for people in vulnerable groups. And several QI projects to Improve the accessibility of recruitment processes; Promote opportunities more effectively and in a more targeted way; Provide pre-employment opportunities; Provide in-work support for new recruits and Provide support for managers & clinical teams to recruit from service users and other disadvantaged groups. The team have started to collect data related to their testing and have recruited 5 service users from the population into Health Care Support Worker roles in Luton.

In Newham, the work received funding from the ELFT charity to support some of their work to improve the wellbeing of children and young people in Newham by focusing on 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'. The project has agreed on two interventions to look at:

1 Healthier Wealthier family's pilot – placing financial advisors into community children's centres and specialist children's clinical services. The team are working with University College London department of Population Health
2 Family Literacy Project – Partnership with the bank HSBC and East London Business Alliance to offer health literacy courses to Specialist Children and Young Peoples Service (SCYPS) and Child and Adolescents Mental Health Service (CAMHS) families in Newham.

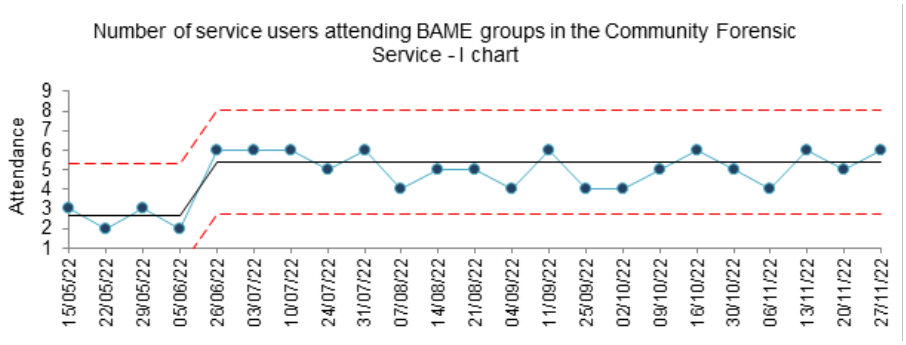
Improving Experience of Care

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 has been supporting teams to understand what contributes to inequity within the populations they serve, use improvement methods to test meaningful change ideas and develop measurement plans to know if they are making an improvement.

Currently thirteen teams are part of the programme. Since the programme launched, 11 of the teams are testing change ideas, with four having seen an improvement. Four teams are developing driver diagrams to construct their change theory and are receiving coaching support to help them begin testing change ideas. All teams are developing change ideas, with 10 teams actively testing.

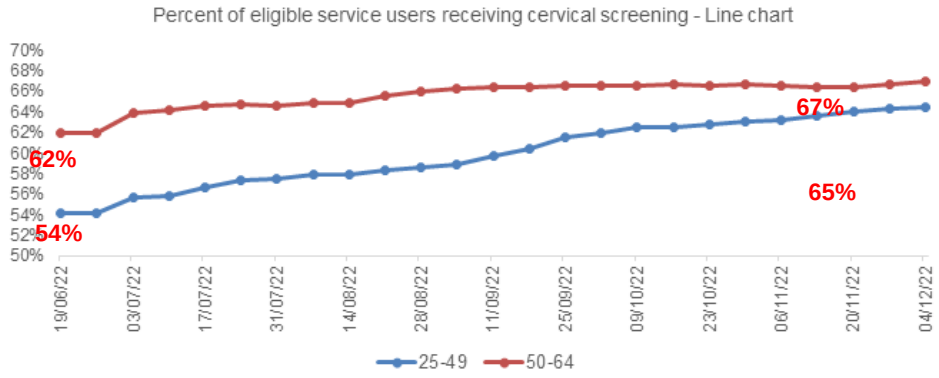
Two inpatient teams are focussing on improving the experiences of LGBTQ+ service users on their wards. At the Coborn centre, the team are working with young people to improve their experiences and are testing having LGBTQ+ champions and the use of pronouns on room doors. Ruth Seifert ward in City and Hackney are collecting data via a patient and staff confidence survey to help understand their issue. They are testing training staff on LGBTQ+ issues and weekly ward huddles for staff and service users to discuss topics around LGTBQ+ issues on the ward.



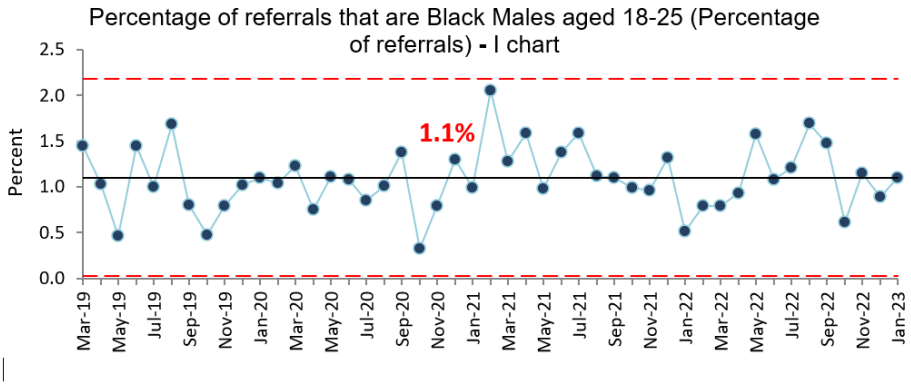
Bow Ward in Forensics have been testing the use of therapeutic groups to talk about sexual health and normalising the use of sex toys on the ward, as well as making changes to the recording of screening status on RiO (clinical recording system). As a result of their work, 100% of the women cared for have been offered cervical screening with 40% uptake, up from 23% the previous year.

Several teams have been working to improve outcomes, access, and experience for Black, Asian, and Minority Ethnic (BAME) service users. Tower Hamlets Early Intervention Service saw a 27% increase in the number of BAME service users receiving treatment because of prioritising service users who had recently been discharged from wards, and by introducing family-based therapy. Meanwhile, the community forensic team have been testing a weekly service user group welcome to anyone to discuss issues around race. Attendance at the group has increased over time as a result of offering a virtual option. One service user reflected “the group has been constructive and people that come here get energy from it and that it starts off the week, it's a time for reflection... I find it innovative".

Cauldwell medical centre based in Bedford have been working to increase the percentage of eligible women receiving cervical screening. They identified that only 55% of women between 25-49 received screening compared with 63% of women over the age of 50. The team have tested a range of change ideas including text message reminders, changing the language of letters and outreach events, and have managed to increase overall screening rates and reduce the equity gap between women under and over the age of 50. The percentage of women aged 25-49 receiving cervical screening has increased from 55% to 63%. The percentage of women aged 50-64 receiving screening has increased from 63% to 66% (chart below).



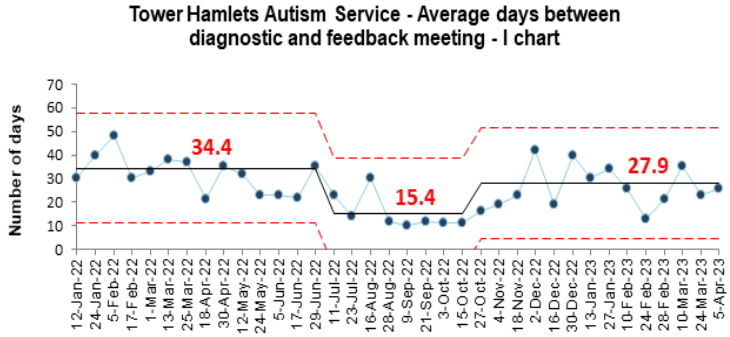
Improving Access to Psychological Therapies (IAPT) service team in Newham, are working to improve uptake of their service by Black men aged 18-25. This population is currently underrepresented, making up only 1% of all service users (chart below). All ideas have been developed and tested in collaboration with service users. Ideas include adapting social media presence to be more representative and inclusive; partnering with local gyms and barbers to provide free merchandise and offering digital links to their service to encourage conversations around mental health. Design for year two of the pursuing equity programme is underway. A Trust-wide scoping exercise has been conducted with all directorates to identify equity work that they want to support in 2023/24. A recruitment campaign will begin in May 2023 to identify teams that would like to use QI to approach an equity issue.



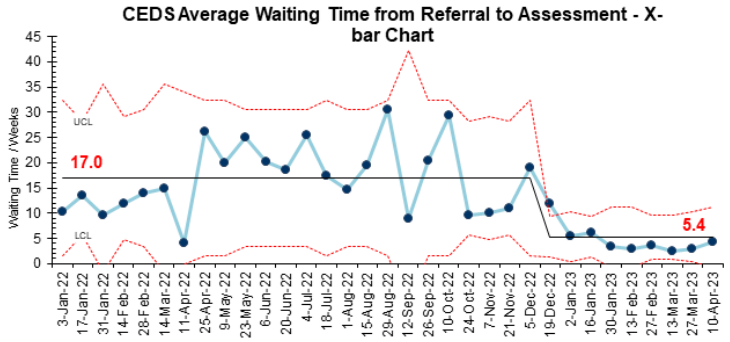
Optimising Flow programme

1.1 Since June 2022, 19 teams have been coming together to share ideas and apply QI to optimise flow through patient pathways in their services. A mid-programme evaluation demonstrated improved service user involvement in the work and that the programme has helped accelerate team progress. Of the teams on the programme, 16 progressed to the point of testing change ideas, with five teams showing improvement. Two teams were developing their change strategy and one team is in the implementation phase.

1.2 Tower Hamlets Autism Service: their aim was to reduce the wait time from referral to assessment by 50% in one year. Ideas tested include a referrals pack to streamline the process, this resulted in a 38% reduction in the wait time from referral to the active list (chart below). Additionally, increasing the time of their weekly assessment meeting by one hour meant they could discuss more cases and reduce the time a diagnosis is received by one week.



1.3 The East London Children's Eating Disorder Service (CEDS) identified that there are long wait times for young people to receive an assessment after referral to the service. The aim of the project was to reduce their wait times and improve patient experience. They developed a process map to better understand where there were inefficiencies and bottlenecks in the system. Their change ideas included discontinuing the triage process, introducing a single assessor, and updating the referral form. After testing these ideas for a few months, the team saw a reduction in the average wait time of 17 weeks to 5.4 weeks (chart below).



Improving Staff Experience

Capability Building:

Building capability in QI skills is an important part of developing and maintaining a culture of QI across the Trust.

Pocket QI, the Trust's one-day foundational QI training is accessible to all staff and service users which means they will be able to apply QI methods to complex issues that require improvement in their area. The training is in both London and Bedfordshire and is consistently well attended. During the year, this training also received CPD (continuous professional development) accreditation after being scrutinised by an external accreditation organisation to ensure integrity and quality compatible with global CPD requirements. Efforts to align capability building for quality improvement into directorate annual planning has contributed to an increase in staff attending all QI training programmes. Pocket QI has seen a 150% increase in graduates in the past 10 months with a current average of 65 graduates per workshop. To meet the increased demand, the number of London training sessions has been doubled to one every month.

In March 2023, 167 staff and service users graduated from the six-month long Improvements Leaders Programme (ILP) to lead and support teams to progress with their improvement work in their areas. During the year, the programme was received CPD accreditation. Over a hundred teams displayed their improvement work to celebrate their progress. One senior leader graduate has now requested all the management team members in his area to attend the next wave of ILP, to embed the improvement culture in his area and the projects he is a sponsor for. A service user attending from Tower Hamlets mental health services reported that the ILP made her understand why her part in a project was so important and felt motivated to do more. The number of active QI projects has returned to pre pandemic levels throughout 2022 with a notable increase in November as a result of the onset of the current Improvement Leaders Programme.

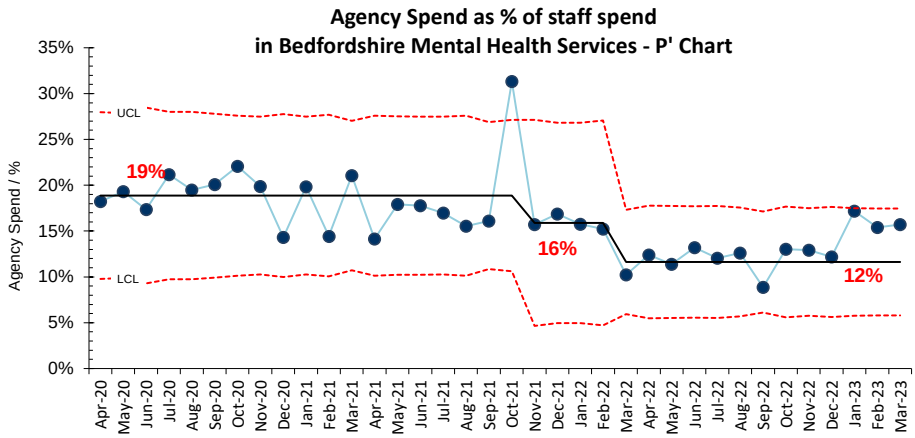
Also in March 2023, 55 staff and one service user graduated from the Improvement Coaching Programme (ICP), a seven-day course over six months equipping QI coaches with a deeper knowledge in improvement science so that they can support and guide teams working on QI projects. One of the many stories of how staff are benefiting from QI training, in addition to helping improve services, is from a QI coach on the current ICP. They work as a Life Skills Recovery Worker which involves supporting nurses and healthcare assistants with their care roles and facilitating activities and events on the ward for and with service users. They were encouraged by their manager to go on the Improvement Leaders Programme. They have been using the plan-do-study-act approach regularly in their job and even in their personal life and business. They were involved in a QI project that improved service user satisfaction with the quality of 1:1s from 65% to 93%, and staff reported that they felt more confident in facilitating 1:1s as a result of the project. The skills and experience they obtained from this work has built their confidence to speak and lead a team. They even had the confidence to present the work at a QI conference at the Royal College of Psychiatrists. This has given them the confidence to become a QI coach and support others with their QI projects.

Improving Value

Agency spend project:

The Trust-wide project on staff agency spend reduction has seen a reduction in percentage of agency spend in six areas across the Trust. Of particular interest is in Bedford Mental Health

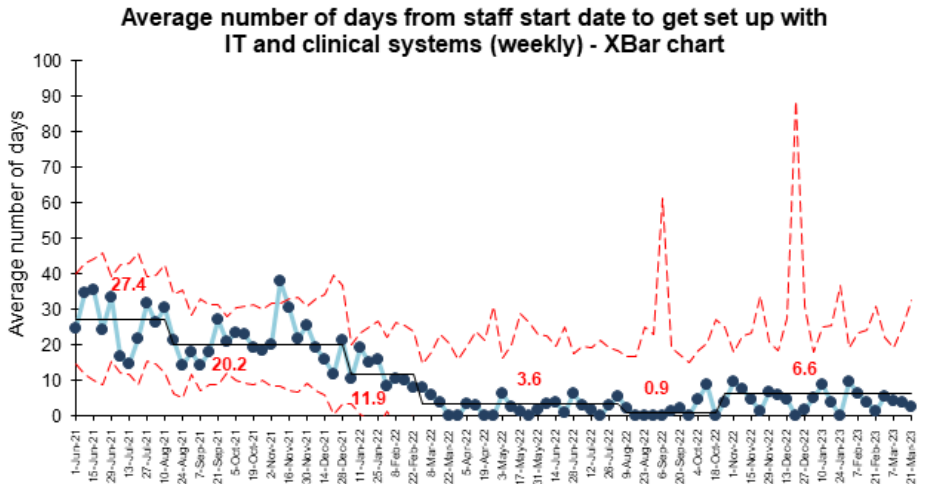
where the project team primarily focussed their tests of change. They were able to reduce the percentage of agency spend from 19% to 14% and have sustained this for more than a year (chart below). Some of the change ideas from this work were applied across the organisation, Trust-wide data remains unchanged with an average of 7.7% of total staffing costs being spent on agency staffing. Change ideas that have been implemented into business as usual include redesigned job descriptions; internal process for agency pay rate limit and approval; finance business partner approving and coaching budget holders; appointment of a medical resourcing manager; an incentive scheme to encourage staff to take on staff bank shifts instead of filling those through an agency; changing to a direct engagement supplier whereby the Trust saved on VAT by paying agency staff directly or a 3rd party instead of by their agency. A recommendation from the work was to develop a central structure for managing temporary staff which is now established.

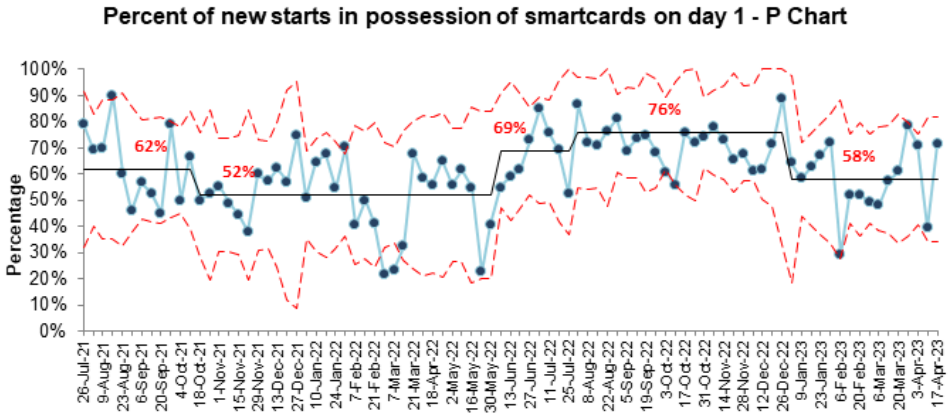


New Starter Project:

A team consisting of team members from people and culture, IT helpdesk and digital have been working towards improving the experience of new staff starting at ELFT. Their aim is that all staff on day one are in possession of their 'smartcard', a card that enables access to NHS systems, and that they are able to access clinical IT systems within one week of their start date. Access ensures clinical staff are equipped with essential patient information, a key factor in patient safety. Improving data quality and internal process change has resulted in clinical staff accessing clinical systems within seven days (chart below).

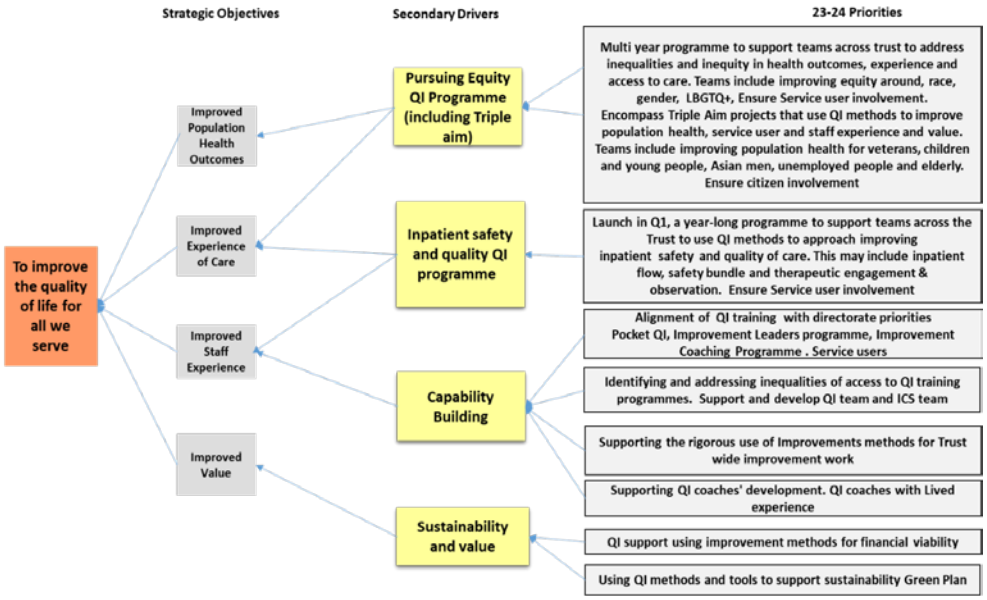
The team achieved an improvement in access to smartcards, however, sustaining the gain has been more challenging due to operational issues. A change in process was difficult to implement due to staff turnover and a lack of connection to the project work. A workshop was held for all staff involved to explore why the process change was difficult to adopt. An implementation package was designed with staff to standardise, document, and disseminate the process change. To continue to regain the improvement gains the team will train all incumbent staff and have made a commitment to have daily huddles and regularly review the data to enable a rapid response to any deviation from improvement.


Average number of days from staff start date to get set up with IT and clinical systems (weekly) - XBar chart
Average number of days
27.4
20.2
11.9
3.6
0.9
6.6


Percent of new starts in possession of smartcards on day 1 - P Chart
Percentage
62%
52%
69%
76%
58%

2.2. Quality Priorities for the coming year – looking forward to 2023/24

The driver diagram below sets out our priorities for the coming year, and shows how quality improvement projects across the Trust links to the key strategic priorities for ELFT and the annual plan for 2023/24.



2.3 Participation in Clinical Audits

2.3.1 National Audit

Throughout 2022/23, ELFT participated in five national clinical audits and one national confidential inquiry covering services the Trust provides. A list of these are below, along with the organisation that relevant data was submitted to.

Description of National Audit/Confidential Inquiry	Submitted to
Prescribing Observatory for Mental Health (POMH-UK) Topic 1h & 3e: Prescribing high dose and combined antipsychotics	Royal College of Psychiatrists
Prescribing Observatory for Mental Health (POMH-UK) Topic 21a: The use of melatonin	Royal College of Psychiatrists
Prescribing Observatory for Mental Health (POMH-UK) Topic 20b: Valproate prescribing in adult mental health services	Royal College of Psychiatrists
National Clinical Audit of Psychosis (NCAP) Early Intervention in Psychosis 2023	Royal College of Psychiatrists
Parkinson's National Audit	Parkinson's UK
Transition from Child to Adult Health Services	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

Data was submitted to five national clinical audit projects and one 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 a 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	Organisations	Submissions	
POMH-UK Topic 19b: Prescribing for depression in adult mental health services[1]	22	73	60	4742	Dr Dominic Dougall
POMH-UK Topic 1h & 3e:	23	190	62	7759	Dr Phillip Baker

[1] The Trust participated in POMH topic 19b in 2021/22 however, the report was published in May 2023.

Prescribing high dose and combined antipsychotics					
POMH-UK Topic 21a: The use of melatonin	6	64	61	5097	Dr Cathy Lavelle
POMH-UK Topic 20b: Valproate prescribing in adult mental health services	15	77	60	4662	Dr Syed Ashraf
NCAP: Early Intervention in Psychosis Audit 2023	4	400	Not yet published	Not yet published	Dr Olivier Andlauer
NCEPOD: Transition from child to adult mental health services study	1[2]	1	Not yet published	Not yet published	Dr Cathy Lavelle
UK Parkinson's Audit	1	20	Not yet published	Not yet published	Karen Coupland

In 2022/23, reports for three national audits were released, including a report for a national audit the Trust participated in during 2021/22. Reports for three national audits and one confidential enquiry are yet to be released.

The reports for NCAP Early Intervention in Psychosis Audit 2023 and POMH Topic 20b are due to be released in May 2023. NCEPOD will release the report for the study on transitions from child to adult mental health services on 8 June 2023. The UK Parkinson's Audit report will be released later in 2023.

The report for POMH Topic 19b: prescribing for depression in adult mental health services, was released in May 2022. This follows a baseline audit completed in 2019 (Trust sample size of 33). The re-audit in 2021 had a sample size of 55. Although larger than the baseline audit the sample size remains small therefore, the results are interpreted with caution.

The findings showed both good rates of documentation of co-morbid alcohol and drug use, physical and mental illness and good augmentation of antidepressants with antipsychotics. The findings will be discussed at the Trust medicines committee. The findings have been shared with relevant local teams, including neighbourhood teams, to highlight the importance of documentation. In response, a teaching event/webinar on best practice for the management of treatment refractory depression is being considered.

[2] 1 clinician questionnaire and 1 organisational questionnaire were requested by NCEPOD from ELFT. An ELFT patient was identified as eligible for inclusion in the study as a result of data submitted to the study by another Trust.

The report for POMH topic 1h&3e: prescribing high dose and combined antipsychotics was released in December 2022. The findings will be highlighted to the clinical directors working with inpatient mental health services. Support will be tailored down to team level to ensure those teams with relatively poorer performance in the Trust are assisted to review their practice.

The report for POMH Topic 21a: use of melatonin was released in February 2023. The audit focused on the prescribing of Melatonin to treat disturbances in sleep in children and young people. The findings were shared with all consultants' groups for the relevant services, including CAMHS and community paediatrics. In response to the audit findings, a CAMHS pharmacist was invited to attend the consultant group meetings to discuss melatonin prescribing. There will be further discussion collectively with the pharmacist lead for children's services around actions to be taken. Actions will include producing pre-prepared guidance covering advice around sleep hygiene and off-labels, to be provided to parents before prescribing melatonin.

ELFT children's services already have guidance for melatonin prescribing, including use of branded products, which will be refreshed and prescribers will be reminded of the requirement to conduct reviews at three months and annually. Further action to address regular reviews may involve conducting an internal audit. All guidance will also be shared with non-medical prescribers.

2.3.2 Performance against the NHSE Learning Disability Improvement Standards Year 4

The NHSE Learning Disability Improvement Standards were launched in 2018 by NHSE to ensure the provision of high quality, personalised and safe care from the NHS for the estimated 950,000 adults and 300,000 children with learning disabilities as well as the 440,000 adults and 120,000 children with autism across England. These standards were designed together with people with learning disabilities, autistic people, family members, carers and health professionals, to drive rapid and substantial improvements to patient experiences and equity of care (National Benchmarking Network).

The four standards that Trust's performance is measured cover:

1. Respecting and Protecting Rights
2. Inclusion and Engagement
3. Workforce
4. Specialist Learning Disability Services

The first three standards are universal and apply to all areas in all Trusts submitting a completed benchmarking tool. The fourth standard applies specifically to Trusts commissioned to provide specialist services to meet the needs of people with a learning disability and autistic people.

There is a data collection tool that is provided to bring together both qualitative and quantitative data. In addition, there is a staff survey and a service user survey that are distributed across participating teams.

The Trust receives a bespoke report from the NHS Benchmarking Network which demonstrates both compliance with the standards and also data that reflects where ELFT are performing in comparison to other Trusts across England. Of note, in Year 4 of the standards, 206 organisation participated, with 56 organisations providing specialist services.

ELFT's bespoke report returned positive outcomes in a number of areas which included being able to make reasonable adjustments for people who have a learning disability, being able to

disaggregate data to track people's journey through the organisation, routinely monitoring waiting times, and flags on electronic systems.

Total numbers of incidents of Physical Restraint were well below the mean average in comparison to other Trusts (Mean = 318, ELFT = 88)

ELFT also had a very low rate of Serious Incidents relating to people with a Learning Disability and Autistic people in comparison to other Trusts.

There was evidence demonstrating that all adult areas had 'Stopping over medication of people with a learning disability, autism or both' **(**STOMP) action plans or Quality Improvement projects, to reduce inappropriate prescribing for people with a Learning Disability.

There was also a clear commitment by the organisation to embed LeDeR (Learning from Lives and Deaths of People with a Learning Disability and Autistic People) with representation on internal meetings such as the Learning from Deaths Panel and the Patient Safety Group, as well as attendance and involvement in both ICB LeDeR Governance Groups.

The areas for development and improvement are outlined below:

- Ability to disaggregate data for Autistic people without a Learning Disability
- Monitoring readmission rates for people with a Learning Disability and Autistic people
- Monitoring total number of Safeguarding referrals made for children and adults with Learning Disabilities and/or Autism
- Monitoring the percentage of Safeguarding referrals that progress to a S42 Enquiry
- Consider creation of a dedicated post for a person with a Learning Disability or their family Carer on the Council of Governors or Board Sub-Committees
- The need to increase the number of people with a Learning Disability and/or Autistic people employed by the Trust
- Implementation of Ask, Listen, Do as a central component of responding to complaints, although this is practiced locally in responses to individuals
- The need to have a specific focus on workforce development for Learning Disability Services in the Trust Workforce planning
- Inclusion of a section about Learning Disability and Autism in the Trust Induction
- Accessible versions of Trust reports
- Sing up to STAMP (Supporting Treatment and Appropriate use of psychotropic Medication in Paediatrics)

The staff survey within the Standards reflected similar results with regard to the provision of reasonable adjustments, although there was a clear pattern of staff feeling that people with Learning Disabilities were not routinely involved in the planning of Trust services, and also that people with lived experience were not consistently involved in training other staff within the Trust

The service user survey highlighted that people felt that they were always treated with dignity and respect, and that staff cared about them. Positive response rates of 100% were evident around issues such as flexible appointment times, and whether the purpose of the appointment was explained to the person. However, only 44% of service users reported that staff provided choices about the way that they were cared for.

Unfortunately, there is no narrative reporting for this domain, so no ability to drill down on where this might be happening, but this will feature in the action plan going forward about how we can develop our conversations with people about their care and treatment.

Next Steps

As part of the Learning Disability Learning Network, a Benchmarking Task and Finish Group has been formed to review, address and escalate areas of action from these standards.

The group has representation from different areas across Learning Disability Services, and is currently in the process of identifying how areas of improvement can be met, either within specialist Learning Disability and Autism Services, or through collaboration with wider Mental Health, Community Health and Corporate colleagues.

It is proposed that the group uses Quality Improvement Methodology to review the data provided in the ELFT bespoke report, develop ideas and actions to test, with the intention that the following data return will feature a data set that has a greater degree of quality and compliance.

2.3.3 Trust Clinical Audit Activity

During 2022/23 the Quality Assurance team continued to facilitate the Trust-wide Clinical Audit programme. Audits were conducted in three cycles that took place in June, October, and February.

The Clinical Audit Programme consists of a mixture of pharmacy related audits, infection control audits, and directorate specific audits. All 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
14 x Individual Directorate Audits (NICE/Safety Critical Standards)	Quality Committee / Directorate DMTs	All

One medicines audit, the Controlled Drugs audit, continues to be audited 4 times per year, at the start of each quarter, as per regulatory requirements.

During 2022/23 Bedfordshire and Luton Community Mental Health Directorate designed and implemented their Directorate specific audit. This was audited for the first time in February 2023. This audit focuses on record keeping, showing each services compliance around updating dialog, sharing care plans with service users, offering and completing Care Act assessments.

The Trust continues to have a clear process to support learning and drive improvement from the clinical audit programme. 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 has an allocated owner who is responsible for completing the action and update the tracker accordingly.

An example of this is the Tower Hamlets Mental Health directorate. In this directorate all teams review results and discuss actions at local meetings with the Tower Hamlets Clinical Governance Coordinator. These actions are recorded on a Governance Tracker and progress against actions is monitored by the Clinical Governance Coordinator.

Another great example remains the Forensics directorate. Action plans are recorded on shared tracker which is also visible to the Quality Assurance Manager. The actions are then monitored in the Forensics Quality Committee and in Clinical Improvement Group meetings.

2.3.4 Service User Led Accreditation

The Service User Led Accreditation programme, launched in 2019, has continued in 2022/23. 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 award.

Services who 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 successfully transitioned back to being conducted in person after being moved virtually due to the Covid-19 pandemic. This has enabled a better experience for both services users involved and clinical teams. This programme is a crucial aspect of our commitment to providing high-quality services that are responsive to the needs and preferences of our service users. All visits include a Quality Assurance member who supports the assessors and ensures the process is as smooth as possible for the service involved.

In the past year, 13 clinical teams have registered to take part. Out of these, five teams have completed their assessment and visit, two teams have dropped out of the process before its conclusion, one team has requested to defer starting the process until summer 2023. Four teams are due to commence the programme in the next few months. Lastly, we are working with one of our Primary Care services to understand how the accreditation programme can work for them. Hopefully, this will inspire other teams to join our programme.

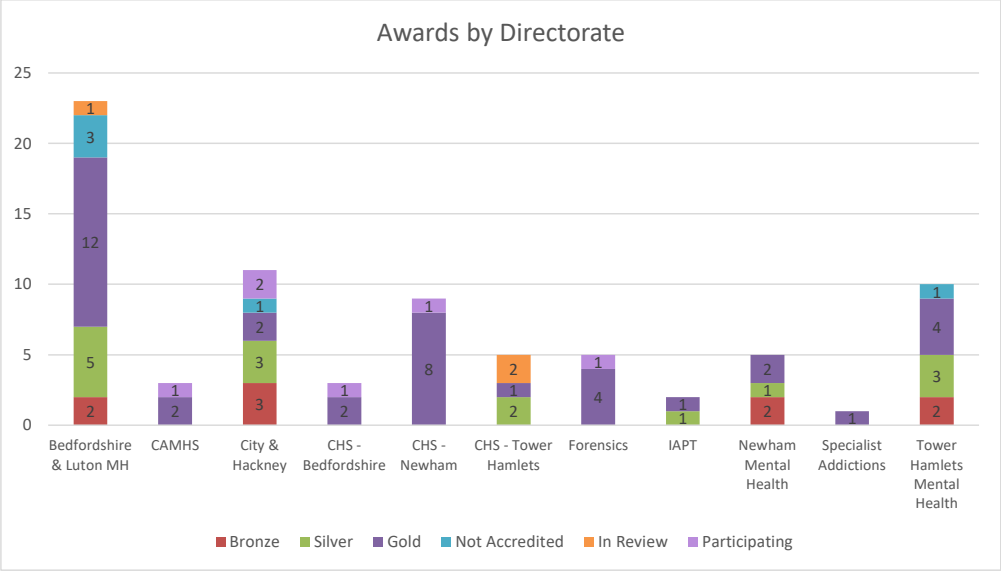
A total of 84 clinical teams have participated since the start of the programme.

The QA team and a service user have started a project to increase the number of registrations by two per month by May 2023. The project aims to encourage more services to participate in the programme and increase the uptake, ensuring that service users continue to be involved in developing and improving the services they use. As part of the project, we have also introduced Q&A sessions which provide an opportunity for services to ask questions and learn more about the accreditation process. By facilitating these sessions, we aim to increase understanding and awareness of the programme.

The QA team are also working with Service Users to introduce a developmental offer to services, which will aim to support services who do not yet feel ready to be accredited.

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 further assessment.



Impact of the programme

As part of the accreditation process, feedback is routinely collected from the clinical teams and assessors involved. In addition, feedback is discussed weekly at team meetings.

"That outside view on things from experts by experience is invaluable. And at the end its great reward for hard work – for us it was a real morale boost after working through some significant challenges."
(Maham Shahzad, Service Manager, Brett Ward)

Feedback collected from clinical services showed that all would recommend other services to take part and rated the experience as valuable.

The impact of the programme has further been explored via storytelling. So far, two clinical teams have been interviewed to share what participating meant. Sharing these stories 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.

We have continued to host regular ‘Assessors together’ sessions with our assessors. This provides a space for shared learning and connections between assessors.

We also strongly focus on involving our service users in the process. Our QA Service User Lead produces newsletters designed to provide updates and information on upcoming visits and other opportunities for our service users to get involved in the programme.

To further involve our service users in the programme, we hold regular service user panels where service users can provide feedback and suggestions on reports from services going through the process. We also invite service users to deliver certificates to teams that have been accredited, recognising their contribution to the programme.

Overall, our approach to QA prioritises collaboration and engagement with our service users, ensuring that their perspectives and experiences are incorporated into our processes and decisions. We believe this approach will improve outcomes for everyone involved in our programme.

We are continuously improving and developing the programme, which is a main QA priority for the following year.

In May 2023 we will be launching the Platinum Award. The standards for the Platinum Award where designed in co-production with service users from across the Trust. Service users were asked to reflect on experiences of exceptional service and care and, using the Trust's values and current domains of the Accreditation as lenses, discuss what would need to happen make the services they access to be providing the same level of service. Following this exercise the feedback was collated and analysed and refined into three new 'Platinum Domains'; Place-Based Partnerships and Population Health, Peer-Support and Flexibility, Staff Wellbeing.

We are continuously improving and developing the programme, which is a main QA priority for the next year. We will continue to partner with our service users to review and develop our processes.

2.3.5 External Accreditation

The Trust has gained national accreditation for the quality of services provided in many wards and teams.

Accreditation scheme	Location	Services Accredited
QNWA CCQI QUALITY NETWORK FOR INPATIENT WORKING AGE MENTAL HEALTH SERVICES	**Newham**	Ivory Ward Opal Ward Ruby Ward Sapphire Ward Topaz Ward
	Tower Hamlets	Brick Lane Ward Roman Ward
	Bedfordshire & Luton	Ash Ward Coral Ward Crystal Ward Onyx Ward Willow Ward

Accreditation scheme	Location	Services Accredited
CAMHS QUALITY NETWORK FOR COMMUNITY CAMHS	**East London**	East London Community Eating Disorders Service for Children and Young People
	Bedfordshire & Luton	Bedford Child and Adolescent Mental Health Service Luton Child and Adolescent Mental Health Service
	City & Hackney	City and Hackney Child and Adolescent Mental Health Service
	Newham	Newham Child and Adolescent Mental Health Service
	Tower Hamlets	Tower Hamlets Child and Adolescent Mental Health Service
CAMHS QUALITY NETWORK FOR INPATIENT CAMHS	**East London**	Galaxy Ward, Coborn Centre Coborn Centre GAU
ACOMHS ACCREDITATION FOR COMMUNITY MENTAL HEALTH SERVICES	**Tower Hamlets**	Bethnal Green CMHT
ECTAS ECT ACCREDITATION SERVICE	**East London**	Tower Hamlets ECT Clinic
	Bedfordshire & Luton	Luton ECT Suite
MSNAP MEMORY SERVICES NATIONAL ACCREDITATION PROGRAMME	**City & Hackney**	City and Hackney Memory Service
	Luton & Bedfordshire	Luton Memory Assessment Clinic
	Newham	Newham Diagnostic Memory Clinic
	Tower Hamlets	Tower Hamlets Diagnostic Memory Clinic
PLAN PSYCHIATRIC LIAISON ACCREDITATION NETWORK	**Tower Hamlets**	Tower Hamlets Mental Health and Psychological Medicine Team
	City & Hackney	Homerton Psychological Medicine
POMH-UK PRESCRIBING OBSERVATORY FOR MENTAL HEALTH-UK	**East London NHS Foundation Trust**	East London NHS Foundation Trust
PERINATAL QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES	**Community**	
	City & Hackney	City and Hackney Perinatal Outpatient Service
	Bedfordshire and Luton	Bedfordshire and Luton Perinatal Mental Health Service
	Tower Hamlets	Tower Hamlets Perinatal Service

Accreditation scheme	Location	Services Accredited
	Inpatient	
	City & Hackney	Margaret Oates Mother and Baby Unit
PICU QUALITY NETWORK FOR PSYCHIATRIC INTENSIVE CARE UNITS CCQI	**City & Hackney**	Bevan Ward
	Bedfordshire and Luton	Crystal Ward (PICU) Jade Ward
QNLD QUALITY NETWORK FOR INPATIENT LEARNING DISABILITY SERVICES CCQI		Clerkenwell Ward Shoreditch Ward
FORENSIC QUALITY NETWORK FOR FORENSIC MENTAL HEALTH SERVICES CCQI	**Forensics**	John Howard Centre/Wolfson House
QNCRHTT QUALITY NETWORK FOR CRISIS RESOLUTION AND HOME TREATMENT TEAMS CCQI	**Tower Hamlets**	Tower Hamlets Home Treatment 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 three 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).

Recruitment into research studies has increased 65% in two years back to pre-pandemic levels. Overall, we enrolled 768 participants into 25 studies from the Department of Health and Social

Care's (DHSC) National Institute for Health Research (NIHR)[3] research Portfolio.[4] This is 48% above the average of 518 participants recruited at other London-based trusts providing mental health services; indeed ELFT is the highest recruiting mental health trust in the North Thames region.

Partnership with the University of Cambridge

Our most significant achievement is execution of an agreement to establish a new hub for health research in Bedfordshire and Luton to help improve patient care in primary and community healthcare services. The University of Cambridge and ELFT will together run the research hub, which is the first partnership of its kind for the University.

The new hub will carry out its research programmes working closely with healthcare staff in primary and community health and social care services in the area, and with the patients and carers of Bedfordshire and Luton. It will also help to bring new academic opportunities to GPs and community healthcare professionals in the area, offering training and support to help them get started on their research journeys.

The research will address some of the area's most important healthcare problems, such as frailty amongst older people as well as long-term medical conditions, and explore how primary and community healthcare can best address the needs of the local population.

Training and development is imperative. For this reason, in collaboration with Queen Mary and City University professors, we developed the Research Skills Series, fortnightly training with sessions covering how to get a grant, research methodology, and various analysis techniques. These sessions are being recorded and uploaded to the R&I section of the ELFT website to create an enduring resource.

This year we also collaborated with City University to provide two master's students with a week-long work experience with the R&I team. Students learnt about the life cycle of a research project and were encouraged/equipped to undertake their own research project at ELFT. In line with our role as a Marmot Trust, we hope to expand this offering and extend it to local colleges and undergraduate programmes.

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 2022/23.

---

[3] 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.

[4] 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.*

The Trust received an inspection of four Acute Working Age Mental Health Wards during February 2023. The inspections looked into serious incidents of suicides and self-harm, ligatures, observations and learning in in-patients wards. The wards inspected were:

- Willow ward (Bedfordshire)
- Coral ward (Luton)
- Gardner ward (City and Hackney)
- Roman ward (Tower Hamlets)

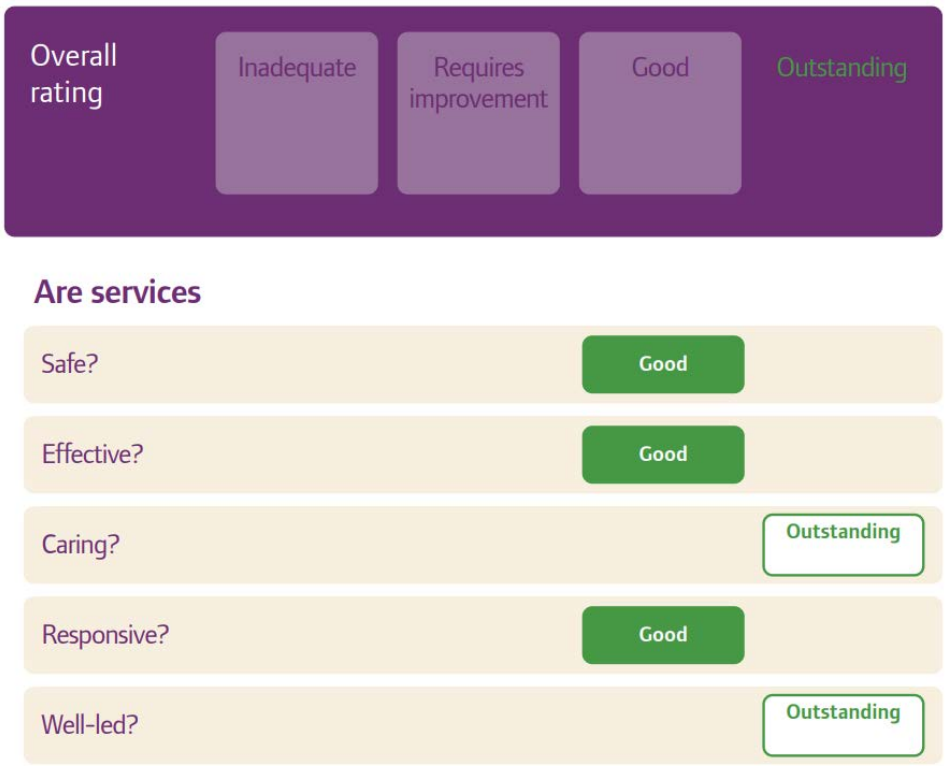
The formal written report from CQC is expected in late May 2023. In the meanwhile, we have received verbal feedback during the engagement meeting in February, which highlighted the following

Positive practice:

- staff had good level of awareness around serious incidents that occurred across the Trust, and the learning from them,
- action plans from incidents were being implemented
- wards had embedded learning into day to day practice
- patient feedback was largely positive;
- staff feedback was positive and reflected a supportive work culture.

Areas for improvement identified:

- staff vacancies were noted across in-patient services
- variation in standard of documentation in patient record, particularly care plans and Dialog+;
- capacity and best interests assessments were not recorded in the notes in sufficient detail (an observation repeated during MHA visits);
- monitoring process for statutory and mandatory training was not working, requiring workarounds and introducing risk.



Special Reviews

The Trust has not participated in any special reviews during 2022/23.

2.6 Learning From Deaths

Numbers of Patient Deaths Reported by ELFT in 2022/23

During the reporting period 1 April 2022 to 31 March 2023, ELFT reported a total of 2,863 patient deaths of which 2,520 were reported as expected and 343 were reported as unexpected. This showed an increase in deaths by 679 compared to the previous reporting period (2021/22), when 2,184 patient deaths were recorded by the Trust. Overall expected deaths were higher than unexpected deaths.

Table 1 Total deaths reported by ELFT 01 April 2022 - 31 March 2023

Period	Number of reported deaths
Quarter 1	696
Quarter 2	721
Quarter 3	721

Quarter 4	725
Totals	2863

**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 1216 (42.47%) of all reported deaths were subject to an investigation. 863 investigations were conducted using the Trust's Structured Judgement Review/Case Record Review process (SJR/CRR) and 330 investigated through the Trust's internal Serious Incident Review process including; 219 48hr Reviews; 57 Concise Reviews; 54 Comprehensive/Serious Incident [SI] Reviews) .

There were 23 Learning Disabilities Mortality Reviews (LeDeR). The youngest was a 21-year-old man who had number of physical health needs including a profound learning disability and had a feeding tube and a tracheotomy in situ.

Table 2 Investigations per quarter and types

Period	**Reported deaths**	**Investigation Type**				**Total Investigations (%)**
		SJR/CRR	**48hr**	**Concise/SI**	**LeDeR**	
Quarter 1	696	166	43	29	6	244 (35.05%)
Quarter 2	721	183	59	26	8	276 (38.28&)
Quarter 3	721	277	67	32	5	381 (52.84%)
Quarter 4	725	237	50	24	4	315 (43.44%)
Totals	**2863**	**863**	**219**	**111**	**23**	**1216 (42.47%)**

Patient Deaths Investigated and Adjudged to be Potentially Due to the Patient Care Provided

None of the 863 SJRs undertaken during the reporting period concluded that poor care provision was contributory to the patient deaths.

A total of 124 Coroners Inquests were concluded. A finding of Suicide accounted for 29 of the unexpected deaths. There were five Prevention of Future Death (PFD) reports issued by HM Coroners to the Trust during the reporting period (although the period during which the deaths occurred extends back outside of the reporting period for this document).

Reviews of the 124 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 identified:

- Poor or lack of communication.
- Failure to assess for venous thromboembolism (VTE) risk in contravention of Trust policy
- Inadequate assessments
- Inadequate falls risk assessment
- Failure to carry out enhanced observations according to policy
- Failure to carry out physical health observations according to policy
- Failure to record information
- Failure to complete an adequate search
- Failure to understand and provide emergency medical support
- Delay in decision making about the correct pathway for a patient.
- Uncertainty whether Cardiopulmonary Resuscitation (CPR) should be commenced.

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	696	1	0.14%
Quarter 2	721	2	0.27%
Quarter 3	721	0	0%
Quarter 4	725	2	0.27%
Totals	2863	**5**	**0.17%**

Summary of ELFT Learning from Case Record Reviews and Investigations Undertaken in 2022/2023

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 45 patients died, during the reporting period, Trust-wide who had tested positive for COVID-19 in the 28 days prior to death, five of which were inpatient deaths.

The remaining 40 deaths took place in the community where death occurred either in a care home; an acute hospital; or in the patient's own home.

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 2022 and 31 March 2023 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 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' 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. The youngest patient to die was 19 years old.

Gender

Differences in the numbers of deaths in males and females were noted monthly throughout the reporting period. Variations in gender were minimal. This had been consistent throughout the reporting period.

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 to consider 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 2022 and March 2023 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 ELP or a Co-ordinate My Care plan (CMC) in place.
Patients that did not have an ELP 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, followed by respiratory conditions and dementia. Cancer related deaths were higher in all age ranges. Older patients also died from causes related to end stage dementia.

Actions Taken and Planned based on Learning from Deaths

The Learning from Deaths Panel review process for the Trust evolved during the course of 2022/23.

The panel is responsible for overseeing the SJR process and compliance with EoLP expressed preferences. During the course of the year End of Life Pathways were reviewed to determine whether patients' preferences, including their wishes related to where they wish to die, had been met or not.

Engagement with Primary Care and Homeless Services, Rough Sleepers Mental Health Project (RAMHP) and St Mungo's Homeless Charity progressed. This continues to look at and improve the access to palliative care for this group of people.

Embraced learning from Prevention of Future Deaths (PFD's) reports issued to other organisations where the patient safety of ELFT patients can be further enhanced.
The Trusts team of Serious Incident Reviewers received bereavement awareness training to improve the support offered to families.

Going forward, The Learning from Deaths Group 2023-2024 plan is to focus on

- Patient Safety Incident Response Framework
- Reviewing, with the aid of the Structured Review of Deaths Toolkit inclusive of the Patient Safety Incident Response Framework. As part of working towards introducing PSIRF the Trust will use SJRs as one of the tools used to review patient safety incidents.
- Engage with Primary Care services
- Inclusion of PFD's actions and learning in the Learning from Deaths Quarterly meetings. PFD's and actions will be presented by responsible persons.
- Development and commencement of a new PFD's executive level oversight and sign-off system within the Learning from Deaths panel.
- The Learning from Deaths panel is currently under review as part of our work to design our new Patient Safety Incident Response Approach, with a focus on enhanced continuous learning and improvement. The review will consider how to make best use of qualitative and quantitative mortality data, the methods used to learn from both individual deaths and

mortality themes as well as ensuring learning involves and engages staff, carers and service users in a compassionate and meaningful way.

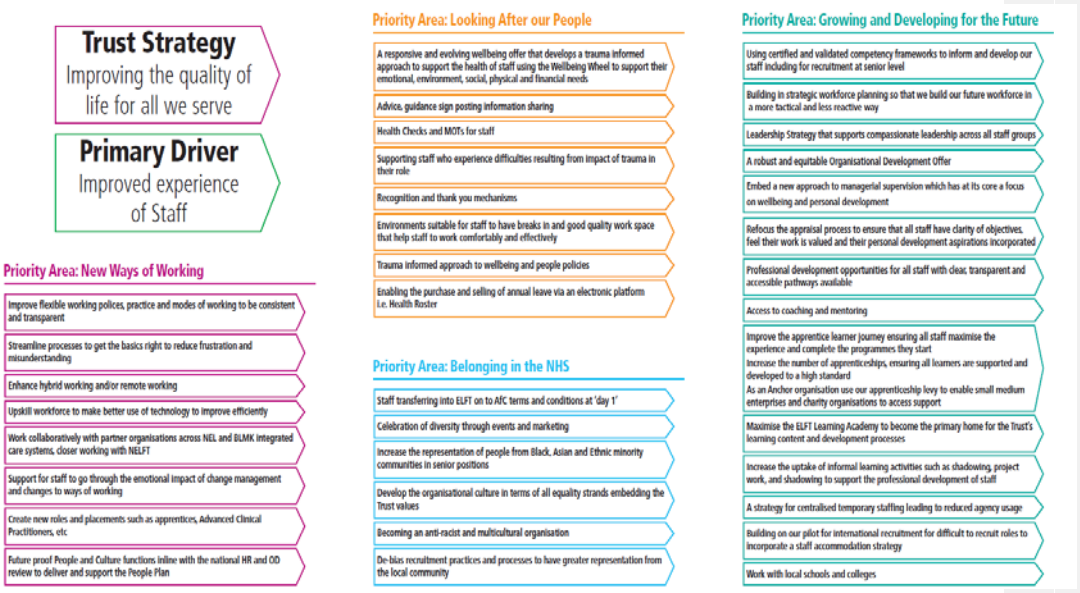
At the time of writing, the Trust has responded to five of the issued PFDs and has taken appropriate actions to address the issues raised in the PFDs.

2.7 Staffing

2.7.1 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. One key measure of progress is the annul NHS Staff Survey.

NHS Staff Survey

The Trust has recently received results from the 2022 NHS Staff Survey. The overarching themes emerging are:

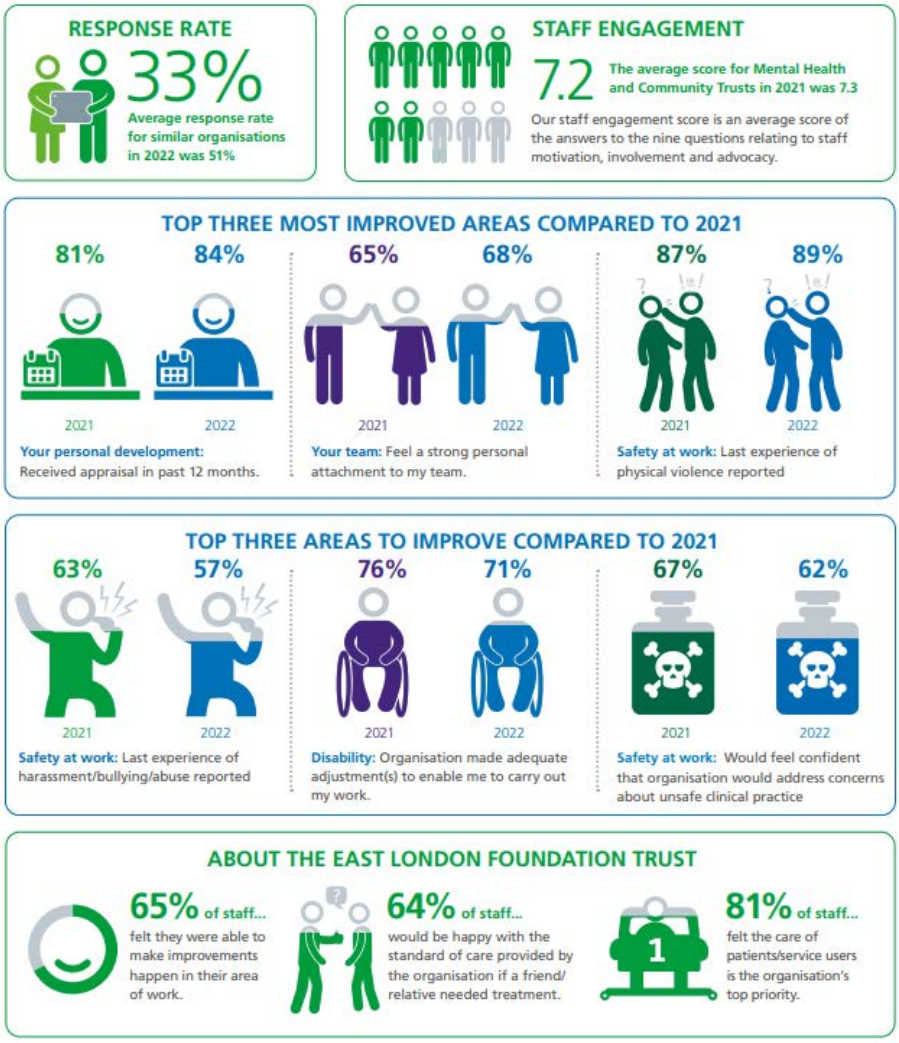
- Equality, diversity and inclusion.
- Retention and Morale.
- Staff wellbeing.

The Staff Survey draws on item banks within the survey to report on seven People Promise indicators. The People promise indicators measure the extent to which the Trust are compassionate and inclusive; staff feel recognised and rewarded, staff have a voice that counts; safe and healthy; always learning, working flexibly and work as a team. The Trust score consistently higher on each of the seven People Promise indicators compared with the national average. Compared with other Mental Health, Learning Disability and Community Health Trusts, the Trust score slightly lower than the national average on compassionate and inclusive, recognised and rewarded, safe and healthy, working flexibly and working as a team and scores the same as the national average for a voice that counts and always learning.

Staff engagement is made up from nine questions from the overall survey to create a 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. The Trust score consistently higher for staff engagement and for morale compared to the national average and other Mental Health, Learning Disability and Community Health Trusts.

People Promise Indicator	**Average National Overall**	**Overall Average MH & LD and MH, LD & Community**	**ELFT**	**ELFT Compared to National Average**	**ELFT compared to MH & LD and MH, LD & Community**
We are Compassionate and Inclusive	7.2	7.5	7.4	↑	↓
We are Recognised and rewarded	5.8	6.3	6.2	↑	↓
We have a Voice that counts	6.7	7	7	↑	=
We are Safe and healthy	5.9	6.2	6	↑	↓
We are always Learning	5.4	5.7	5.7	↑	=
We work Flexibly	6.1	6.7	6.5	↑	↓
We are a Team	6.7	7.1	7	↑	↓
Staff engagement	6.8	7	7.2	↑	↑
Morale	5.7	5.7	5.8	↑	↑

The infographic provides a handy overview of the Trust's report.



As part of the delivery of the people strategy, there is a range of work ongoing that address the three 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.

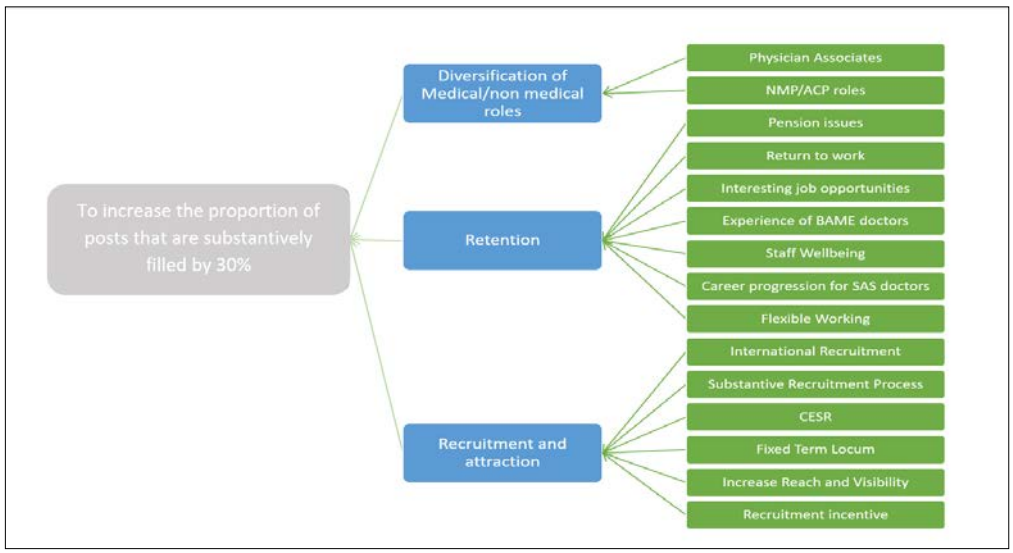
Recruitment and retention

The Trust vacancy rate remains stable at 8.7% despite an increase in establishment of 6.24% in the last financial year. Promoting ELFT as an Employer of Choice through enhancing our Staff Benefits offer, offering flexible working options, diversification of roles, creating more training roles and opportunities, engaging with our local schools and communities via Anchor, Veterans and other community involvement and support programmes, improving retention remains a priority and increasing the reach, visibility and enhancing the content of our adverts.

Although we have an additional 140 WTE nursing staff in our workforce as compared to the previous year, achieving a slight drop in nursing vacancy rate, we continue with focused efforts to recruit into MH Inpatient and Community based nursing roles via domestic and overseas routes. We have developed international recruitment pathways, such as Capital Nurse Programme, direct and indirect nurse recruitment via ethical routes, whilst developing pastoral support and an on-boarding package to enable integration of overseas recruits into our existing workforce. We are also strengthening our overall overseas recruitment including Medical and Allied health professionals to fill critical workforce gaps by tapping into qualified and experienced talent from abroad. However, Psychologists and Psychotherapists vacant roles at Band 7 remain a key area of focus with more work required to address these gaps.

A QI project has been launched to help tackle the medical vacancy hotspot in Luton and Bedfordshire directorate with an overall aim to reduce vacancy numbers helping tackle agency spend. The multipronged approach has proven beneficial so far in reducing gaps and making

improvements in areas of high agency spend. A GMC sponsor route is being developed to support overseas IMG's. This project also focuses on increasing the reach and visibility of existing roles across the directorates promoting Luton and Bedfordshire as a desired place to live and work. The driver diagram below outlines the project aim and identifies key primary drivers as well as secondary drivers to address some of these challenges.



Another QI programme within the Primary Care directorate which aimed to reduce the vacancy rate has proven beneficial with a tangible outcome within this directorate.

The newly developed posts of Physician Associates across directorates including child and adolescent services, forensic services, learning disability services and inpatient services, across East London, Luton and Bedfordshire play a key role in the management of patients, and to support the effective functioning of the multidisciplinary inpatient and community teams aiming to contribute to wider service developments.

In 2022, we saw 66 colleagues start an apprenticeship at ELFT, and a further 70 apprentices complete their studies leading to development of skills across a range of health and care and administrative services. Additionally, we continue to work to increase involvement in a Trust-wide Work Experience Programme and T-levels to encourage young people into NHS careers

Wellbeing

Whilst the Trust has long recognised the connection between staff wellbeing, satisfaction and happiness, and the care and treatment we provide, the current context has been challenging with systemic issues impacting staff experience. In the Trust's continued focus on staff wellbeing, it has been necessary to support staff with specific initiatives to reduce the burden of the cost-of-living crisis. Specific initiatives have included enhancement of mileage rates, targeted at our community health services staff who use their own transport to visit service users in their homes; money management workshops to empower staff to manage their financial resources more

effectively and pension workshops to encourage staff to think about the importance of saving for their future retirement in the light of changes to the NHS Pension Fund.

The Wellbeing and Engagement team continue to offer a plethora of wellbeing and engagement initiatives to staff via regular wellbeing bulletins and by visiting teams and services across the Trust. This year's 'Sunshine in my Pocket' campaign saw the team dispatching 1,853 three-month packs of Vitamin D to staff members in the Trust during the Autumn. During the year, three cohorts of Non-Violent Resistance Parent classes have been run by internal staff and a parent. The workshops focus on Non-Violent Resistance, an approach to communicate effectively, establish boundaries and improve family relationships.

Paul Calaminus, CEO was appointed the Trust's Wellbeing Champion and co-chairs the Trust's Wellbeing Forum with Tanya Carter, Chief People Officer. The forum meets regularly to discuss and shape the Trust's wellbeing initiatives.

2.7.2 Raising concerns - Freedom to Speak Up

ELFT staff have a clear, confidential and safe process to raise concerns about any matter that is damaging to patient care or which puts patients at risk.

The NGO clarifies that Freedom to Speak Up is about speaking up about anything that gets in the way of colleagues doing a great job.

- ✓ Contact the FTSU Guardian:
  - o FTSU ELFT inbox elft.freedomtospeakup@nhs.net
  - o By phone: call FTSU Guardian directly **07436027388**
  - o Online Referral: All referrals are treated in strict confidence and seen only by the FTSU Guardian https://www.elft.nhs.uk/intranet/all-about-me/freedom-speak/freedom-speak-form
  - o In writing to: Robert Dolan House, Trust Headquarters, 9 Alie Street, London, E1 8DE
- ✓ Contact a FTSU Champion
- ✓ In addition, staff can contact the Senior Independent Director
- ✓ Staff can also raise whistleblowing concerns via **Protect – Speak Up, Stop Harm** (https://protect-advice.org.uk/) Call **020 3117 2520**
- ✓ Staff can also seek advice from Staff Side/Trade Unions
- ✓ 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.
- ✓ A signposting document on the FTSU intranet page also supports with directing staff to the appropriate support
- ✓ All information relating to Freedom to Speak Up and who to contact is available on the FTSU intranet page https://www.elft.nhs.uk/intranet/all-about-me/freedom-speak

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

172 concerns were raised to Freedom to Speak Up during 2022/23. This is an increase of 53.6% from 2021/22.

The most common themes of concerns raised relate to those of Processes/ Organisational Structure/ Other, Worker Safety and/or Worker Wellbeing and staff experiences of behaviours that amount to bullying and harassment.

FTSU Data: 1st April 2022 to 31st March 2023

FTSU Concern Themes	Number	Percentage %
Element of patient safety/ quality of care	50	15.7%
Element of bullying & harassment	51	16%
Processes/ Organisational Structure/ Other	118	37%
COVID19 related	3	1%
Worker Safety and/or Worker Wellbeing	61	19%
Other inappropriate attitudes or behaviours	33	10.3%
Unknown	3	1%
Total Number of Themes Raised*	**319**	100%

*__Total number of themes__ *will not 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.

2.8 Goals Agreed with Commissioners for 2022/23

Use of the CQUIN Payment Framework

In light of the impact on the Covid Pandemic the CQUIN scheme for Providers was suspended in 2020/21, the scheme resumed for 2022/23. Performance against targets is set out below.

East London

East London CQUIN	2022/23 Target	Q4 Position	Year end 2022-23 position
CCG1 - Flu Vaccinations for frontline health workers	70-90%	63% (Trust-wide) 48% (East London)	63% (Trust-wide) 48% (East London)
Mental Health CQUINs	**2022/23 Target**	**Q3 Position**	
CCG9 - Cirrhosis and fibrosis tests for alcohol-dependent patients*	20-35%	0%	0%
CCG10a - Routine outcome monitoring in CYP and perinatal mental health	10-40%	58% (Trust-wide) – February-23 56% - Perinatal (East London) 79.6% - CAMHS (East London)	58% (Trust-wide) – Feb-23 68% - (CYP and Perinatal East London)
CCG10b - Routine outcome monitoring in community MH services	10-40%	36% (Trust-wide) – February-23 49% (East London)	36% (Trust-wide) – Feb-23 51% (East London)
CCG11 - Use of anxiety disorder-specific measures in IAPT	55-65%	72.3% (Trust-wide) 68.4% (East London)	71% (Trust-wide) 68% (East London)
CCG12- Biopsychosocial assessments by MH liaison services*	60-80%	96%	92%
Community Health CQUINs	**2022/23 Target**	**Q3 Position**	
CCG13 - Malnutrition screening in the community	50-70%	93.7%	87%
CCG14 - Assessment, diagnosis and treatment of lower leg wounds*	25- 50%	52%	46%

CCG15 - Assessment and documentation of pressure ulcer risk	40-60%	90.6%	85%

Luton and Bedfordshire

Bedfordshire & Luton CQUIN	**2022/23 Target**	**Q4 Position**	**Year end 2022-23 position**
CCG1 - Flu Vaccinations for frontline health workers	70-90%	63% (Trust-wide) 52% (Beds & Luton)	63% (Trust-wide) 52% (Beds & Luton)
Mental Health CQUINs	**2022/23 Target**	**Q3 Position**	
CCG9 - Cirrhosis and fibrosis tests for alcohol-dependent patients*	20-35%	0%	0%
CCG10a - Routine outcome monitoring in CYP and perinatal mental health	10-40%	58% (Trust-wide) 38% - Perinatal (Beds & Luton) 85.7% - CAMHS (Beds & Luton)	58% (Trust-wide) – Feb-23 66% - (CYP and Perinatal Beds & Luton)
CCG10b - Routine outcome monitoring in community MH services	10-40%	36% (Trust-wide) – Feb-23 33% (Beds & Luton)	36% (Trust-wide) – Feb-23 42% (Beds & Luton)
CCG11 - Use of anxiety disorder-specific measures in IAPT	55-65%	72.3% (Trust-wide) 78.8% (Bedfordshire)	71% (Trust-wide) 74% (Bedfordshire)
CCG12- Biopsychosocial assessments by MH liaison services*	60-80%	90%	85%
Community Health CQUINs	**2022/23 Target**	**Q3 Position**	
CCG13 - Malnutrition screening in the community*	50-70%	Standard not applicable	Standard not applicable
CCG14 - Assessment, diagnosis and treatment of lower leg wounds	25- 50%	15%	18%
CCG15 - Assessment and documentation of pressure ulcer risk*	40-60%	Standard not applicable	Standard not applicable

Specialist Services

Mental Health CQUINs	2022/23 Target	Q4 Position	Year end 2022-23 position
PSS6 - Delivery of formulation or review within 6 weeks of admission, as part of a dynamic assessment process for admissions within Tier 4 CYPMH settings	50-80%	83%	87%
PSS7 - Supporting quality improvement in the use of the restrictive practice in Tier 4 CYPMH settings	65-80%	100%	98%
PSS8 - Outcome measurement in perinatal inpatient services	75-95% (CROM), 35-55% (PROM)	90% CROM 70% PROM	81% CROM 38% PROM

Action taken where targets have not been met:

Flu Vaccination for staff

Actions taken for Q4	Plan for the next year 2023-24
In order to increase vaccination rates among our staff, we collaborated with Flu leads across the Trust and held outreach meetings every Monday. These meetings provide an opportunity for Vaccinators and Flu leads to request additional support from the central Flu team, who can then go out to their directorates to provide assistance. By providing this support, we overcame challenges that were hindering vaccination efforts and increased uptake among our staff. Waiting response on next steps from NHSE regarding how this issue can be sorted from their end.	Campaign Review – The Flu team has already sent out an end of campaign Survey to all staff and Flu leads to evaluate the different approaches used and things to improve on. A written report is shared with the Trust directors and planning for the next season begins based on recommendations and suggested improvements. Ordering of 2023/24 Flu vaccines made early to aid with earlier rollout for the next season. To form centralised Flu team and hub vaccinators that will be able to do ad hoc clinics for hard to reach areas. Directorate based data will shared with the individual directorates on weekly basis which help them to review their current progress and could take appropriate steps/plans to improve the uptake. Further discussions with NHSE to resolve the denominator issue.

Cirrhosis and fibrosis tests for alcohol dependent patients

Actions taken for Q4	Plan for the next year 2023-24
East London During Q3, the service provider wrote letters to the ICB to inform them of the significant challenges faced in delivering the CQUIN and requested additional assistance to address the issues. The Interim Medical Director also reached out to the neighbourhood Acute Trust Medical Directors throughout East London to establish direct referral pathways and jointly address the challenges faced. However, due to a lack of engagement from the commissioners and Acute Trust Medical directors, no further work was carried out on this CQUIN in East London. *Luton & Bedfordshire* The Luton & Bedfordshire service is collaborating with the Clinical systems team to upload the referral letter onto RiO. After the letter is successfully uploaded, a pathway will be established to enable electronic transmission of referral letters through our RiO clinical system to GPs for individuals diagnosed with alcohol dependency, allowing referrals to be processed and managed through primary care.	***The CQUIN has been discontinued for the year 2023-24 as a result of learning and feedback from providers.***

Assessment, diagnosis and treatment of lower leg wounds

Actions taken for Q4	Plan for the next year 2023-24
During Q4, additional changes were made to the wound assessment template, including the addition of 'location of wound', which was not previously read coded. A number of cases where dopplers were not completed within the expected timeframe were due to a shortage of staff and ability, as well as issues with equipment availability due to servicing needs. A number of patients were seen and treated with no reason for onward referral at this time due to suitability for compression, if the wound does not show improvement in compression, the patient would then be referred onwards as per clinical pathways. This is reflected in the number of N/As above, removal of these results in 50% compliance for those applicable to the CQUIN for all CQUIN criteria being achieved.	This CQUIN is to be continued into the next financial year and therefore work will be done to renew training sessions that were previously given by the Tissue Viability Nurses (TVN)s throughout July and August 2023 in all localities to introduce new changes made to templates and care plans for the treatment of lower leg wounds within the community. The TVN Training sessions incorporated how to complete wound and leg ulcer assessments, and changes to SystmOne to reflect current guidance including Doppler and onward referral criteria to improve compliance. Work will also be undertaken to cascade further changes made to SystmOne following the end of 22/23 and we will continue to review and report 20compliance quarterly.

2.9 Data Security and Quality

IG Audit	Primary diagnosis correct %	Secondary diagnosis correct %	Primary procedure correct %	Secondary procedures correct %	Unsafe to Audit %
2020/21	98.00%	98.01%	N/A	N/A	0
2021/22	100.00%	98.00%	N/A	N/A	0
2022/23	100.00%	98.00%	N/A	N/A	0

ELFT's Data Security & Protection Toolkit Assessment Report overall score for 2021/22 was 'Standards met'. Due to changes made during the pandemic the submission date has altered to 30th June each year. ELFT's overall score for 2022/23 is therefore unavailable at this time

2.10 Reporting against core indicators

NHS England (NHSE) Assurance

This section of the report sets out indicators that are part of the NHSE Oversight Framework 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.

2.10.1 Single Oversight Framework Indicators

These indicators form part of appendices 1 and 3 of the 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):

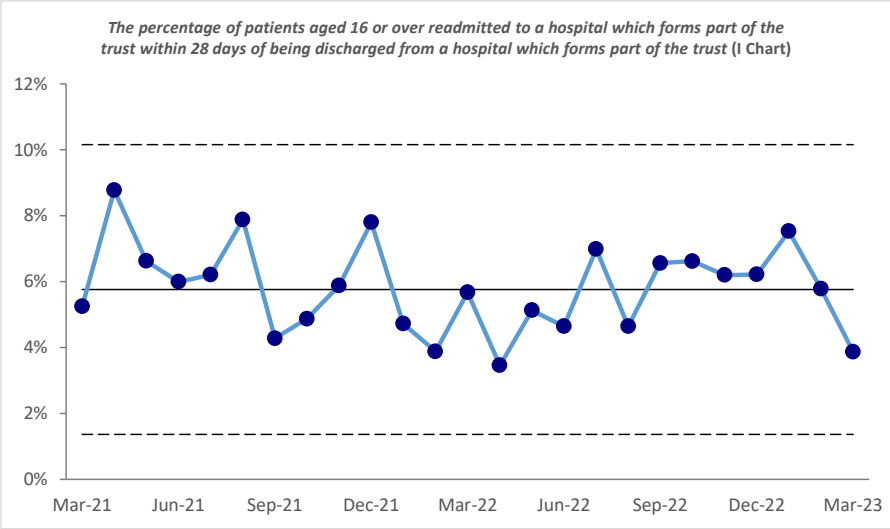
Quality of Care Indicators	**Target**	**Actual 2018/19 Q4**	**Actual 2019/20 Q4**	**Actual 2020/21 Q4**	**Actual 2021/22 Q4**	**Actual 2022/23 Q4**
Admission to adult facilities of patients under 16 years old	0	0	0	1	2	0
Meeting commitment to serve new psychosis cases by early intervention teams' measure. People experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	50%	88.24%	70.2%	50.7%	73.3% (During Q4)	76.8% (During Q4)
Operational Performance	**Target 2018/19**	**Actual 2018/19 Q4**	**Actual 2019/20 Q4**	**Actual 2020/21 Q4**	**Actual 2021/22 Q4**	**Q4 2022/23**
Proportion of people completing treatment who move to recovery (from IAPT MDS)	50%	53.2%	51.6%	**55%**	52% (During Q4)	51%

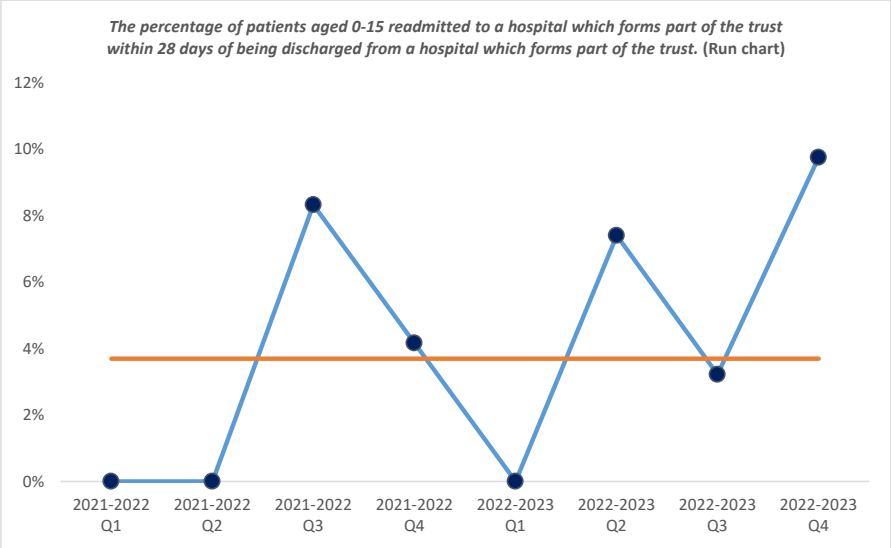
Improving Access to Psychological Therapies - Patients referred with 6 weeks measure	75%	97.1%	98.1%	99.6%	98.4%	97.2%
Improving Access to Psychological Therapies - Patients referred with 18 weeks measure	95%	99.6%	100%	100%	100%	100%

2.10.2 Quality of Care Indicators

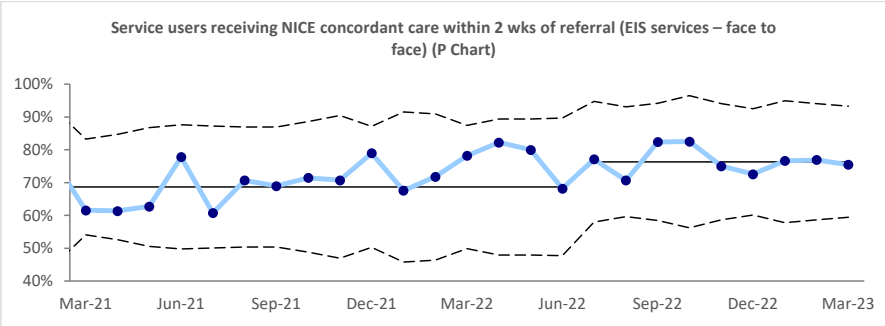
Admissions to acute mental health services

		Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.		100%	100%	100%	100%	100%

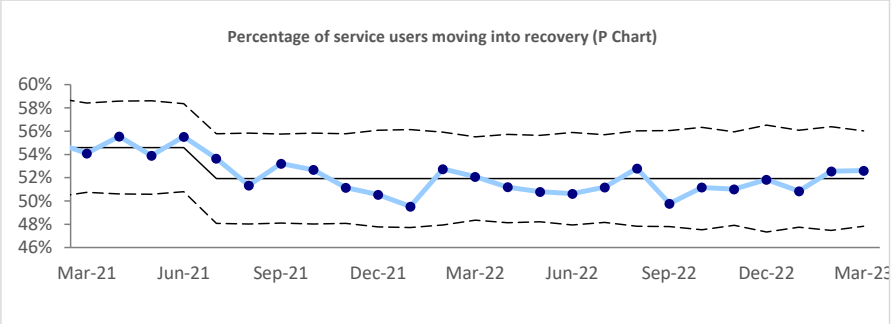


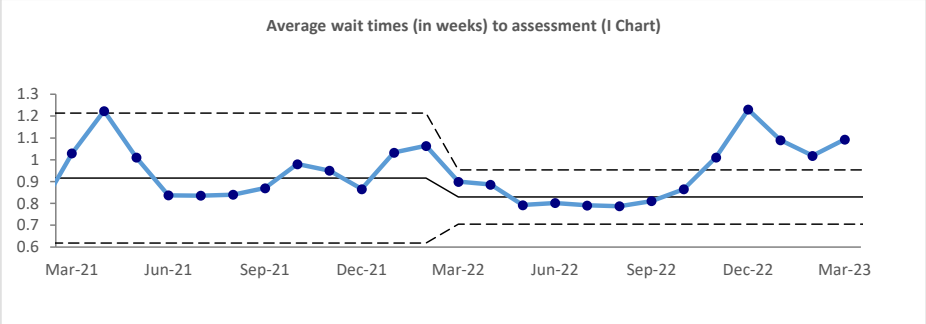


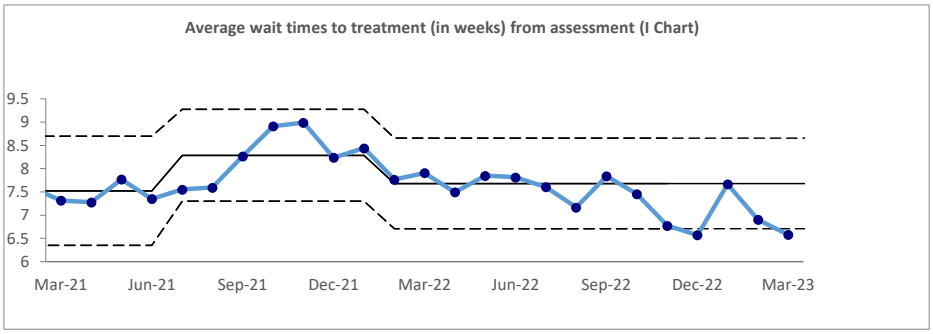
Percent of service users receiving NICE Standard treatment within two weeks of referral to early intervention in psychosis service – *excludes telephone or face to face contacts as per current definition* (Trust-wide)



Psychological Therapies





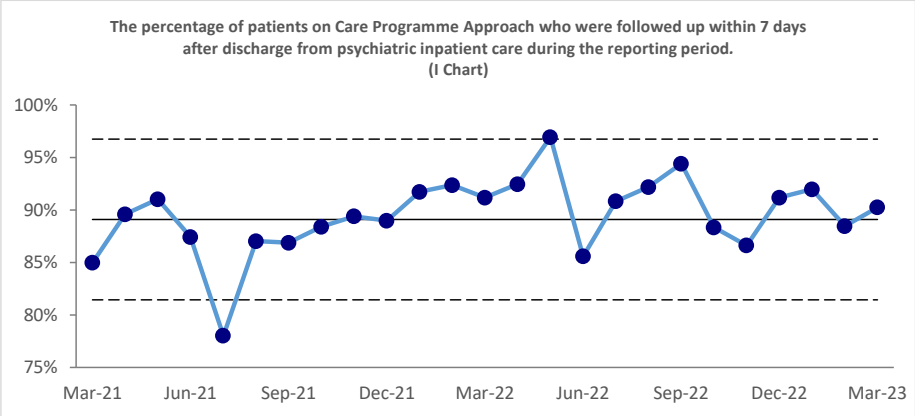


2.10.3 Care Programme Approach (CPA)

The CPA is the delivery framework for the care and treatment of a large proportion of the Trust's service users. The table below contains locally defined indicators and targets agreed with commissioners.

Indicator	Target	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23

CPA patients – care plans in date (documents 12 months old)	95%	58.7% 2061/3510	58.6% 2050/3498	53.1% 1877/3537	54.4% 1939/3562	53.2% 1891/3557
CPA patients – care plans in date (documents 6 months old)	N/A	42.5% 1492/3510	42.9% 1501/3498	37.9% 1342/3537	38.1% 1358/3562	39.5% 1405/3557



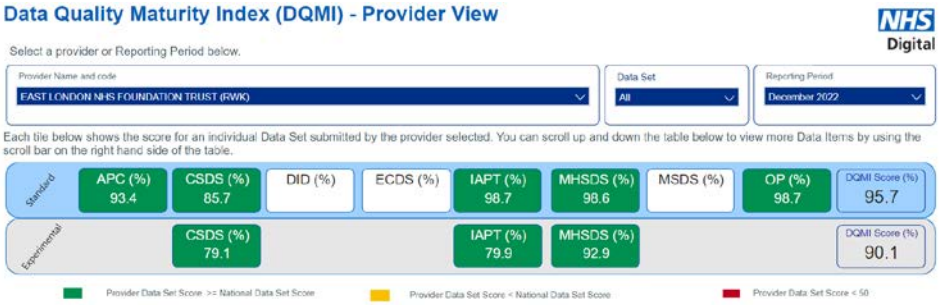
Trust services embed the new process and the use of RiO and continue to monitor reviews regularly focusing on supporting teams that are not meeting the target.

2.10.4 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 NHSE website and can be found here (DQMI)



PART 3 – Other Quality Performance Information 2022/23

3.1 An Overview of Key Dimensions of Quality During 2022/23

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.

In addition to routine monitoring of key data, the Board also receives regular quality reports that include updates on the progress of priority quality improvement work, and assurance in relation

to key, current quality and safety issues. Over the last 12 months the Board has received 6 such quality deep dives, the subjects of which are set out below:

Trust Board Meeting	Topic	Themes of learning and areas of action for improvement
May 2022	Triangulation of staff and service user feedback	- There are long waits for some services - Some staff and service users remain dissatisfied with the environments in which care and treatment are provided - Staff and service users are experiencing the impact of challenges in recruitment, leading to shortage of staff, waits or cancellations of appointments, and perception of overworked or stressed staff. - Information provision and communication with service users and carers is very important and could be better
July 2022	Clinical Record Keeping	A more detailed understanding of the underlying system barriers to good record keeping is required to bring further improvement to record keeping practice. Actions put in place to achieve this - a 'system review' of record keeping to fully understand the specific systemic causes of failures in clinical record-keeping - Feeding the findings of the review into a Trust-wide Learning Lessons seminar identify further opportunities to improve the reliability and safety of record-keeping - introducing human factors training for all serious incident reviewers, with a view to action plans being weighted towards systems factors
September 2022	Complaints	Key themes of complaints where work is being undertaken to improve are: - customer service, - to make better information more readily available to our service users and carers - to improve people's experience of phoning our services.
November 2022	Quality and Safety of in-patient mental health services	A focus on how we support the provision of safe, high quality inpatient care, following the two recent television documentaries highlighting significant failings in two mental health providers; The report outlines the approach we take at ELFT to creating an open culture on our wards, enabling service users, carers and staff to speak up about the quality of care being received or provided, and how we can continually improve. Visible and effective leadership is key to safety – the report outlines how we utilise walkrounds at different levels of the organisation, and support team and directorate leaders to be able to identify safe, high quality care and take action to improve when needed.
January 2023	Getting the basics right	The report describes the findings from consulting with service users, carers and Governors about what this phrase means to people. The key aspects that emerge are: - staff attitude - feeling listened to - effective communication - timely access to services.

Trust Board Meeting	Topic	Themes of learning and areas of action for improvement
		These align closely to the key themes that emerge from an analysis of complaints that we receive as a Trust (see September Board quality report). The report outlines the work that is underway across the Trust to improve customer care, to improve integration of services to minimise handovers and repetition of information being required, to improve the way in which we manage and answer telephone calls, and tackling the demand and waits that people are experiencing when trying to access some of our services.
March 2023	Recognition and prevention of closed cultures	This report follows on from the November 2022 board report. The focus is specifically on those inpatient wards that are most at risk of developing closed cultures, outlining the risk factors and warning signs. The report summarises what our data tells us about these high-risk services, based on known warning signs such as incident reporting, use of restrictive practices, openness to external scrutiny and engagement of service users in providing feedback and improving services. The report also outlines the various workstreams underway to continue to strengthen our systems of quality and safety, from the leadership framework that we are currently co-designing across the Trust, to the data systems that give people intelligence about quality and safety within our services, to the testing of a new safety culture survey across inpatient teams

Key metrics in the domains of patient safety, clinical effectiveness and patient experience are drawn from our 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

In 2019, the new NHS Patient Safety Strategy was launched, to support the NHS achieve its vision of continuously improving safety by building a strong patient safety culture and patient safety system.

The Trust has commenced work to deliver on the expectations of the strategy including the establishment of patient safety specialist roles within the organisation and promotion of core learning modules in Patient Safety.

Since 2021, national expectations have grown and the Trust is now mandated to deliver on four further core components:

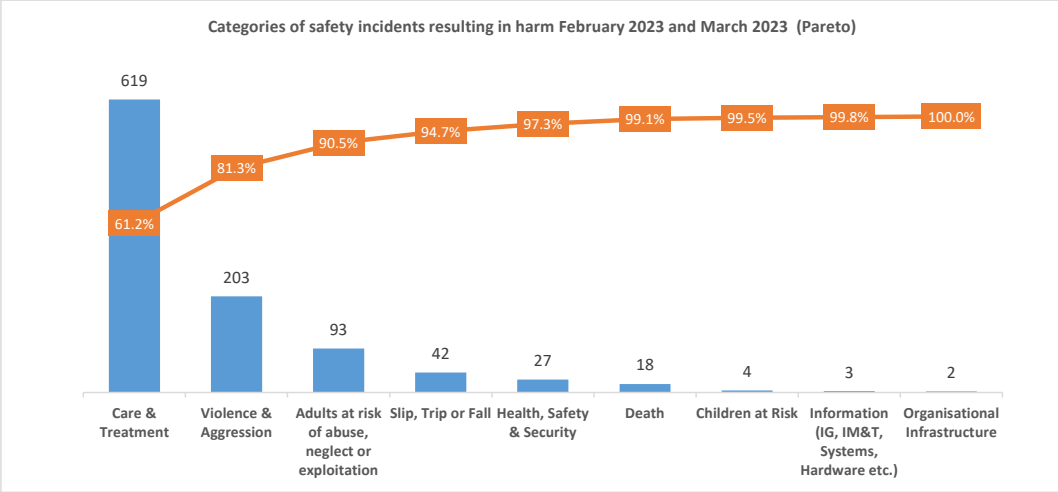
- Adaptation of our reporting systems to align with and feed into the new national **Learning from Patient Safety Events system**;
- Transition to the **Patient Safety Incident Response Framework (PSIRF)**;
- Delivery of the **Patient Safety Syllabus**;
- Engagement of dedicated patient role in safety, known as **Patient Safety Partners**.

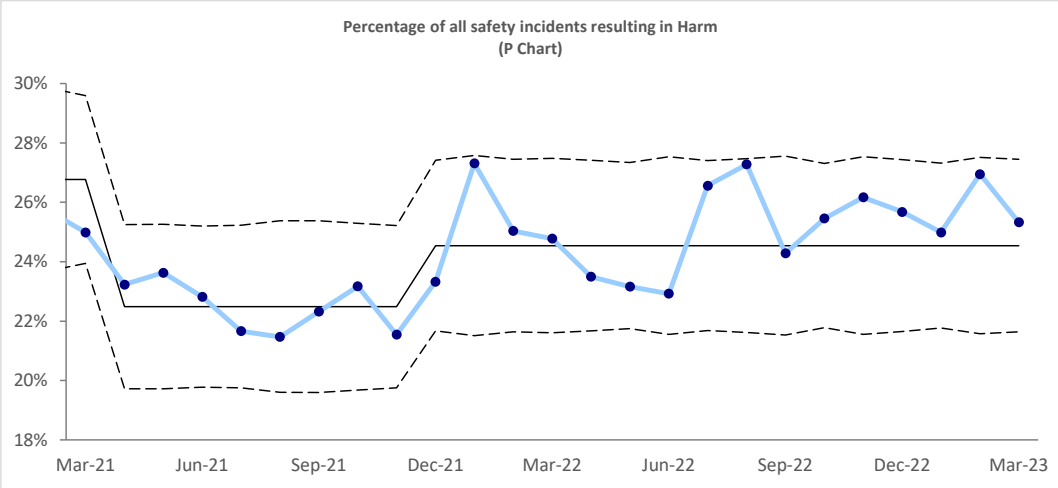
Over the course of 2022, led by the Director of Patient Safety, the Trust developed a Safety Plan, designed not just to deliver on the expectations of the NHS Patient Safety Strategy, but to go further to include evidence-based areas for improvement that are not included in the strategy.

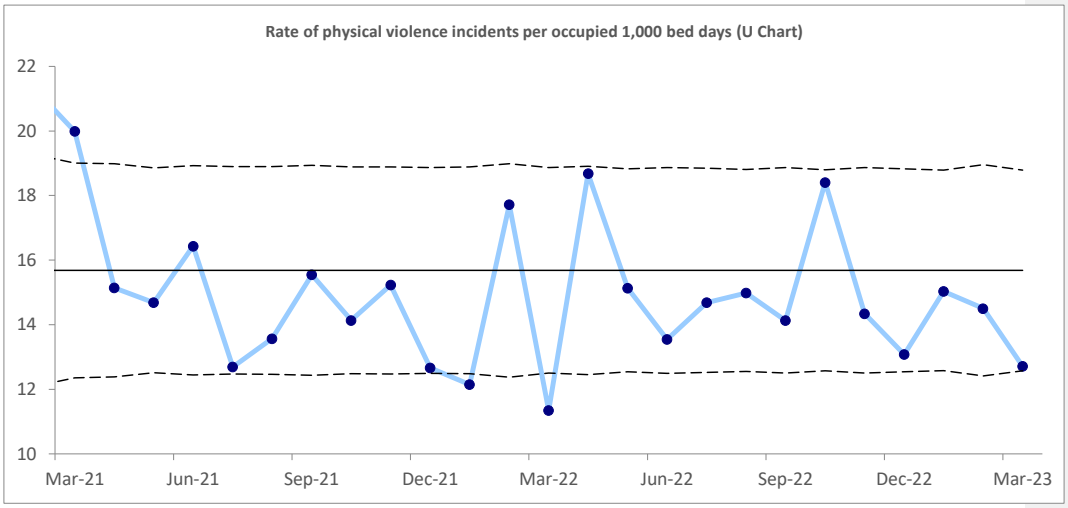
The plan was developed in collaboration with a wide range of staff, stakeholders and service users to understand what safety means to our people, the current status of safety, the gaps in our safety profile and the improvements they think are needed.

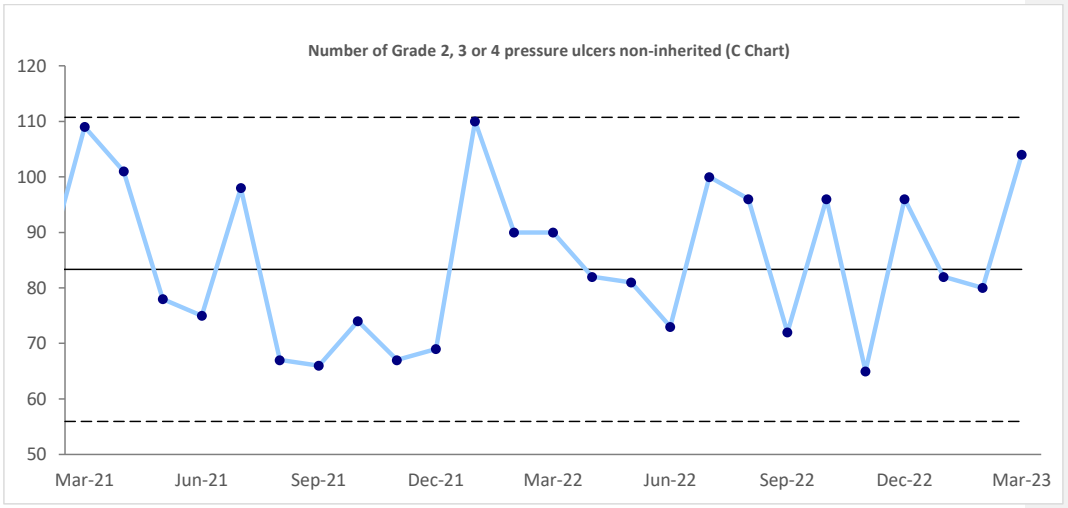
The result is our Safety Plan set out below:

Here we set out some of the key safety metrics the trust has been paying close attention to over the past 12 months.


Categories of safety incidents resulting in harm February 2023 and March 2023 (Pareto)
619
203
93
42
27
18
4
3
2
61.2%
81.3%
90.5%
94.7%
97.3%
99.1%
99.5%
99.8%
100.0%
Care & Treatment
Violence & Aggression
Adults at risk of abuse, neglect or exploitation
Slip, Trip or Fall
Health, Safety & Security
Death
Children at Risk
Information (IG, IM&T, Systems, Hardware etc.)
Organisational Infrastructure


Percentage of all safety incidents resulting in Harm
(P Chart)
30%
28%
26%
24%
22%
20%
18%
Mar-21
Jun-21
Sep-21
Dec-21
Mar-22
Jun-22
Sep-22
Dec-22
Mar-23





During 2022/23 29,102 incidents were reported in total. Of those 13,450 (46%) were designated as patient safety incidents and reported to the central NRLS system. Of those patient safety incidents 195 (1.5% of all patient safety incidents) were categorised as having resulted in severe harm or death.

Most reported incidents are categorised as low or no harm in terms of severity. The Pareto chart above shows the main categories of reported incidents during February and March. 62% of reported safety incidents were associated with care and treatment. The most common themes within the care and treatment category were pressure ulcers or moisture-associated skin damage, self-harm incidents, and complications or unexpected deterioration.

The number of expected deaths remains stable, while unexpected deaths have decreased, due to improvements made by staff in categorising expected deaths more accurately on the incident reporting system. Expected deaths are anticipated due to known illnesses, while unexpected deaths can happen suddenly and without warning. Healthcare professionals can often predict expected deaths, while unexpected deaths may result from accidents, sudden illnesses, or unforeseeable circumstances which may necessitate further investigation to help promote learning and improvement. More information about how the Trust reviews and learns when deaths occur is set out in detail in part 2 of the report.

Staff have actively participated in both established and new learning opportunities, such as a Trust-wide safety learning event, new training for incident response and after-action reviews, and the introduction of a new Safety Newsletter and intranet platform. Learnings from Serious Incidents continues to be shared through a range of channels, including regular cascades, the SI committee, newly launched 7-minute briefings and learning lessons seminars that have seen increasing attendance. Testing of new methods for frontline safety learning, including the After Action Review approach has also started.

The Trust is actively working to achieve its year 1 Safety Plan objectives, which include co-designing a new Patient Safety Incident Response Approach, planning for a new incident reporting system, and engaging with the NHSE Patient Safety Syllabus. Furthermore, plans are underway to develop an overarching Safety Strategy that will bring together all existing and new programmes of work within the organisation that are focused on prioritising efforts to improve the overall safety culture across the Trust.

The rate of physical violence in inpatient settings remains stable, which is encouraging. Teams have highlighted that the recent focus on improving the reliability of "Safety Culture Bundles“ has been useful in promoting a positive and proactive safety culture, and appears to have led to a reduction in the use of prone restraint.

These bundles were developed as part of the violence reduction quality improvement initiative and have a strong evidence base for improving safety. This work is part of the large-scale quality improvement programme on inpatient quality and safety, details of which are contained in the quality report.

The Use of Force steering group is aiding teams in implementing a variety of measures, including training on trauma-informed care, collaborating with Police and Ambulance services to establish effective and compassionate escalation protocols, partnering with service users and staff to create leaflets outlining restrictive practices procedures and Mental Health Law, and setting aside specific time to engage in reflective sessions with service users, aimed at learning and reflecting on how to minimise the use of restrictive practices. As a way to promote psychological safety, Community Health Services are currently testing Schwarz Rounds.

Across Community Health Services, the aggregate number of pressure ulcers continues to remain stable. In Newham, low harm pressure ulcers have reduced between January to March, while moderate pressure ulcers remained at a low and stable level.

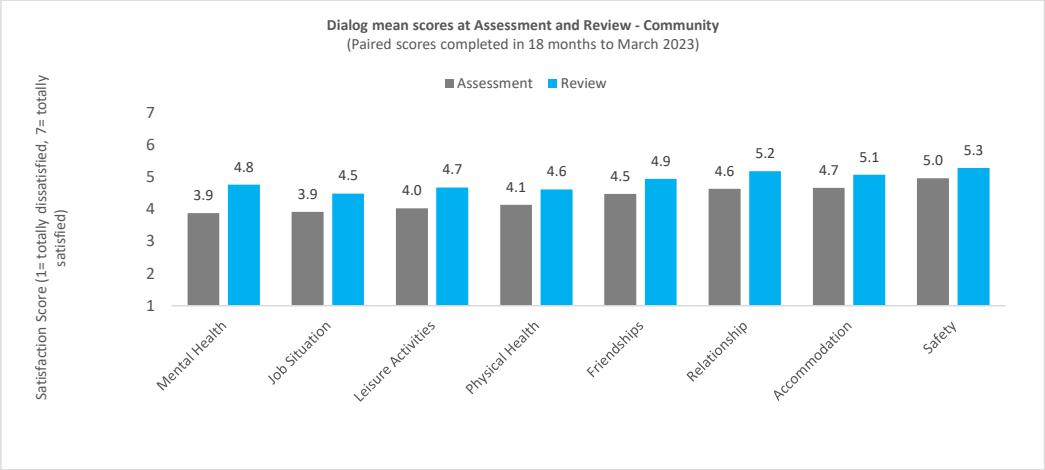
In Tower Hamlets, one week saw higher than usual numbers of low harm pressure ulcers reported, but none worsened to moderate harm, which is a positive sign. In Bedfordshire, there are higher numbers of pressure ulcers, but the count of low and moderate harm pressure ulcers occurring whilst receiving care within the Trust has declined. This reflects the positive impact of staff and service user training and educational material that has been coproduced, encouraging service users to engage and adhere to recommendations and prevent deterioration of pressure

ulcer condition. The Skin Matters steering group in Bedfordshire is aiding staff to conduct frequent assessments and document skin damage and wounds during all visits, with close monitoring.

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



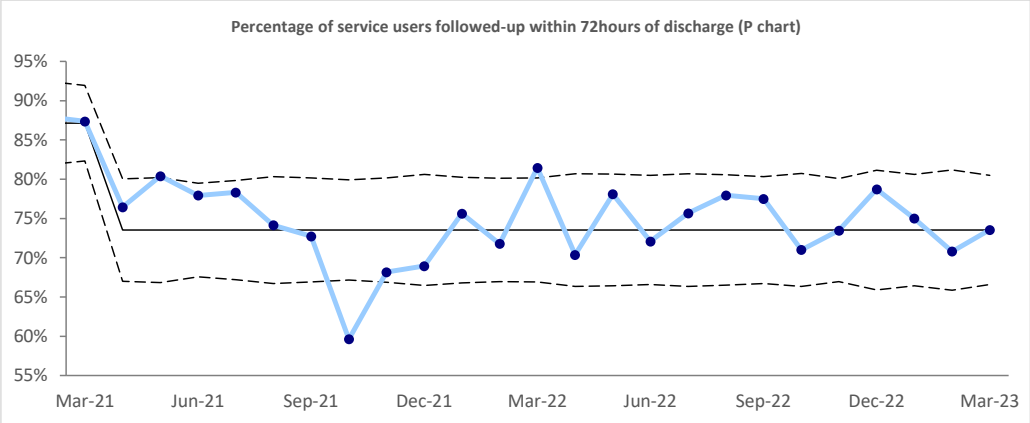
DIALOG is a scale of 11 questions. People rate their satisfaction with eight life domains and three treatment aspects on a 7-point scale. DIALOG provides a score for subjective quality of life and a score for treatment satisfaction. The scale is part of the DIALOG+ intervention but can also be used on its own.

DIALOG+ is a full therapeutic intervention. It incorporates the DIALOG scale but goes far beyond administering a scale.

DIALOG + is the first approach that has been specifically developed to make routine patient-clinician meetings therapeutically effective. It is based on quality-of-life research, concepts of patient-centred communication, IT developments, and components of solution-focused therapy, and is supported by an App. Research studies in different mental health services and multiple countries have shown that using DIALOG+ can improve patients' quality of life.

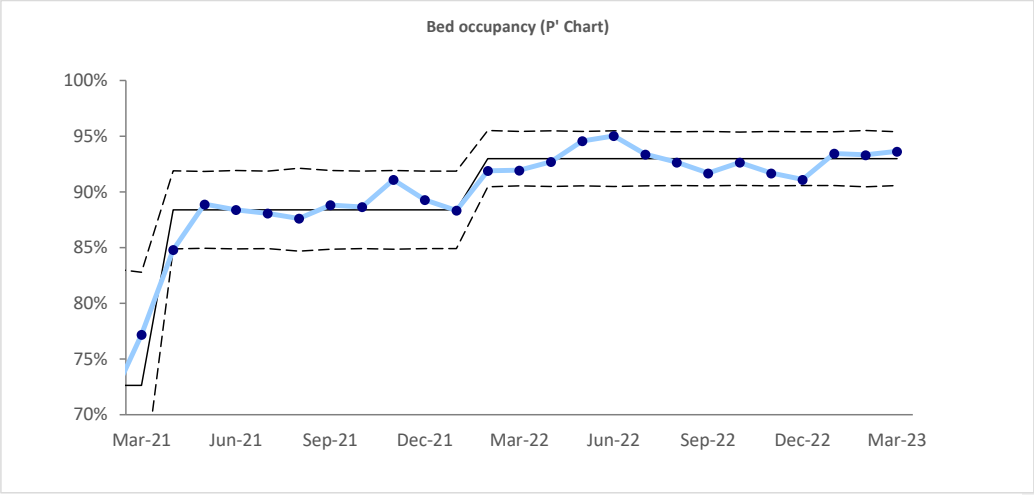
The DIALOG outcome charts above show that mental health services continue to demonstrate a positive impact on all quality-of-life measures. Various initiatives have been put in place to support improvements across directorates, as discussed in previous performance reports. The DIALOG committee is currently in the process of producing guidance to support staff and service users to best utilise DIALOG in preparation for discontinuation of the Care Plan Approach.

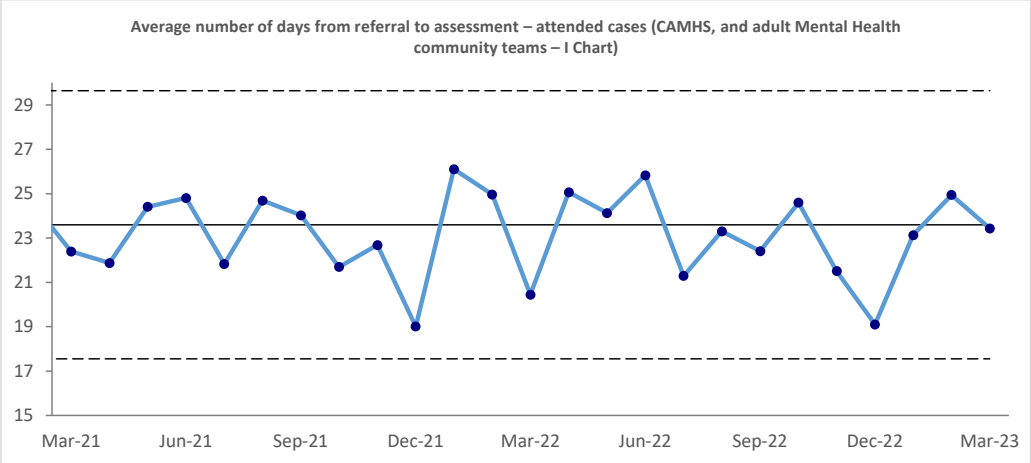
Services that are currently not using DIALOG are being consulted on reasons for non-engagement as well as co-designing it to best suit the requirements of the service user. Perinatal services are exploring specific mother and baby questions being added, which aims to be more inclusive. Learning Disability Services are reviewing the format to ensure it is accessible for service users. Ongoing training is being delivered to staff to best make use of DIALOG.

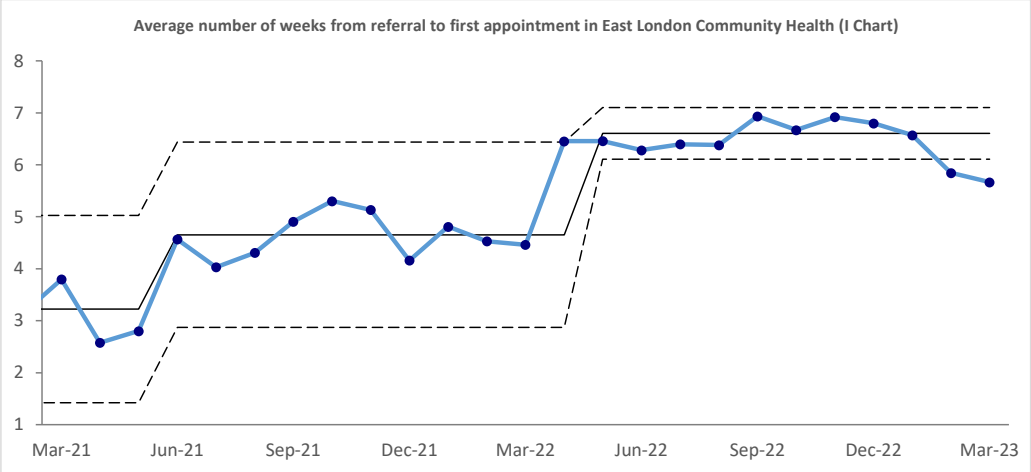


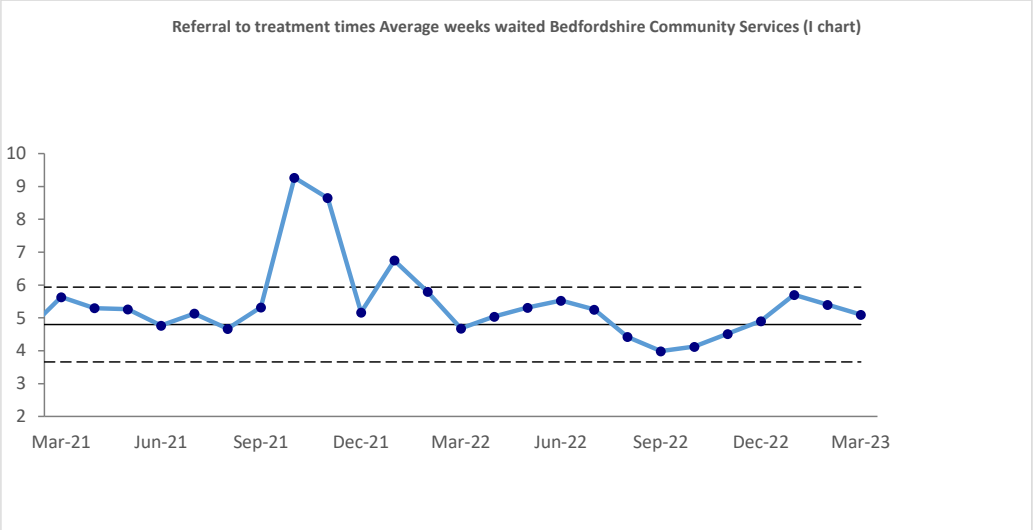
The percentage of service users followed up within 72 hours of discharge from mental health inpatient care is currently at 75%. There is some variation across the different Directorates of the the trust. This month, City & Hackney has seen the greatest drop, achieving 72-hour follow up for 59% of service users. The high bed occupancy in the inpatient unit of 98% has meant that staff are prioritising immediate patient needs. City & Hackney is collaborating closely with the Community Recovery teams and has introduced a daily process for its Flexible Assertive Community Treatment team (FACT) to divide caseloads and ensure that all service users receive follow-up within 72 hours. The aim is to enhance the efficiency of the process and ensure the safety of service users by sharing responsibilities across teams to meet their individual needs. Whilst Bedfordshire continues to surpass the target, achieving 84%.

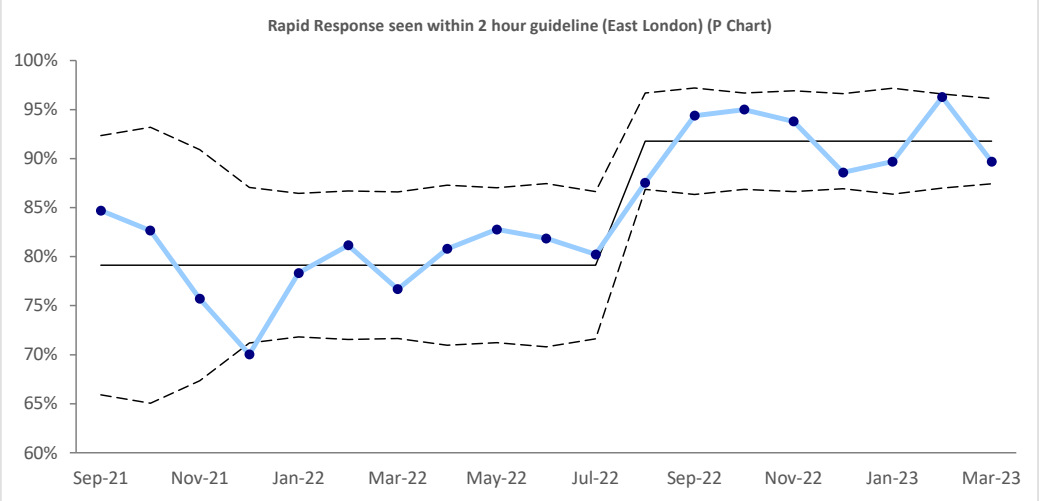
Access to services

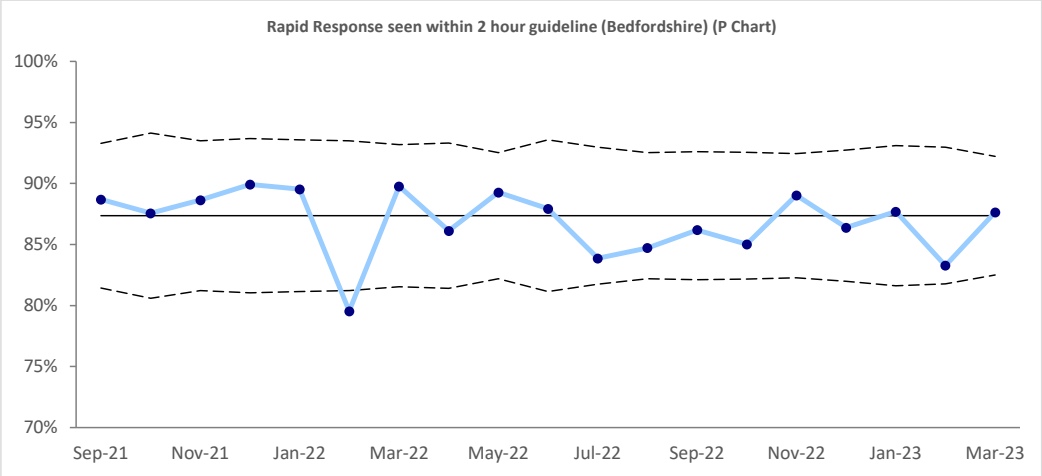



Average number of days from referral to assessment – attended cases (CAMHS, and adult Mental Health community teams – I Chart)
29
27
25
23
21
19
17
15
Mar-21
Jun-21
Sep-21
Dec-21
Mar-22
Jun-22
Sep-22
Dec-22
Mar-23


Average number of weeks from referral to first appointment in East London Community Health (I Chart)
8
7
6
5
4
3
2
1
Mar-21
Jun-21
Sep-21
Dec-21
Mar-22
Jun-22
Sep-22
Dec-22
Mar-23


Referral to treatment times Average weeks waited Bedfordshire Community Services (I chart)
10
9
8
7
6
5
4
3
2
Mar-21
Jun-21
Sep-21
Dec-21
Mar-22
Jun-22
Sep-22
Dec-22
Mar-23


Rapid Response seen within 2 hour guideline (East London) (P Chart)
100%
95%
90%
85%
80%
75%
70%
65%
60%
Sep-21
Nov-21
Jan-22
Mar-22
May-22
Jul-22
Sep-22
Nov-22
Jan-23
Mar-23



While overall number of admissions has decreased compared to previous years, bed occupancy continues to remain high, at an average of 94%. This is related to several factors including higher levels of acuity and complexity, a rise in formal admissions under the Mental Health Act, out of area admissions, and social care related delays to discharge. Services have highlighted an increase in the number of service users who are homeless or lack a permanent residence, and who also have intricate social care requirements that can make the discharge process more protracted.

The Trust collaborated with NELFT to conduct a review of bed capacity, and the two organisations are planning to repurpose an existing ward into an additional male adult acute inpatient ward. This is aimed at improving overall bed capacity in the local system. Plans are also in place to reorganise the Health Based Places of Safety units by closing the facility in Newham and introducing a new one at Goodmayes Hospital. This change seeks to enhance quality and safety for both adults and children by improving the unit's therapeutic environment, reducing delays, and providing case closer to a service user's residence. A promotional campaign is underway to raise awareness of alternatives to A&E, including crisis lines.

Mental Health Joint Response Cars are having a positive impact by providing additional mental health expertise to the ambulance response team. This approach diverts demand away from A&E by conducting assessments and referring individuals to mental health or voluntary sector services as appropriate. Initial review of the data suggests that 81% of people seen by the joint response cars are either treated or referred on, without need to convey to hospital. Additionally, services have reviewed the winter schemes that proved beneficial in managing flow, and are exploring ways to build upon these initiatives. One such approach involves providing additional funding for consultant cover on weekends to improve decision-making and expedite discharge.

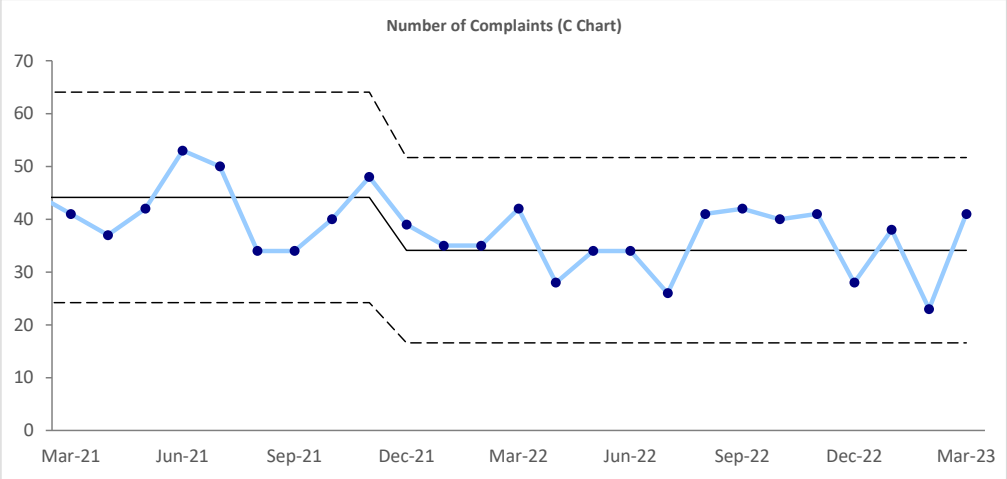
Rapid response in Community Health Services is stable, with 90% in East London and 88% in Bedfordshire assessed within two hours, surpassing the national 70% target. Services in Bedfordshire have highlighted that performance has been maintained despite higher levels of referrals during the past two months, reflecting increased demand from palliative care services. Services are working with acute providers to implement virtual wards in order to support people at home. This can include remote monitoring using apps, wearables, and other medical devices such as pulse oximeters. In Bedfordshire, the initial focus has been with respiratory, frailty, and

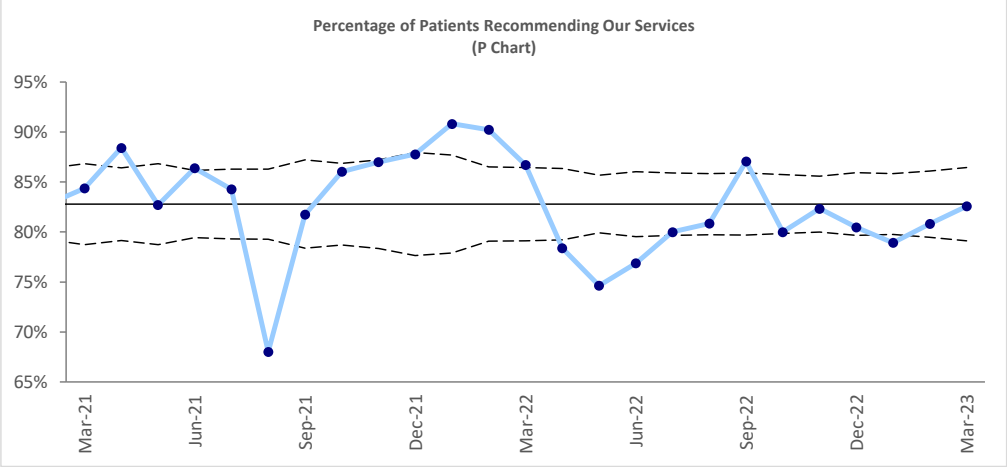
cardio-vascular care pathways. Virtual wards, discharge to assess, and Integrated Discharge Hubs in East London are being strengthened to improve patient flow across the system.

Access and flow remains a priority focus for concerted quality improvement work, and some of the detail of that programme of work is set out in part 2 of the document.

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.



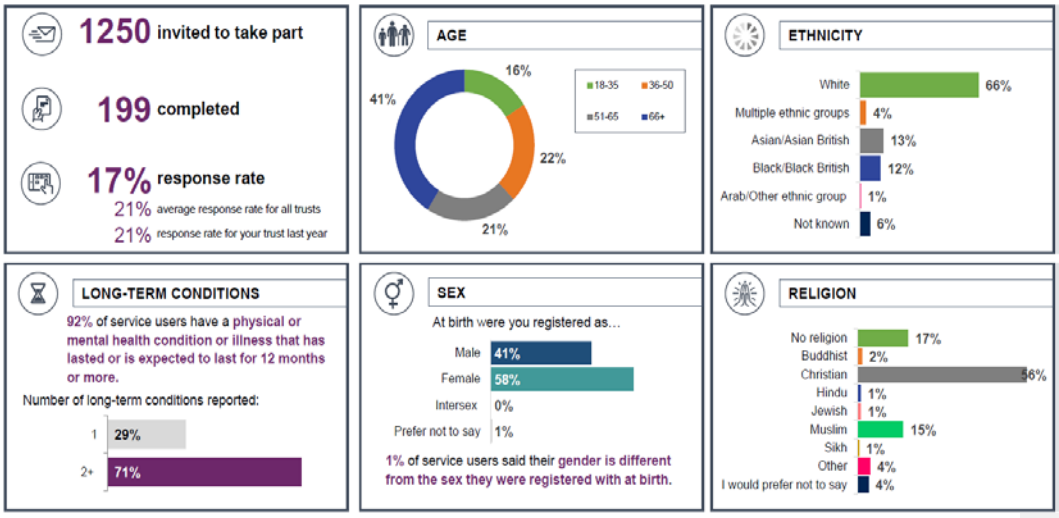


The number of complaints has remained stable, with the majority of complaints received in the past two months being related to behaviour of staff, the management of clinical procedures, accessibility, coordination of care, and communication. As highlighted in the March report, learning from complaints are incorporated into a variety of forums and newsletters within each service to ensure that learning takes place and improvements are made. The complaints procedure is currently under review to enhance the process, and a proposal is scheduled to be presented to the Quality Committee for consideration.

In March, the percentage of service users who would recommend our services has returned to normal levels. In addition to the standard friends and family test, the Quality Assurance team has completed a series of workshops with clinicians and service users to redesign the Patient Report Experience Measures (PREM) survey questions to ensure these align with what matters most for service users. Through the workshops, clinicians and service users identified similar perspectives on the key areas that the Trust should focus on while measuring patient experience, with a common theme centred around 'getting the basics right'. The future survey questions will align to what our service users, carers and Governors have told us are the basics that we need to get right every time such as improving accessibility, communication, information, collaboration, and shared decision-making.

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 in 2022. The figures below summarise participation and the findings of the report.



Headline scores

	Patient Response	Compared with other trusts
Health and social care workers	6.8 / 10	About the same
Organising care	8.1 / 10	About the same
Planning care	6.6 / 10	About the same
Reviewing care	7.0 / 10	About the same
Crisis care	6.5 / 10	About the same
Medicines	7.2 / 10	About the same
NHS talking therapies	7.8 / 10	About the same
Support and wellbeing	4.5 / 10	About the same
Feedback	2.4 / 10	About the same
Overall views of care and services	6.9 / 10	About the same
Overall experience	6.2 / 10	About the same
Responsive care	7.5 / 10	About the same

In addition to the range of work in support of the strategic objective to improve experience of care, during 2022/23 the Trust has been promoting the use of the Care Opinion platform to its understanding of, and ability to respond to service user and carer experience.

Adoption of the platform has grown steadily through the year, with the Quality Assurance team providing dedicated support to services to engage with the platform. Over the past 12 months ELFT services received feedback from 88 service users and carers, and responded directly to 83 of those stories that have been shared.

Linked to this work, in September the Trust launched a Trust-wide Patient and Carer Experience Forum to provide a platform for discussion and review of patient and carer experience data with the aim of learning and, ultimately, improvement of patient experience within the organisation. The group brings together service users, carers and clinicians to perform its core functions:

- To help triangulate and identify themes from the various sources of patient and carer experience feedback across the Trust;
- To coordinate work to tackle opportunities for improvement that emerge from patient and carer experience feedback;
- To identify and celebrate good practice and innovation in relation to understanding and improving patient and carer experience;
- To support and encourage teams and directorates to deepen their understanding of patient and carer experience, identify themes and make improvements.

3.2 Achievements and Awards

March 2023. Two wins and one highly commended for Trust services, for the **Health Service Journal (HSJ) Partnership Awards 2023** that took place on Thursday, March 23, 2023:

Driving for Change, which uses refurbished London buses to provide an all-in-one direct intervention service for people experiencing homelessness, was named Primary Care Project of the Year.
https://www.elft.nhs.uk/news/national-award-driving-change-programme

Compass, ELFT's not for profit social enterprise, was **Highly Commended** in the Best Not for Profit Working in Partnership with the NHS category.
https://www.elft.nhs.uk/news/compass-wellbeing-highly-commended-national-awards

Clinical Associates in Psychology (CAP) was named Best Educational Programme for the NHS. It was also Highly Commended in the **Mental Health Partnership within the NHS** award category.
https://www.elft.nhs.uk/news/second-national-award-apprenticeship-programme

March 2023. The **British Journal of Nursing Awards** saw a Silver Award win for Newham and Tower Hamlets Community Health Services Pressure Teams for their work to reduce pressure ulcers.

March 2023. **Cavell Star** Award for East Ham Care Centre's Clinical Nurse Manager and dementia care specialist Admiral Nurse Tracy Connellan, for her work to improve the experience of people living with dementia, their carers and families.

December 2022. Winners of the HPMA Awards 2022. People & Culture team win Team of the Year & Chief People Officer Tanya Carter wins Director of the Year.

November 2022. Winners of a Forward Healthcare Award 2022. ELFT's not for profit community interest company Compass wins the Innovation in Supporting NHS Trusts award.

November 2022. HSJ Awards 2022. NCEL CAMHS Provider Collaborative of the Year, Place-Based Partnership Award for C&H Integrated dementia service; Workforce Initiative of the Year for the Clinical Associate in Psychology (CAP) programme, shared with EPUT & Sheffield health & Social Care Foundation Trust.

November 2022. The London Pathway Partnership Programme (The Inclusion Health Team based at Homerton Hospital) won at the 2022 London Homelessness Awards.

October 2022. Bow Ward at the John Howard Centre win the Nursing Times Award for Nursing in Mental Health.

October 2022. A Quality in Care Diabetes (CiQ) Award won by a collaborative project between Barts and ELFT for the Wellbeing category.

October 2022. Chartered Institution of Building Services engineering (CIBSE) Awards – Silver Medal for ELFT Director of Estates, David Stevens.

October 2022. RCN London Rising Star Award given to Mary Onikoyi, District Nurse Team Lead & Practice Assessor & Professiona nurse advocate at City University.

August 2022. Winners of the HealthTech Digital Awards 2021, for the category Best COVID-19 Solution for Mental Health. Digital innovators Improve Well and ELFT's QI team worked together to develop a staff wellbeing app.

July 2022 The Royal Statistical Society and the Health Foundation jointly presented the **Florence Nightingale Award** to the Trust's Visual Analytics Team for Excellence in Healthcare Analytics.

July 2022 The Homeless and Vulnerable Person Outreach Service is the national winner in the **NHS Parliamentary Awards for the Primary Care and Community Care category.** Nominated by Dame Meg Hillier MP.

June 2022. ELFTs Quality Department win the **International Quality Awards'** (IQA) Quality Team of the Year Award.

June 2022 Sam Ogunkoya wins **National BAME Health & Care Awards Inspiring Diversity and Inclusion Lead** of the year category.

June 2022 Newham Specialist Children & Young People's Services, (SCYPS) Community Children's Matron Rebecca Daniels is awarded a **Cavell Star** for outstanding contribution to nursing.

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 Integrated Care Boards

Statement from North East London Integrated Care Board to ELFT Quality Accounts 2022 – 2023

NHS North East London Integrated Care Board is the lead commissioner responsible for commissioning health services from East London NHS Foundation Trust on behalf of the population of east London.

Thank you for asking us to provide a statement on East London NHS Foundation Trust's (ELFT) 2022/23 Quality Account and priorities for 2023/24.

We commend the Trust for continuing to provide high-quality care despite the ongoing impact of the pandemic. The Trust has made progress on the delivery of its 2022/2023 annual plan and has continued to make progress on improving population health outcomes; experience of care; staff experience; and improved value.

We congratulate the Trust on the work undertaken to successfully deliver on its priorities. There are a range of excellent examples of how this work is impacting on service users and staff and improving clinical outcomes.

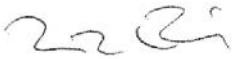
We would like to congratulate the Trust on the impressive list of audits, achievements, awards and the innovative service user accreditation programme. We hope the Trust will be able to report next year that all our east London services achieved service user accreditation and quality network accreditation from the Royal College of Psychiatrists.

We are aware that the Trust has undertaken important work to address health inequalities in the last year. We welcome the range of QI projects planned for 2023/24 that will address inequity of care and patient outcomes and note the strong leadership and investment in this area.

We are grateful to the Trust and its staff for their continued commitment to collaboration and partnership working that will further support and develop our North East London Integrated Care System.

We confirm that we have reviewed the information contained within the account, and checked this against data sources where these are available to us, and it is accurate.

Overall, we welcome the 2022/23 quality account and look forward to working in partnership with the Trust over the next year.



Zina Etheridge
Chief Executive Officer
North East London Integrated Care Board

Statement from Bedfordshire, Luton & Milton Keynes Integrated Care Board to ELFT Quality Accounts 2022 – 2023

BLMK ICB acknowledges receipt of the 2022/2023 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 ICB's Quality Committee & Performance, as part of developing our assurance statement.

The ICB has been working closely with the Trust over the last year now as partners in the ELFT Quality Assurance Groups, gaining assurance and understanding of the challenges and transformation of services to deliver safe and effective care. Across Bedfordshire and Luton we have worked closely with ELFT and Partners (Local Authority, Healthwatch and ELFT senior leaders) in ensuring patient safety and quality of services. In line with the NHS (Quality Accounts) Regulations, BLMK ICB 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 ICB would like to commend ELFT on their continued commitment to patients during a year off high demand and increasing complexity. We recognise the significant increase in demand on both the Community and Mental Health services which includes transformation of services alongside the joint work from ELFT with other local providers to reduce system pressure. People participation further embeds in the development and review of service delivery ensuring a positive patient experience.

We note the achievements over 2022-23 in the ELFT Quality Improvement Plan and the performance of Quality Improvement the golden thread towards delivering their priorities. These include the increased access of cervical screening in primary care and ongoing work to improve access for specific demographic groups in Bedfordshire Wellbeing Service.

The continued embedding of the Improvement Coaching Programme is evidenced in the development of staff who have undergone extensive training, resulting in the success of QI projects with work being presented at a national conference.

The ICB have reviewed the Quality Priorities for 2023-24 with the overarching aim to improve quality of life for ELFT service. The strategic objectives of improved outcomes, experience of care along with improved staff experience and service value replicate the BLMK ICS vision.

Whilst the Quality Account does not specifically reference the Patient Safety Incident Response Framework, the ICB would like to acknowledge the continued partnership working in relation to the development of the Framework for the BLMK system. The partnership work over 2022-23 in developing the future of the Integrated Care System has notably made significant impact with regards to quality and patient experience.

It is assuring to see the continued Trust ambition to become the first 'Marmot Trust' in the country addressing inequity and create a fairer society partnering with the Institute of Health Equity. We will be interested to see how the expansion of the extended offer to local colleges and undergraduate programmes develops over the next year.

The achievement of additional nursing workforce and reduction in agency usage is a positive move towards recruitment challenges. The development of a QI project to tackle the medical vacancies in Luton and Bedfordshire is a welcomed solution to an extremely challenging national

issue. The ICB acknowledges the continued system management of the Children and Adolescent Mental Health Service waiting times with the waiting well programme and development of the iThrive model.

As System Partners with population health priorities, we recognise the transformation of services to support the ever-increasing demands, complexities and challenges of meeting the needs of our people. We are looking forward to further embedding partnership working to improve patient safety, quality of care alongside patient experience.

BLMK ICB looks forward to the continued developing collaboration of services with ELFT across our Integrated Care System in 2023/24 and the impact this will have for BLMK residents.

Signed

Sarah Stanley, Chief Nursing Director
BLMK Integrated Care Board

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 Accounts is available via:

- East London NHS Foundation Trust website (https://www.elft.nhs.uk)

2022/23 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 Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England 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 Accounts.

In preparing the Quality Accounts, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Accounts meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2022/23 and supporting guidance
- the content of the Quality Accounts is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2022 to May 2023, papers relating to quality reported to the Board over the period April 2022 to May 2023
    - 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 Accounts
    - the national staff survey within Quality Accounts
- the Quality Accounts presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Accounts is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Accounts, 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 Accounts is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
  and
- the Quality Accounts has been prepared in accordance with NHS England'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 Accounts.

Commented [LC1]: This is a partial duplication of the first bullet poin

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Accounts.

Signature	**Signature**
Eileen Taylor **Chair**	**Paul Calaminus** **Chief Executive**

Date **Date**

CONTACT US

The Trust's postal address is:

Trust Headquarters
Robert Dolan House
9 Alie Street
London E1 8DE

Switchboard Telephone Number: 020 7655 4000
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

ANNUAL REPORT TO THE QUALITY ASSURANCE COMMITTEE
26 June 2023

Title	Integrated Patient Safety Report
Authors	Charlotte Walton, Deputy Head of Incidents Management Kim MacGillivray, Governance & Risk Senior Manager Ashraf Zaman, Incident Coordinator Deborah Dover, Director of Patient Safety
Accountable Executive Director	David Bridle, Chief Medical Officer

Purpose of the report

This report is the annual integrated patient safety paper covering 2022-2023 (April 2022 until and including March 2023). The report includes:

- **Annualised Patient safety data**
- **Safety management update**
- **Safety learning themes & analysis**
- **Safety Improvement and Oversight Update**
- **Progress on our Safety Plan & first year objectives**

The paper is for information and assurance purposes and approval thereof.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Key messages

ELFT continues to have strong safety systems and a strong framework for responding to patient safety concerns with compassion, transparency and rigour.

Safety data from the year indicates a healthy culture of incident reporting with most incidents reported being in the low/no harm level. Feedback from staff suggest ongoing safety challenges particularly in the areas of staff safety and well-being, safe staffing, violence and aggression, self-harm and access, whilst our Serious Incident Reviews have picked up a range of issues including problems with quality of care and follow up, documentation, training and supervision. These themes have guided the safety improvement work in 22/23 and will be used to determine our safety improvement priorities for the year ahead.

Total deaths and expected deaths over the year were higher than in 2021/22, in line with a similar pattern at a national level. The numbers of unexpected deaths reported has shown a pattern of decline, consistent with improvements in data categorisation during this reporting period.

Timeliness and allocations of our Serious Incident (SI) Reviews has improved as part of quality improvement work led by our chief nurse. Ongoing SI transformation work continues towards embedding of the new Patient Safety Incident Response Framework (PSIRF).

Good progress has been made over the year in terms of developing our new trust Safety Plan, and on meeting the year one priorities which include planning for transition to the new PSIRF in the autumn 2023, transforming our incident reporting system, involving patients and carers and spreading uptake of the new patient safety syllabus e-learning modules. Recent progress includes

commencement of PSIRF training, training of After Action Review Conductors, appointment of our first Service User Patient Safety Partner and improved engagement with learning from Safety seminars, events and communications.

A large amount of work has also taken place during the year to improve oversight, safety culture and learning from safety, and the safety forum has supported a range of large-scale safety improvement work on priority areas.

Strategic priorities this paper supports

Improved population health outcomes	Identifying patient safety risks, collaborating with system partners and implementing systemic learning from safety issues enables us to work towards improved population health.
Improved experience of care	Safety and patient experience are intrinsically connected. This paper supports this priority by reporting on how the Trust meets Serious Incident Framework responsibilities and actions for dealing with Serious Incidents and complaints. Reflecting and learning from patient experience are routinely included in all incident review processes.
Improved staff experience	Our patient safety work supports staff experience by empowering and supporting staff in providing them with the correct tools, policies, procedures, documentation and training to improve patient safety. Supporting staff involved in incidents is also incorporated into our incident processes and quality improvement work.
Improved value	Safer care is economically important and work to provide safer care can significantly reduce the financial burden of safety incidents.

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 plus assurance regarding oversight of our safety improvement work and future work being planned to strengthen our patient safety culture and systems.
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. This paper outlines the way we are working to increase our involvement of patients and carers and support for those affected by incidents.
Financial	There are financial implications regarding resource management & potential for litigation.
Quality	Given the fact that safety is an inherent component of quality assurance and improvement, this report interfaces with our quality reporting in these areas. There is ongoing work needed to ensure reporting is complimentary and avoids duplication where possible. The report suggests patient safety could benefit from closer working with quality improvement to address safety challenges within the organisation.

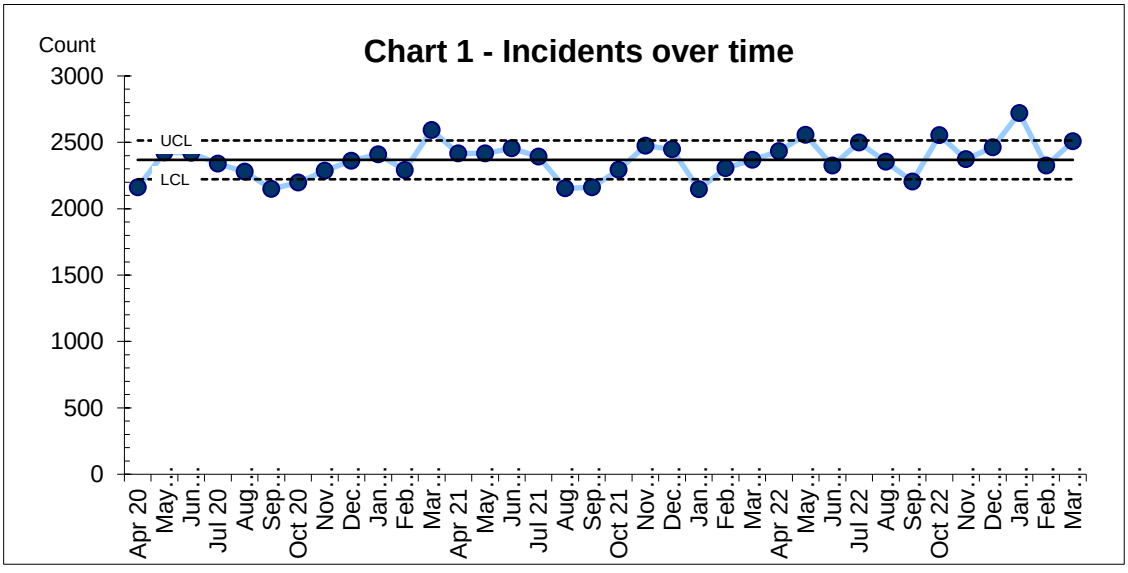
Background & Introduction

This is the first year that ELFT have produced quarterly integrated safety reports for the Quality Assurance Committee. This annual report attempts to bring together a summary of the year's reports, along with a summary of the work undertaken to continuously improve safety management, learning and culture within the trust. There is also a focus on our new trust Safety Plan and progress made on achieving year one objectives.

Safety Culture & Safety Reporting

Data on reporting of incidents and also feedback from our Freedom to Speak Up (FTSU) Guardian indicates that our staff are actively sharing safety incidents and concerns and appear to feel supported when doing so. This year's Staff Survey results also indicate a strong culture of reporting of violence (89.6%). The survey suggests that the majority of staff feel well engaged and view care of patients as their top concern (81%), the majority are confident in raising safety concerns (73.7%) and that these would be addressed by the organisation (61.8%). 78.2% believe the organisation acts on concerns of service users and carers, and the majority of staff believe they are making a difference to patients and are able to make improvements in their area. The survey suggests a need for ongoing focus on reporting of staff experience of bullying, discrimination and abuse, staff morale, stress and staff exhaustion levels, staff feeling valued and their experience of kindness, which are all central to safety outcomes. These results do need cautious interpretation given the modest response rate (33%) this year, but will inform work to improve Staff Safety as part of our Safety mission and within the implementation of our People Plan.

Over the course of this year, reporting of incidents has remained in common cause with 83% of incidents reported rated as no or low harm (see chart for breakdown of incident ratings). Currently 6% are rated moderate and less than 1% rated severe.



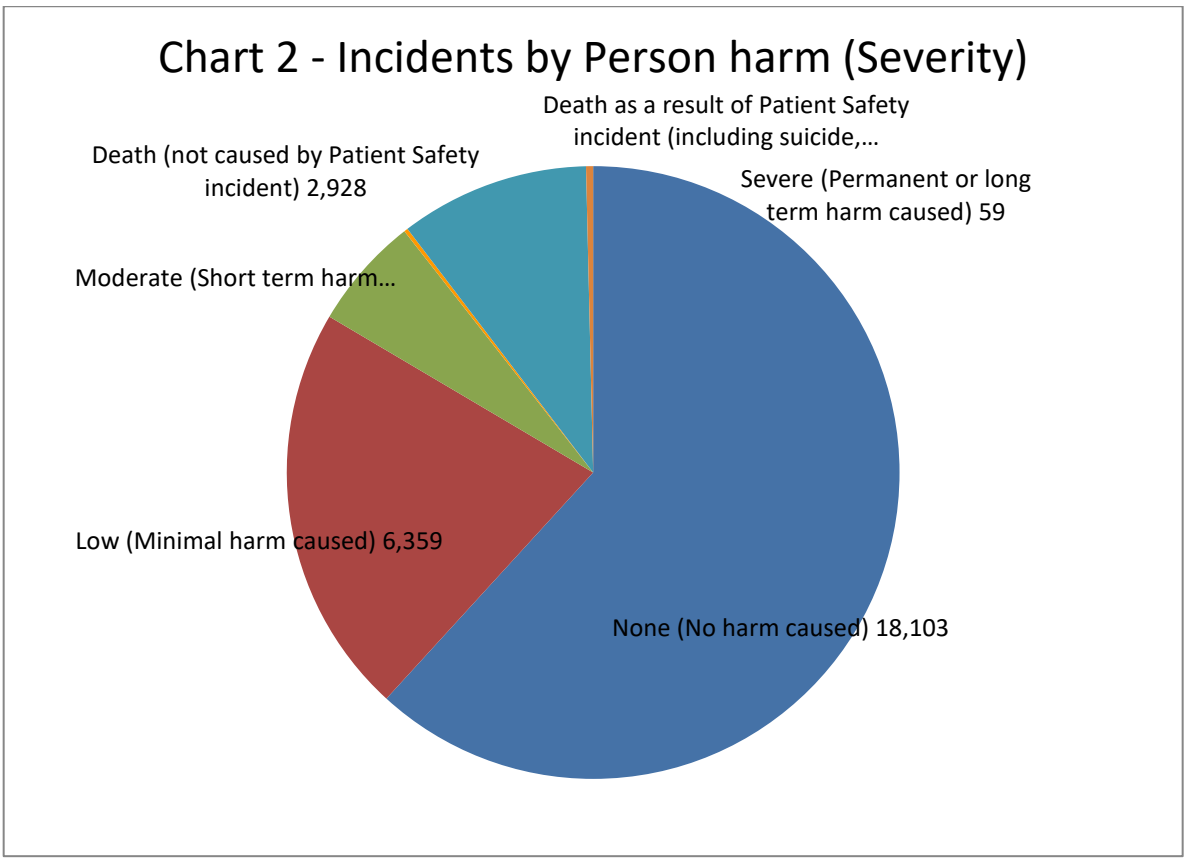


Chart 3 shows the top five categories of incident being reported in this year.

Chart 3 - Top Incident Categories 2022/23	Data
Pressure Ulcer / Moisture Associated Skin Damage	4589
Treatment / Procedure	3395
Death of an Adult Service User	2985
Actual Physical Attack	2569
Self-Harm	1586

Learning from Deaths

The Trust reported a total of 2863 deaths between 01/04/2022 and 31/03/2023, a 13.09% increase from the number of deaths (2184) reported in 2021/22. The increase was consistent with National numbers of expected deaths in the same reporting period.

There were 2520 expected deaths and 343 unexpected deaths reported in 2022/23. A total of 1216 deaths were reviewed for learning. Of the 343 unexpected deaths, 111 were subject to the SI process. A breakdown of the number of investigations completed is shown in chart 4 below, and demonstrates the diligent approach the trust has for reviewing incidents for learning & improvement purposes.

Over the year, we have been sharing learning from deaths within our integrated safety report and within our learning from deaths panel. As part of our Safety shared learning improvement work and PSIRF transformation, in the year ahead, we will be working to strengthen our methods of learning from deaths and the systems for cascade of learning.

Chart 4 – Safety Investigations undertaken in 2022-2023

Period	Reported deaths	Investigation Type				Total Investigations (%)
		SJR/CRR	48hr	Concise/SI	LeDeR	
Quarter 1	696	166	43	29	6	244 (35.05%)
Quarter 2	721	183	59	26	8	276 (38.28&)
Quarter 3	721	277	67	32	5	381 (52.84%)
Quarter 4	725	237	50	24	4	315 (43.44%)
Totals	2863	863	219	111	23	1216 (42.47%)

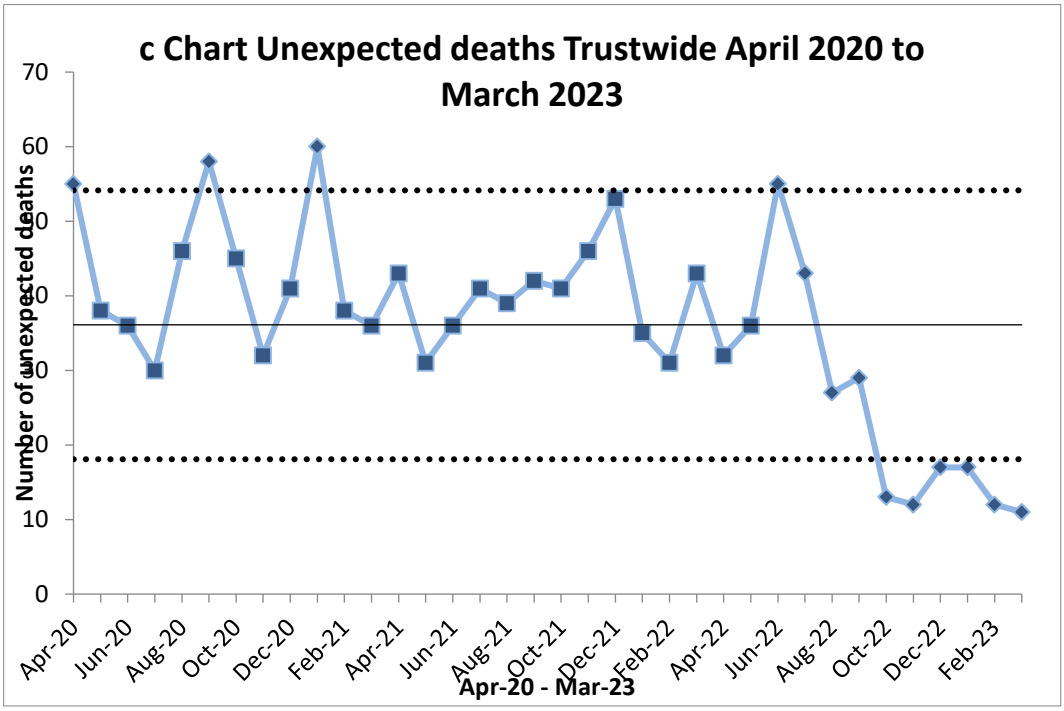
Expected Deaths

2520 patients died expectedly between April 2022 and March 2023, the reporting period. This was an increase of 35.05% (654) from the previous year. 863 of these deaths were subject to a Structured Judgement Review (SJR). The highest number of deaths was amongst the 76 -100 year old group. There were 45 deaths reported between 01/04/2022 and 31/03/2023 where the patient had a positive COVID 19 test in the 28 day period before they died. For the first time since the start of the pandemic, Covid-19 has dropped out of the top five leading causes of death in England. Trust wide, dementia and Alzheimer's disease were named as the highest causes of death. Cancer, respiratory disease and organ failure were the next common causes of deaths reported by the Trust. The office of National Statistics (ONS) revealed that dementia and Alzheimer's disease were the leading causes of death in 2022.

Unexpected Deaths

343 unexpected deaths were initially reported Trust-wide on DATIX (the Trust's incident reporting database) between April 2022 and March 2023. On review of the categories only 304 were found to be unexpected deaths and are shown on chart 5 below. Overall the total of unexpected deaths reported continued to decline over April 2022 and March 2023

Chart 5 - Unexpected deaths between April 2020 and March 2023

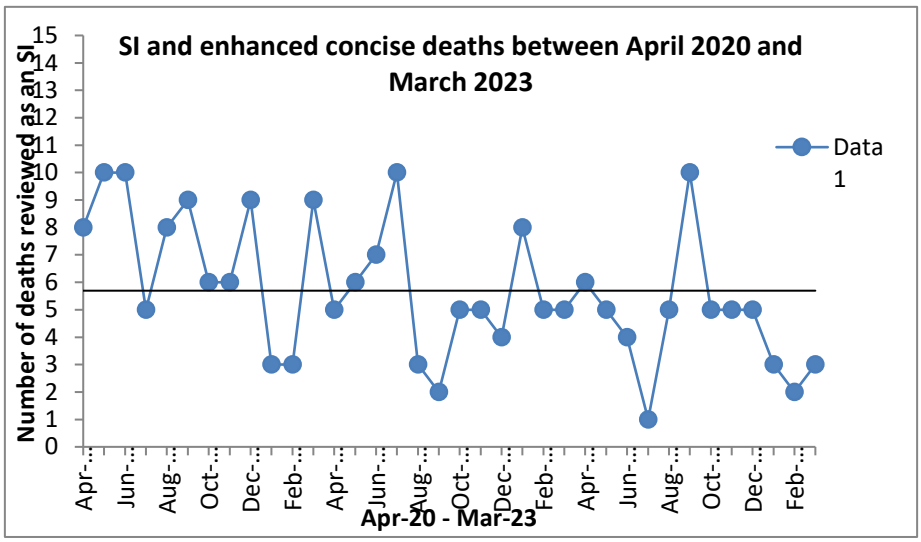


Of the initial 343 unexpected deaths that were reported 219 were reviewed as a 48 Hour report, 108 were closed without further escalation, 39 of which were re-categorised as they were not unexpected deaths. There were 57 Concise Reviews. The remaining 54 deaths were reported on StEIs and reviewed as Serious Incident or enhanced concise Serious Incident review.

Chart 6, below, shows the pattern of deaths reviewed as Serious Incident process. The recent trend is evident, with a reduction in reporting incidents as Serious Incidents. This correlates with a parallel increases in our completion of concise reviews, by 23%, during this period, with a recorded figure of 144, compared to the previous years where it stood at 60. This reflects changes in our approach to incidents, as part of our Quality Improvement work on Serious Incidents and as part of our PSIRF preparation, with an emphasis on improving timeliness and a more flexible approach to learning from safety.

Chart 6 - Unexpected Deaths Raised to SI or an enhanced concise Trust wide from April 2020 to March 2023

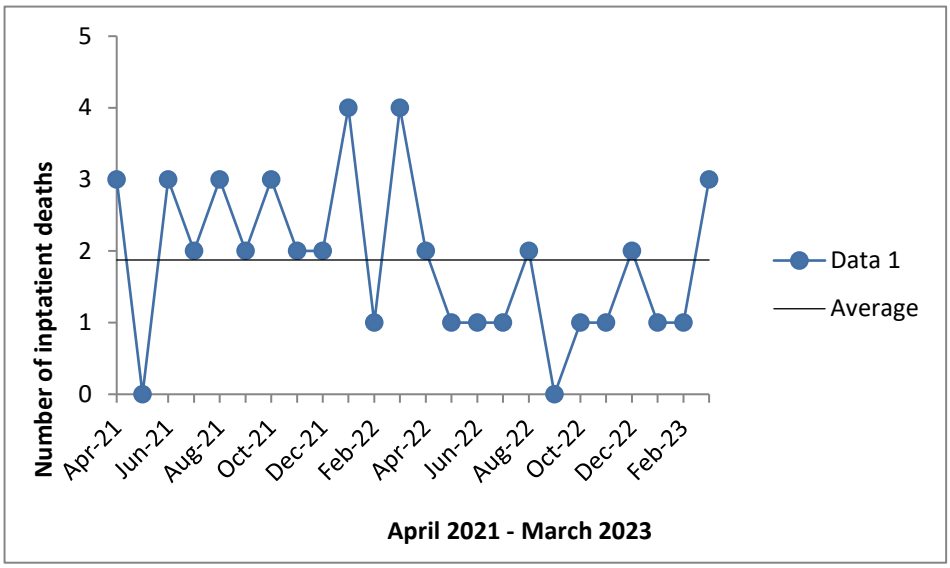
Run Chart



In-patient Deaths

16 inpatient deaths occurred between April 2022 and March 2023 in mental health service, significantly fewer than in the previous year, where there a total of 29 losses (see chart 7). The majority died as a result of physical health causes. More details of these deaths can be found in the quarterly integrated safety reports.

Chart 7 – In-patient deaths in mental health service between April 2021 and March 2023



Deaths in People with Learning disability and Autism

The Trust reported 32 deaths to LeDeR between April 2022 and March 2023. These were people who had a diagnosis of Learning Disability. Eight of the people that died were under the age of 30 years. All 32 patients had underlying physical health conditions. The youngest patient was a 21 year old man who had number of physical health problems and had a feeding tube and a tracheotomy.

During 2022-23, in addition to including LEDER deaths in our Learning from Deaths panel reports, we strengthened our learning from LEDER by incorporating this into our regular integrated safety report and adding sharing of LEDER learning to our patient safety forum rolling agenda.

Learning from Inquests

A total of 121 inquests into deaths of ELFT patients' / service users were concluded at Coroners Court between April 2022 and March 2023. The highest number of deaths heard at inquest were from Bedford Mental Health services with a total of 35. Suicide was the highest cause of death Trust wide, with 29 suicide verdicts, with death related to drug use being the second highest.

Themes arising from inquests relating to safety learning or improvement strongly align with the learning arising from our internal Serious Incident reviews which occurred in advance of the inquests, and include:

- Communication problems
- Inadequate follow up, telephone response and/or assessments
- Failure to carry out observations according to policy
- Failure to record information
- Failure to complete an adequate search
- Failure to follow Trust and national guidelines to maximise the effectiveness of resuscitation.
- Identified risk at CPA not followed though
- Falls risk assessment not undertaken

Regulation 28 Prevention of Future Deaths (PFD) Reports

The Trust were issued with five prevention of future deaths notices between 01/04/2022 and 31/03/2023. These reports have all been reviewed and responded to, with tailored action plans to address both our own and the coroners' concerns. The Trust has introduced the inclusion of PFD's actions and learning in the Learning from Deaths Quarterly meetings. PFD's and actions are presented by identified responsible persons.

Serious Incident Data and Processes

Over the course of this year 92 incidents were graded as requiring serious incident review. 67 of these incidents related to deaths, with 32 being suspected suicides; 18 hanging, 3 on tube/railway, 2 overdose of medication, 2 overdose of illicit drugs, 2 jumping from height /into danger, 2 method unknown 1 suffocation, 1 drowning, 1 burning, 1 laceration. Of the 9 remaining deaths where a cause is known; 3 were alleged homicide (2 where the perpetrator is a service user, 1 the victim), 2 natural cause, 2 road traffic accident, 2 suspected unintentional overdose of illicit drugs. The 24 remaining death SIs declared remain unknown of the cause of death at present. See appendix 2 for further details.

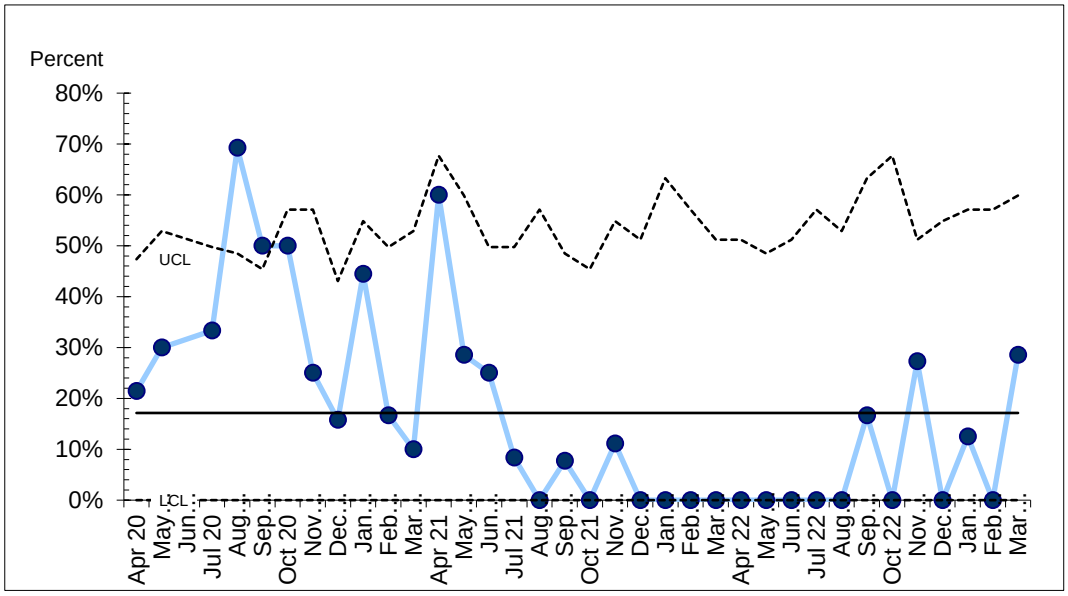
Two serious incidents relating to in-patient deaths in previous years remain under Independent review by North East London Integrated Care Board due to family request. In one case, which occurred in 2021, a full Serious Incident Review has been completed, but in the second case from 2022, the ICB requested that the independent review take place in place of the internal review. The independent reviews commenced in February 2023, and recommendations are expected to be shared with ELFT upon completion.

Incidents that do not reach the threshold for SI review, but show potential for learning, are reviewed as concise reports. Over the course of this year, 144 Concise Reports were requested from services across the Trust, of which 35% (50) were completed within the 10-day time limit. Our grading panel continue to review all concise reports before sign-off to support quality assurance.

Over the couse of the year, all patient deaths raised to an SI level of review have been solely in Mental Health Services. Bedford Mental Health Services reported the highest number, accounting for 37% (25) across 7 directorates . Previous analysis has compared directorates relative to population size, and has found no significant difference in rates between directorates.

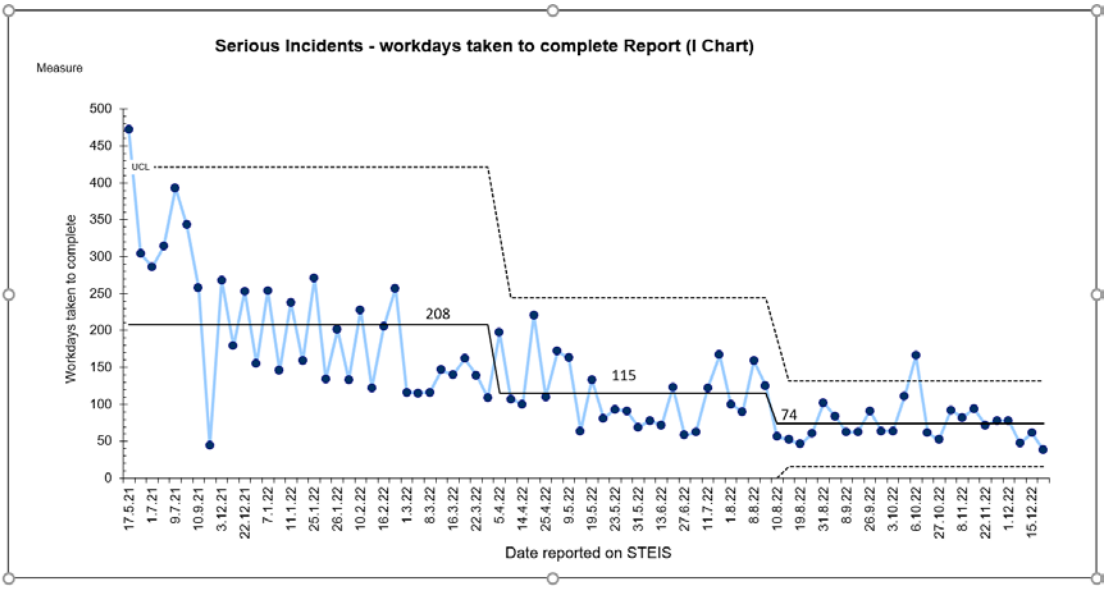
Timeliness of allocation of SIs and completion of reports has been actively addressed using Quality Improvement methodology since autumn 2022 and there has been a slight improvement in reports currently meeting the 60-day target and notable improvement in timely allocation.

Chart 8 – Percentage of SI Reports Produced to Timescale



As of 13 April 2023, there were zero unallocated Serious Incidents (compared to 2 unallocated in the previous reporting period). 29 SI reports have been allocated and are currently in progress. The number of days since the incident was reported is also shown in the data dashboard, 10 sitting at 60-90 days since they were allocated to a lead reviewer and 14 reports remain incomplete beyond 90 days since the incident was logged on STEIS.

Chart 9 – Completion time for Serious Incident Reports



* Please note that although the x-axis ends in 2022, due this being the STEIS opening date, the data within this chart relates to SIs that have reached completion, up to and including March 2023.

Since early September 2022, an SI QI recovery plan has been implemented to address the backlog of SIs that were not allocated due to the prioritisation of Coroners cases post COVID-19. The graph above demonstrates progress on this improvement journey. Focus has included review of current systems, roles and responsibilities in the team, admin role to support the functions of the team, implementation of once weekly Quality Assurance Meeting, work on recruitment and retention and staff well-being, and improving quality of reporting through training and implementation of Patient Safety Incident Response Framework (PSIRF).

Quality improvement work is also in place to improve support to staff involved in SIs.

Learning and Notable Good Practice Themes from Serious Incidents

110 Serious Incident Reviews were completed over the course of the year (10% more than in 2021/22). The top 5 learning themes identified from care/service delivery problems and other lessons learnt across the year included:

- Admin/process tasks
- Clinical care/failure to follow policy or NICE guidance
- Improvements required to record keeping
- Training, induction and supervision
- Transition between services

Notable good practice within our Serious Incident Reviews:

Significant notable good practice has been identified in cases presented at SI Committee across the year. A random sample has been reviewed of SIs carried out across eight Directorates.

The most widely recognised notable practice areas were around involving family in the patient's care (four cases) and prompt and extensive follow up efforts when patients did not attend or were hard to reach, including contacting other ELFT services, GP and acute hospital (four cases).

There was high quality care coordination, senior oversight, and good management of clinical care and responsiveness. Examples include a long standing relationship between a care coordinator and patient enabling early identification of deterioration, timely Mental Health Act Assessment (MHAA), a compassionate and trauma-informed approach to mental health management, swift investigations regarding physical health on a mental health ward, and appropriate escalation when a patient declined physical health nursing intervention in the community.

In two cases reviewed there was notable robust remedial action following an incident with early learning identified, and effective staff support.

As well as notable practice, our Serious Incident Reviews have also highlighted a number of areas for learning and improvement. The top 10 themes for learning from 2022-23 are:

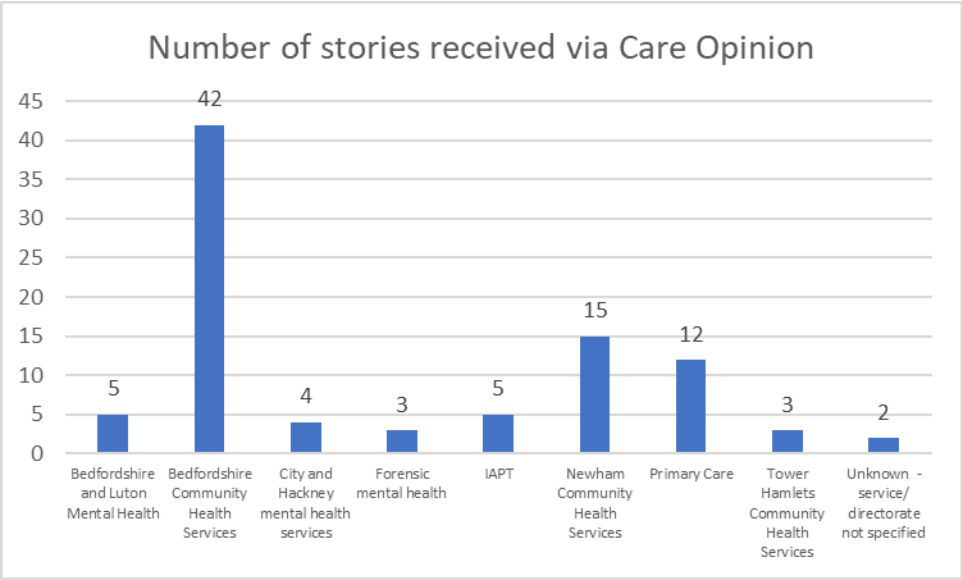
1. Issues relating to clinical care/failure to follow up
2. Poor record keeping/ IT connection
3. Issues with training, induction & supervision
4. Poor transition between services
5. Lack of engagement/involvement of carers / families
6. Safeguarding
7. Discharge issues/ joined up working with external agencies
8. Inability to meet physical health needs
9. Lack of engagement/communication with patients

These themes have guided our safety improvement work this year, and will be used to develop our priorities for learning and improvement in 2023-24.

Learning from Patients

As well as increasing our service user participation this year, to support learning, we have used complaints data and also the Care Opinion platform to take additional learning from service user feedback and concerns. Across the year, 91 stories were received on Care Opinion. 17 teams from across the Trust and two directorates have started using the platform. 77% (70/91) of the stories received were positive. In many positive stories, service users specifically named staff members that helped them and thanked them. The breakdown of the number of stories received between 1 April 2022 and 31 March 2023 by each directorate can be seen in chart 9 below. Thematic analysis of care opinion stories has identified a main positive theme in service users experiencing supportive staff, feeling listened to and receiving prompt help and care. The most common safety issues reported include difficulty accessing services, negative attitude of staff, a lack of communication including appointments cancelled without notice and not being rescheduled, not sharing information as promised. Care opinions information will help inform our Safety improvement work for 2023/2024 and beyond.

Chart 10 – Stories received via Care Opinion over 2022/2023



Learning from Staff

Our safety team have captured staff views and concerns regarding safety within a staff safety survey undertaken across the trust this year, as part of our PSIRF planning, where staff were asked what safety issue most concerns them and how they think these are best addressed. 69 staff have completed the survey so far, with the main themes arising as follows:

- Staff safety/well-being (22) – including violence and aggression, racism, sexual safety, lone working, workload & burnout.
- Staff shortages (10)
- Physical health (10)
- Self-harm (9)
- Access – to beds, waiting lists (8)
- Violence and aggression (6)
- In-patient care – observations, ligatures (5)
- Partnership Working (5)
- Safe environments – estates, waiters (5)
- Safeguarding (2)
- Drug-taking on wards (1)

These results, triangulated with other safety data, and the ideas staff had for improvement, will be used to inform our safety plan, PSIRF and safety work priorities for the year ahead.

Our freedom to speak up guardian system provides an additional channel for the trust to learn from staff safety concerns for the purpose of early detection of issues, learning and improvement.

Data from our FTSU team suggests staff have been using this channel actively over the last year, with 50 out of 172 concerns pertaining to patient safety or quality of care. Themes raised to FTSU relating to safety include:

- Staff shortages/resources and impact on safety
- Leadership behaviour & culture affecting safety
- Violence and aggression (from service users to staff and to other service users)
- Workload
- Concern re clinical management and decision-making
- Observation practices
- Datix processes

- Drug-taking on in-patient wards

Alongside proactively flagging these issues to local leadership, our Freedom to Speak Up Guardian is engaged in our regular trustwide patient safety forum where there is the opportunity to consider safety concerns and/or activate trustwide improvement work required in relation to these themes.

Safety Oversight, Learning and Improvement

Over the year, relevant safety information has been presented to the Trust Board regularly within the Integrated Performance Report, the Quality Report, the People Plan Report and the Safer Staffing Report. The Quality Assurance Committee also are sighted on the Directorate Quality & Safety Reports and the Quality Assurance Dashboard.

The Quality Committee and Patient Safety Forum have continued to oversee reports on all key safety areas including Safeguarding, Health, Safety and Security, Infection Control, Central Alerting System, Medicines Safety, Serious Incidents, Prevention of Future Deaths, Complaints, Claims, Restrictive Practices, Use of Force and Safety Improvement Areas, with cascade to the Quality Committee by exception reporting.

Safety reporting has been strengthened this year, with the introduction of the QAC integrated safety report, a new Patient Safety Forum exception report to the Quality Committee, and embedding of QAC Safety material into the board Quality Report.

Over the year, ELFT has maintained a strong structure for safety leadership, governance & oversight both at a board and executive team level, within directorates and with the support of our dedicated governance & risk team. The well-embedded and robust Trust wide safety huddle structures, local safety leadership and forums & executive walkaround programme have been ongoing.

This year, the trust has gone further in developing safety leadership, with the commencement of the first Director of Safety, who sits on our trust board and has been leading on developing the new Safety Plan, and also with the introduction of a new head of incidents role and a PSIRF Lead role. Governance has also been strengthened in a number of ways including:

- Introduction of a new executive-led system for PFD review and sign-off
- Expansion of the trust Serious Incident Grading panel, to include co-reviewers, concise authors, director of Safeguarding, and a number of other subject matter experts.
- Expanded membership of Patient Safety Forum to include FTSU guardian, directorate quality governance leads, QI colleagues, subject matter leads/experts, and performance team colleagues.
- Representation of ELFT safety leadership at ICB-level safety specialist, safety and PSIRF forums.

The monthly Trust **Patient Safety Forum** has met monthly over the course of this year, and continues to oversee work to embed our Patient Safety Plan alongside Trust wide Safety improvement priority work which is identified by triangulating themes from triangulated safety data alongside soft intelligence from staff and service users, huddle system, operational forums & walkarounds.

This year the Safety forum also benefitted from a review workshop with the input of the IHI, which also served as an opportunity for further co-design of the Safety Plan with trust clinical leaders and colleagues in safety roles

Standing items at the forum this year have include updates and progress on the Safety Plan, involvement of services users & carers, Updates on PSIRF and LFPSE, learning from CQC themes and PFD reports, Directorate improvement work.

Trust wide safety improvement work supported by the forum this year include:

- Violence & aggression
- Transitions
- Safety planning
- Ligatures
- Physical Healthcare – smoking, falls, diabetes, dysphagia/SLT, Pressure Ucer
- Use of Force/Restrictive practice
- Suicide Prevention
- Medicines Safety
- Greatix
- Resuscitation
- VTE
- Therapeutic engagement & observation
- In-patient Safety Culture
- Police liaison
- Working with coroners

The forum also provides an opportunity for sharing of learning, which this year has included learning from inquests, FTSU, Care Opinions, LEDER, safeguarding, thematic reviews and serious incidents.

In the year ahead, we will be inviting our complaints team to also contribute relevant safety data and learning to the forum and we will be including learning from our new learning methods, such as cluster reviews and After Action Reviews.

Safety Improvement

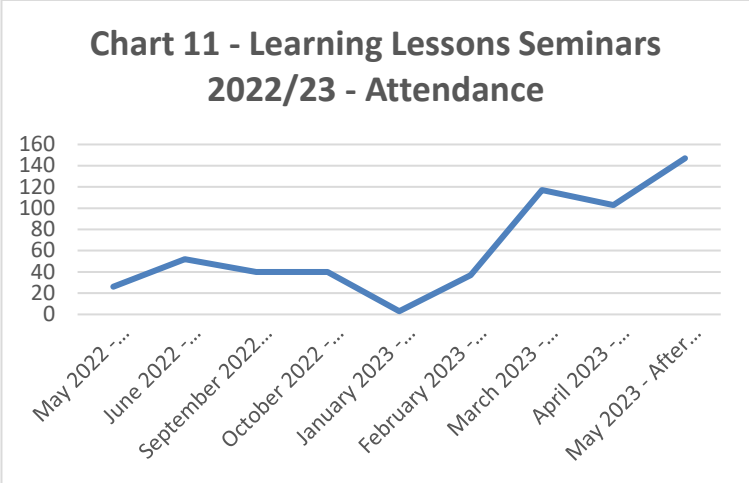
The vast majority of our **quality improvement work** has a focus on patient safety, either directly or indirectly. This year we have launched a number of new trustwide safety improvement initiatives. More detail can be found via our regular Trust Quality and Quality Assurance Reports, the quarterly integrated safety reports and on the LifeQI Platform.

Sharing of Safety Learning

We have worked on improving sharing of safety learning in a number of ways over the year, coordinated by our newly established learning from Safety QI initiative and team. Tests of change have included

- Establishment of quarterly safety newsletter, with two editions so far, both attracting high number of views (>3500).
- Work to improve Trust learning lessons seminar which has led to a significant increase in attendance (see chart 10 below)
- Launch of Safety learning resource page on ELFT intranet
- Development and cascade of 7-minute Safety Learning Briefing based on themes from SI committees (see appendix for examples of the first two briefings).

- Training of first cohort of 15 ELFT After Action Review facilitators, with piloting of AAR across the trust.
- Safety Learning and Improvement and Safety Plan Launch event, which was attended by a large group of staff and service users, and included a service user and safety expert speaker, updates on our Safety Plan and PSIRF journey plus Safety Culture SWOT analysis work, Safety Improvement work World Cafe. There was an exercise to generate and co-define our Safety Improvement priorities. Outputs and resources were shared with the wider trust via ELFT communications.



Safety Culture Improvement Work

Safety culture improvement has been a priority area of work in the last year. Piloting of the Safety Culture In-Patient Team Staff Self-Assessment tool has now been completed within NEL Adult In-patient Wards, and is in progress for Luton & Bedfordshire wards, as part of the annual QCQ readiness programme. The aim is to improve awareness, triggering Safety Culture conversations and improvement work. In parallel, our Quality Assurance team have strengthened the Service User feedback questions to enable improved triangulation of understanding around our Safety Cultures across services.

Safety Culture SWOT analysis undertaken with 100 staff, service users and leaders, using NHS Scotland Safety Culture Discussion Cards with group-work to consider how leaders can support the ongoing improvement around this area. Safety Culture is also a standing item within the new Safety newsletter and features strongly within our new safety intranet platform.
Our Community Health Services are piloting Schwarz Rounds (structured forums where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare) as a means of modelling and further developing psychological safety across our services.
Safety Culture is a major focus of our new PSIRF approach and our Safety Plan and we are also continuing to plan towards collaboration with the new Patient Safety Research Collaborative as part of a University of Leeds 5 year NIHR funded Safety Culture research grant.

Our Director of Safety and risk and governance team have been actively engaging with the workforce to help support a culture where safety is a priority and everyone's business. This includes the delivery of Patient Safety training modules to all ward managers, aspiring band 6 nurses, provision of simulation training for staff to support them in their role within coroner's inquests and development of staff support resources/signposting on trust intranet. She has also led walkarounds, visits and presentations on safety topics to directorate teams, Quality Assurance Groups, huddles and awaydays, a board development workshop (on learning from Prevention of Future Deaths) and a governors' engagement session (on the topic of Patient Safety).

Thematic Reviews

The trust have been working on three thematic reviews over this year:

- Cluster review of pressure ulcers, led by our CHS Nursing Director, which is recently completed and scheduled to be presented at our safety forum for sharing of learning and consideration of next steps.
- Triage, Assessment and Brief Intervention (TABI) Service thematic review; review underway, awaiting feedback and due for sign off.
- Cluster learning review for five community patient deaths connected by a theme of patients being found in states of decomposition. Review has been undertaken; awaiting finalisation and sign off.

A further review is at the scoping stage, and will focus on safety aspects relating to neighbourhood teams in City & Hackney services.

In the year ahead, we will be working on strengthening our thematic review approach, as part of our PSIRF planning, and with the support of the Research and Innovations Team.

Progress with ELFT Safety Plan and Year One Objectives

Since commencing in post in Q1 of this year, our Director of Safety has collaborated with trust staff, service users, system partners and safety experts to co-design our new Safety Plan which has been shared at the trust board and is likely to be signed-off early in 2023-24. Work undertaken this year to develop the plan include:

- Staff interview exercise conducted using an appreciative enquiry approach to understand safety themes, concerns and issues.
- Service User and carer focus group workshops to define what safety means to our people, and what matters to them.
- Staff workshops to co-design safety priorities and to generate Safety Plan change ideas.
- Partnership established with AD for QI to support Safety Plan from QI perspective
- Establishment of Year One priorities and work against these objectives.
- Implementation plan developed with Gantt chart to establish milestones
- Approval of draft Safety Plan by trust board.

Progress on year One Objectives:

1. Transition to the new Patient Safety Incident Response Framework

The Trust is making good progress towards transition, in line with implementation plans recommended by NHSE. Transition is planned for November 2023. Progress over the year include:

- Establishment of Senior Responsible Officers (SROs), engagement of a new PSIRF Lead role and commencement of a PSIRF implementation steering group to support development of our PSIRF priorities, plan and new operational processes.
- PSIRF vision and ambition co-designed with staff and service users.
- Subgroup work on key areas including “knowing our safety profile”, “compassionate engagement of people affected by safety”, “learning and improvement for safety” and “developing our restorative just culture”.

- Ongoing communications with trust staff via awaydays, directorate and trust forums, and establishment of our PSIRF Open Forum, to enable engagement with wider organisation and system partners.
- Review of 3-years safety data and use of whole trust safety priority survey to inform choice of safety priorities and to identify ways to strengthen the contribution of our QI methodology to our safety review approach.
- Delivery of the first session of PSIRF Systems Approach training for first year training of key staff, Serious Incident reviewers, co-reviewers, directorate leads and Involved Service Users.
- Delivery of After Action Review Conductor training package
- Process mapping is planned to identify areas for redesign and improvement in the incident review pathway.
- Draft plan and policy due to be submitted to our ICB by end of July.

Objective 2: Involving Patients & Carers in Safety

- The objectives for involving service users in safety this year have been to recruit to our Patient Safety Partner roles, embed service users and carers into our safety forums and ensuring our Safety Plan is co-designed with our people. We have made good progress including:
- Successful recruitment of Service User representatives to the Patient Safety Forum & PSIRF Steering Group
- Prominent service user leadership & involvement in safety learning events
- Service User input into Safety Plan development and design
- Shortlisting of two dedicated service user roles as Patient Safety Partners for ELFT

Objective 3: New incident Reporting System and embedding of the NHSE Learning from Patient Safety Events reporting system

The Trust have completed a procurement process to identify an iCloud solution to enable delivery of a new incident reporting system. Considerable consultation has been undertaken with end users to review products on the market which are LFPSE compliant. The new provider, InPhase has been commissioned and a project manager with LFPSE implementation responsibility has commenced in role.

A communications strategy is under development and work with people and culture to utilise existing training platforms in terms of equipping staff for the transition. Work is underway to redesign our current incident form and this will be tied into to the introduction and implementation of LFPSE. This form will be signed off with NHSE in parallel with the training, support and communication work with staff towards transition later in the year.

Objective 4: Embedding the NHSE Safety Syllabus

During this year, we have made all three NHSE Safety Syllabus e-learning modules available to staff via the Learning Academy. We have also undertaken promotion of these modules via the intranet, trust communication channels and via training sessions. Completion has been undertaken on a voluntary basis, to support positive engagement.

2. Recommendations

a. The Quality Assurance Committee is asked to approve the current paper for assurance purposes.

3. Action Being Requested

a. The Quality Assurance Committee is asked to **RECEIVE** and **DISCUSS** the report

East London
NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE

26 June 2023

Title	Annual safeguarding report
Author	Dinh Padicala and Victoria Winfield-Brown Associate Directors for Adult and Children Safeguarding
Accountable Executive Director	Claire McKenna Director for Nursing and Lorraine Sunduza Chief Nurse, Deputy chief executive.

Purpose of the report

This is the fifth 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 2022-2023.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Key messages

This year the country ended the Covid-19 pandemic. Its impact however will be long felt with the Cost of living crisis affecting substantial numbers of the population; impacting on all age groups and significantly affecting people with mental and physical health problems, children with disability and older people.

Our Local Authority partners report an unprecedented amounts of concerns raised, and those figures that we hold for ELFT Services reflect this. We previously reported in 2021/22 year an increase in complex cases, this trend has continued throughout the following year – the complexity often relates to treatment challenges, legal complexity and risk. Consequently, both the increase in concerns and their complexity has resulted in greater pressure on operational services to respond and safeguard.

We know that some families have linked complex difficulties in their lives such as learning disabilities, physical disabilities, domestic violence and abuse, mental health conditions, substance or alcohol misuse. 'Think Family' is an area of practice that helps to understand the unique circumstances of the child and the adult. This approach has been particularly focussed on some of the key areas – self neglect, child neglect and domestic abuse. All these categories of abuse have been subject to increase, in terms of numbers and in risk/complexity. Domestic abuse awareness and associated risks was highlighted through the Covid-19 period and particularly lock down. This focus continues with sustained emphasis.

Another category of abuse that has seen a dramatic rise and complexity is self-neglect. This increase coincides with the worries about a 'cost of living crisis' and the growth in financial crisis put

upon our service users (and their networks)– some of which already have self-neglect concerns. Self-neglect is now a rolling agenda item on the quarterly safeguarding event. The ELFT safeguarding team have actively promoted information points and advice for those subject to a particular crisis. This signposting has often been to our local authority/ public health partners, who have responded well to the challenge and provided specialist advice and support.

Strategic priorities this paper supports

Improved population health outcomes	☒	Work around Making Safeguarding Personal (MSP) and Think family agenda is likely to improve experience
Improved experience of care	☒	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	☒	Providing combined adults and children's training and supervision to enable staff to 'Think Family'

Implications

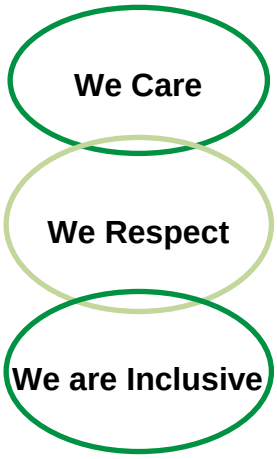
Equality Analysis	This report provides an overview of actions the safeguarding team have taken to identify inequalities that can contribute to vulnerabilities of service users and strategies to address these.
Risk and Assurance	The report provides assurance of the monitoring and understanding the occurrence 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.

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
Luton
Bedford Borough
Central Bedfordshire

1.3 The Trust employs 7136 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 organisation's 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 Director of Nursing has 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 Associate Directors of Safeguarding and Domestic Abuse (Adults and Children) have provided operational leadership and co-ordination for the corporate safeguarding teams.

3.7 Named Professionals provide the Trust with operational advice, support and training. The

professionals are committed to supporting embedding safeguarding into 'everyday business' and improving outcomes for service users. They are allocated to each borough, (Appendix 1 and 2).

3.8 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.

3.9 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.

3.10 The Safeguarding Committee meets quarterly 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.

3.11 Quarterly 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 Integrated Care Boards (ICB's) in line with the reporting arrangements.

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

3.13 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.

3.14 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.

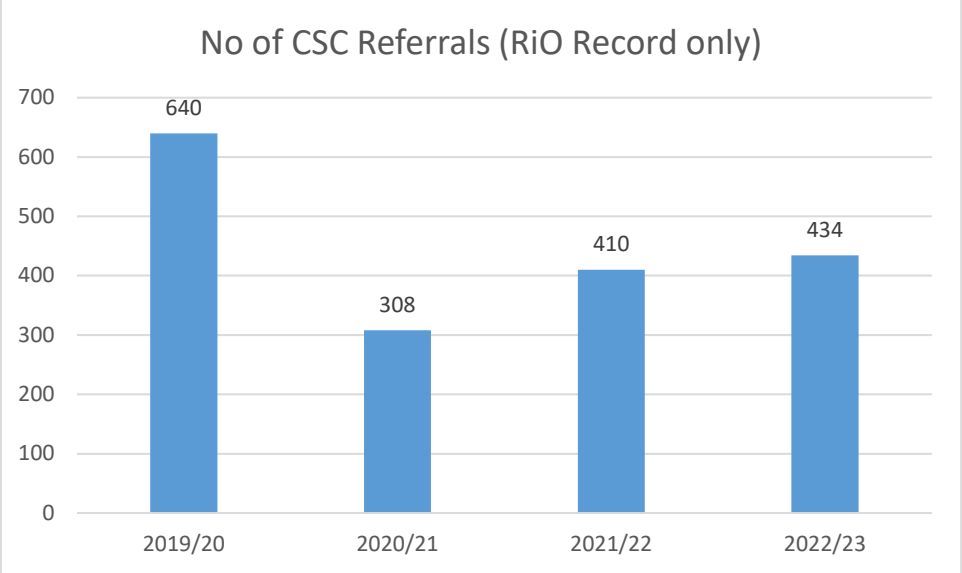
4.4 There have been safeguarding adult reviews, child safeguarding practice reviews, domestic homicide reviews, learning disabilities mortality reviews, channel panel, PREVENT/CONTEST boards and serious incidents which ELFT has been representing in the reporting year.

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 multiagency training with the LASB and LSCPs.

4.6 In 2022-23 approximately 2535 safeguarding concerns were raised for ELFT service users by staff across the trust compared to 2100 safeguarding concerns in 2021-22.It shows a 17% increase in concerns raised across the trust.

4.7 The Trust was involved in about a 302 section 42 enquiries in 2022-23 compared to 570 Section 42 enquiries in 2021-22 which is a sharp drop in the number of enquiries compared to the previous year. The volume of section 42 enquiries complete by the trust reflects the national picture and shows self-neglect and domestic abuse as major concerns which remains consistent with the previous year's reporting. The reduction in Section 42s could be understood to be a reflection of good working relationships with local authorities, whereby assurance can be given that action has been taken to safeguard service users without the need of the section 42 structures

4.8 During the reporting period ELFT RIO recording system recorded 434 referrals to children social care. This is a slight increase on last years recorded referrals from 410.



This figure is likely to be an underrepresentation of the actual amount of referrals being undertaken within the trust. A quality improvement project is currently underway piloting the completion of a datix when a referral to children's social care is undertaken. This project is being piloted in five areas across the trust; The Evergreen unit, Tower Hamlets perinatal service, Bedfordshire and Luton perinatal and inpatient service, and the learning disability service.

4.9 The top three recorded reasons for referral were other, emotional harm and domestic abuse. The high use of the category other has highlighted the need to amend the categories within RIO whilst the QI project is underway. They will now be amended to reflect the four categories of abuse; physical abuse, sexual abuse, emotional abuse and neglect. There will then be further sub categories to select options such as child sexual exploitation and domestic abuse.

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.
- Attendance at Domestic Abuse steering groups across the trust.
- 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

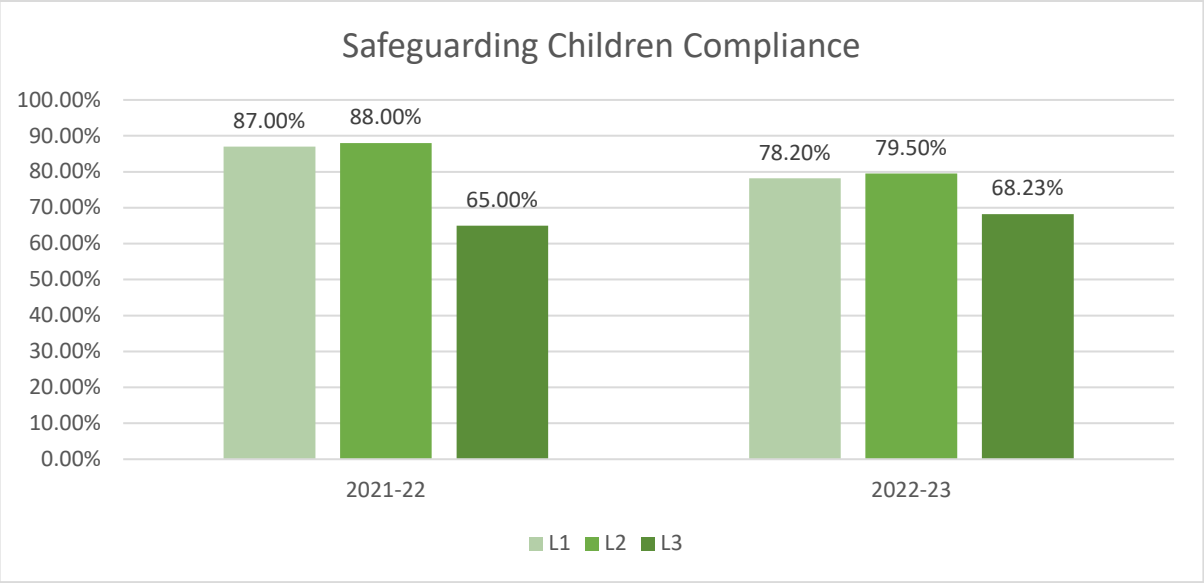
5.0 Safeguarding Training Compliance

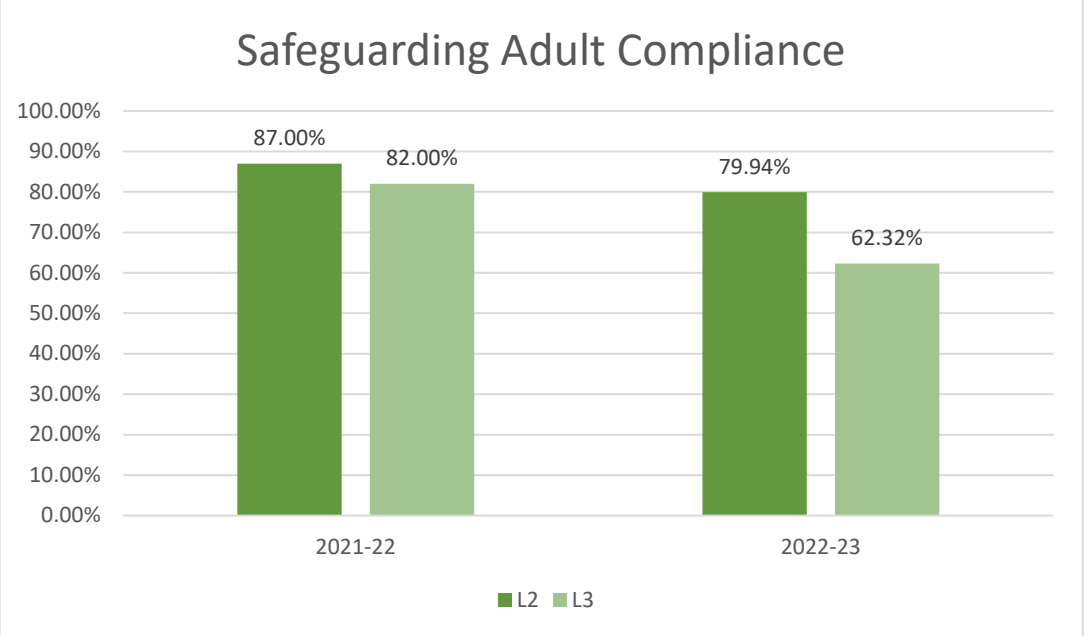
5.1 The Trust has a Safeguarding Training Strategy and Training Needs Analysis in place is based on the Intercollegiate Document, Safeguarding Children and Young People: Roles and Competencies for Health Care Staff. Fourth edition (2019) and Adult Safeguarding: Roles and Competencies for Health care Staff. First edition: August 2018.

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

5.3 During the majority of 2022-2023 there was a lack of training compliance data due to the trust moving to a new learning academy and the data not being available. Registers of attendance were kept by the safeguarding team during this period to monitor attendance and report at the safeguarding committee.

5.4 Level 1 and level 2 safeguarding children training and level 2 adult safeguarding adult training is completed via an online package. The level 1 children's safeguarding compliance is currently at 78.23% and the level 2 safeguarding children compliance is 79.50%. The level 2 adult safeguarding training is at 79.94%. There is a drop in compliance since the new data was released by Learning and Development team after they move to the new platform. This data is being reviewed as discrepancies have been identified in the mapping.





5.5 The level 3 safeguarding training continues to be delivered by virtual platform, facilitated by the named professionals for safeguarding. The compliance for level 3 safeguarding children is currently 68.23%, a slight increase from the last reporting period of 65%. Adult Safeguarding level 3 training compliance has significantly dropped since the last reporting period from 86.33% to 62.32%. This data is being reviewed as discrepancies have been identified in the mapping. Post this process if compliance figures remain low a recovery plan will be put in place, which will be monitored through the quality commettee.

5.6 The Trust compliance with WRAP (Workshop to Raise Awareness of Prevent) training is at 82.43% compared to 87% in the previous year. The Basic Prevent Awareness remains consistent at 83.37%.

5.7 The safeguarding team delivered 68 level 3 adult and children's Safeguarding training sessions

and trained 2650 staff members across the trust in 2022-23.

5.8 Further to the statutory trainings the safeguarding team offered quarterly “Think Family” themed training and bespoke training to the trust staff where deficits in practice was identified which was picked up in the monthly audits and supervision.

5.9 The quarterly training covered the following topics:

- Learning From Safeguarding Adult Reviews and Domestic Homicide Reviews
- Learning from safeguarding children practice reviews
- Self-Neglect
- Neglect of children
- Domestic Abuse and its impact
- Mental Capacity Assessment around executive capacity
- Preventing Abuse and Staff Responsibility
- Criminal exploitation of children
- Safeguarding Across The Dual Diagnosis Landscape
- Gambling and its impact
- Child protection case conference attendance
- Child protection case conference report writing

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 in 2021-22 and has since gained momentum. The uptake for supervision is 60% to 80% and it covers over 200 teams across the trust.

6.4 The safeguarding team have offers advice to staff across the trust on safeguarding and non-safeguarding cases with varying degree of complexity. The Named Professionals have attended high risk panels, complex case panel, MARAC and MAPPA to support staff with the management of such cases.

6.5 The most common themes that’s discussed during safeguarding supervision are as follows:

- Section 42 cases
- Complex cases involving safeguarding, mental capacity and potential criminal allegations.
- Information and signposting around issues of “ no recourse to public funds”
- Information sharing issues and communication between partners

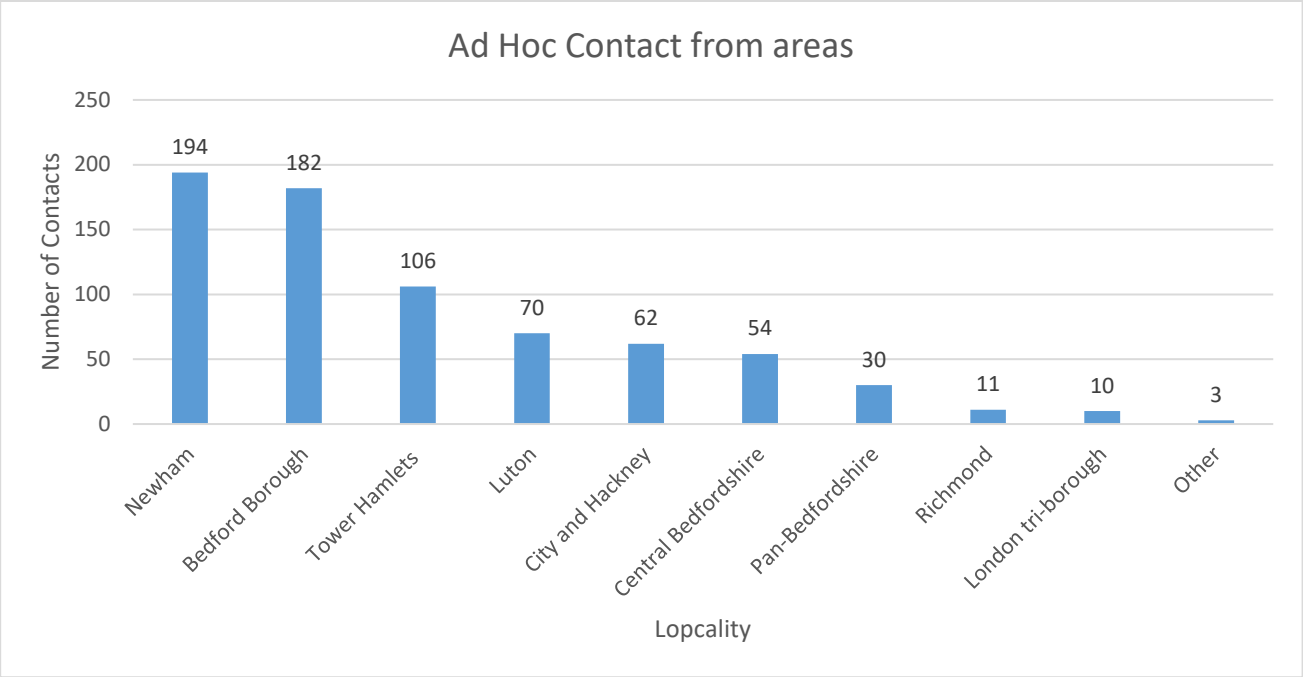
- Non-recent abuse
- General themes raised continue to be around the topics of MCA
- Person in position of trust (PiPOT) – how to report and respond
- Completion of Domestic Abuse Stalking Harassment and Honour based violence assessment tool (DASH) risk assessments
- Cases where patients and carers refuse to engage with services.

6.6 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.

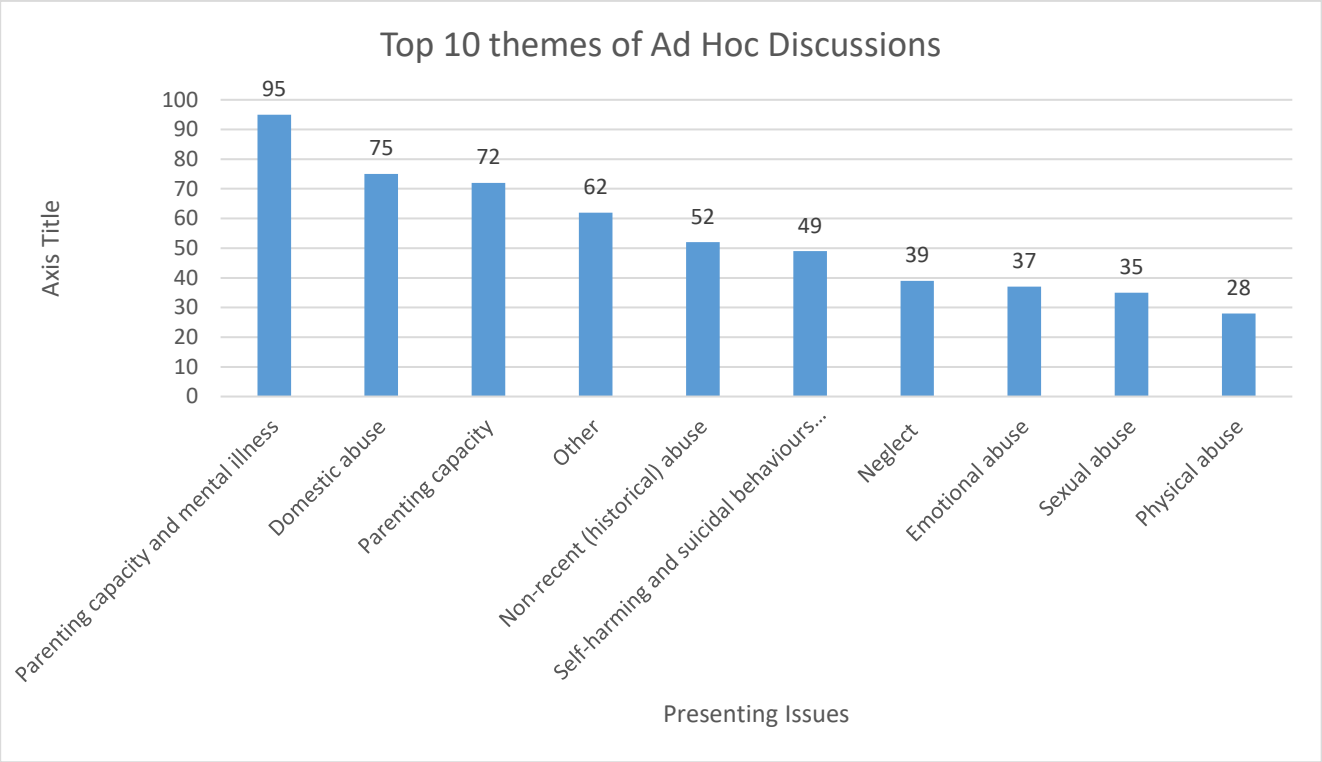
6.7 The safeguarding team provides group, one to one and ad-hoc safeguarding supervision including telephone advice to staff across the Trust to ensure effective support and guidance is available to staff appropriate to their roles. Data collection tools have been developed to provide a broader picture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

6.8 The safeguarding team provide ad hoc advice and support to practitioners, either directly from the allocated named professional, or via the duty named professional in their absence. During 2022-2023, the safeguarding children team were contacted for ad hoc advice and support 711 times. In the previous reporting year the team were contacted approx. 1200 times however this included the planned supervision contacts. The total number of ad hoc contacts during the previous year were 693.

6.9 Newham and Bedford were the areas where practitioners contacted the team the most across the trust. The highest proportion of ad hoc advice contacts in Newham were in relation to children admitted to the Coborn unit, talking therapies and specialist children and young people services. Across Bedford, the contacts were a relatively even distribution from a variety of teams. The named professional for Bedford is going to undertake some targeted work on specific themes within the area to support staff.

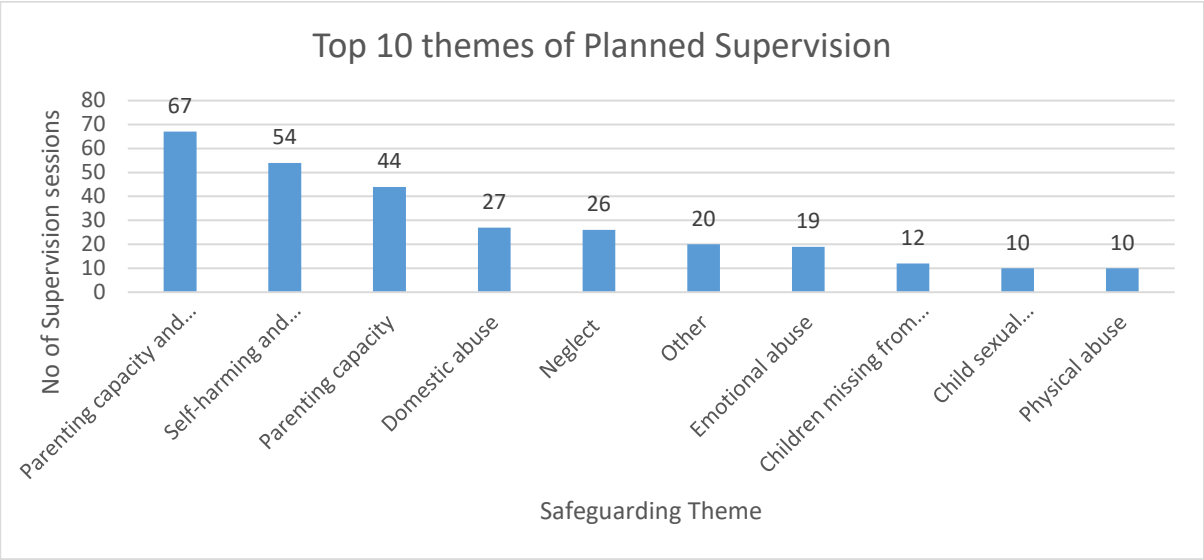


6.10 The top three reasons practitioners contacted the team for ad hoc advice and support were parenting capacity and mental illness, domestic abuse and parenting capacity:

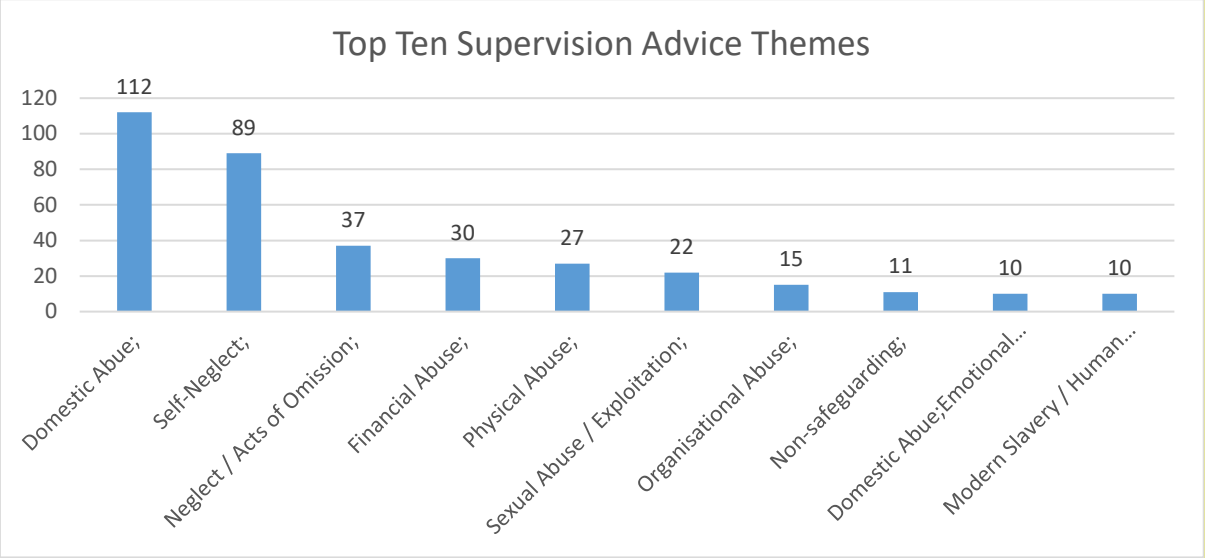


6.11 The safeguarding children team provided planned supervision to 188 teams across the trust. The top three themes discussed in planned supervision across the trust were parenting capacity and

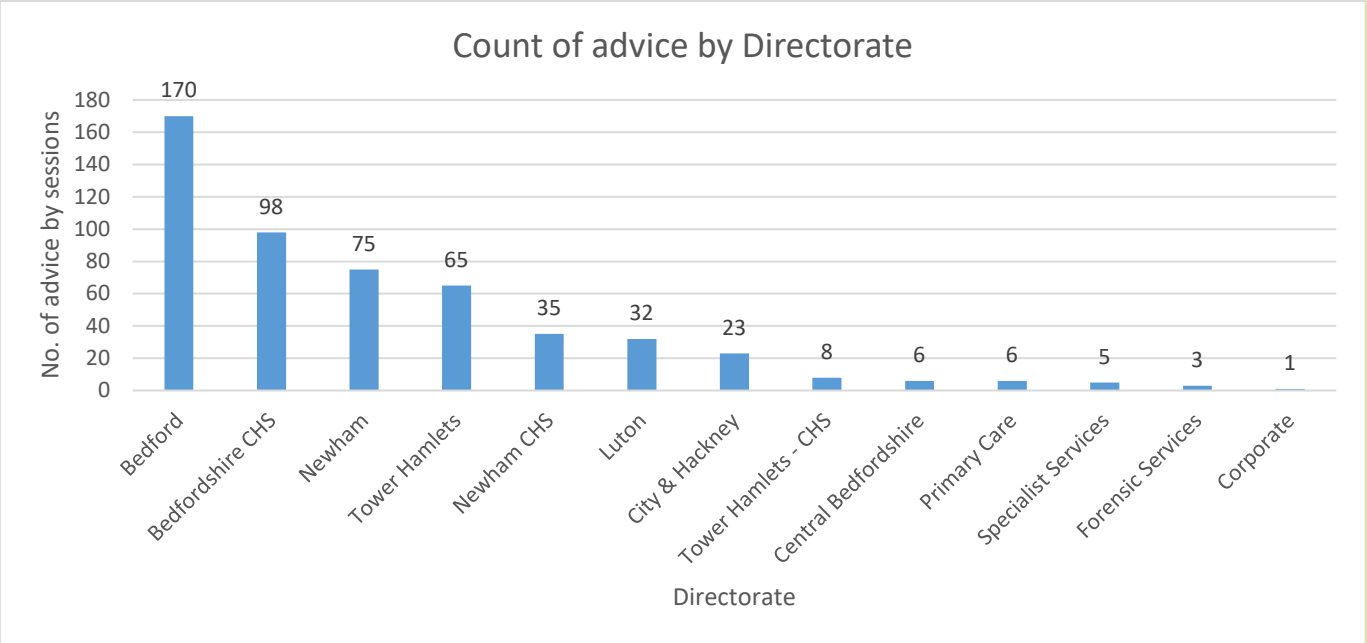
mental illness, self-harming and suicidal behaviours and parenting capacity.



6.12 During 2022 – 2023 the safeguarding adult's team were contacted for approximately 544 safeguarding advice excluding section 42 support. The section 42 support offered involves multiple meetings and this information will be captured in the future report.



6.13 The top three themes Domestic Abuse, Self-neglect and Neglect and Acts of omission remains consistent across the adult safeguarding landscape when offering advice and providing supervision to staff across the trust.



6.14 Bedford MH and Bedfordshire CHS accounts for the highest number of advices due to staff seeking additional support to manage section 42 enquiries and complex case issues. The trend is the same across all the directorates however due to staffing issues the data in the other directorates of the trust was not captured for few months.

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.

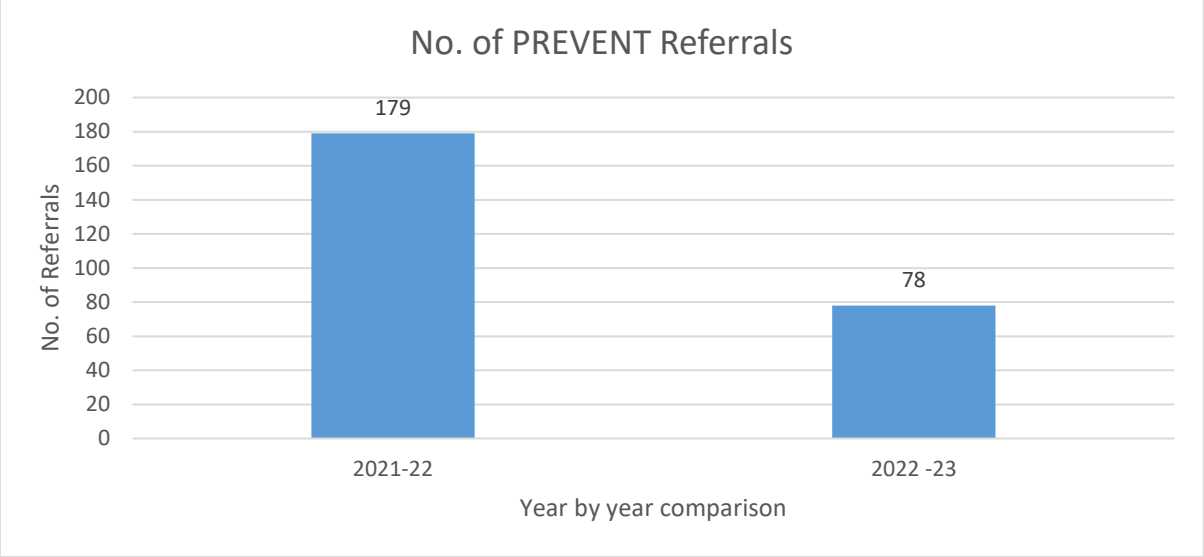
7.4 ELFT safeguarding team supports staff with reporting and sharing information about individuals affected or suspected of being victims of Modern Slavery and trafficking. This includes referral procedures for those requiring the National Referral Mechanism (NRM).

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:

8.4 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.

8.5 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.

8.6 The staff have achieved 89% compliance with WRAP training and 82.43% compliance with the Basic Prevent Awareness training against an expected target of 83.37%.

8.7 In total the trust responded to 78 PREVENT related concerns in 2022-23 compared 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.

8.8 In 2022-23 and in 2021-22, the Trust has seen a decrease in reporting of Prevent referrals and this is consistent with the national picture.

8.9 Channel Panel across the country has reported a drop in adult referrals and an increase in children's referrals, one of the major reason in the decrease of adults referral is because Mixed, Unclear, Unstable (MUU) Prevent referrals are increasing and 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.

8.10 PREVENT team consistently identify around a third of cases, where mental health is an apparent factor, and they are not known to health services. Many of the trends we see appear to reflect the national conversation in mainstream media about young people and declining mental health.

8.11 Teenagers and people with autism and mental health issues make up an increasing proportion of suspects prosecuted for terror offences, with police attributing this variously to the ease of accessing terrorist propaganda online

8.12 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.

8.13 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.

8.14 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.

8.15 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 "Sections 1 to 3 of the Domestic Abuse Act 2021 create a statutory definition of domestic abuse, which is set out below:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if— (a) A and B are each aged 16 or over and are "personally connected" to each other, and (b) the behaviour is abusive. A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child). Behaviour is "abusive" if it consists of any of the following—

a) physical or sexual abuse;
b) violent or threatening behaviour;
c) controlling or coercive behaviour;

d) economic abuse;
e) psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.

Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to acquire, use or maintain money or other property, or obtain goods or services. Two people are "personally connected" to each other if any of the following applies —

a) they are, or have been, married to each other;
b) they are, or have been, civil partners of each other;
c) they have agreed to marry one another (whether or not the agreement has been terminated);
d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
e) they are, or have been, in an intimate personal relationship with each other;
f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2));
g) they are relatives.

A child is considered a victim of domestic abuse if they see or hear, or experiences the effects of, the abuse, and they are related to A or B".

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 has seen a sharp increase in the number of Domestic Homicide Reviews (DHR) and the Safeguarding team have been involved in about 31 DHRs across the trust.

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

9.6 The Trust has reviewed its Domestic Abuse and Harmful practices policy and updated it in line with the new Domestic Abuse Act 2021.

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

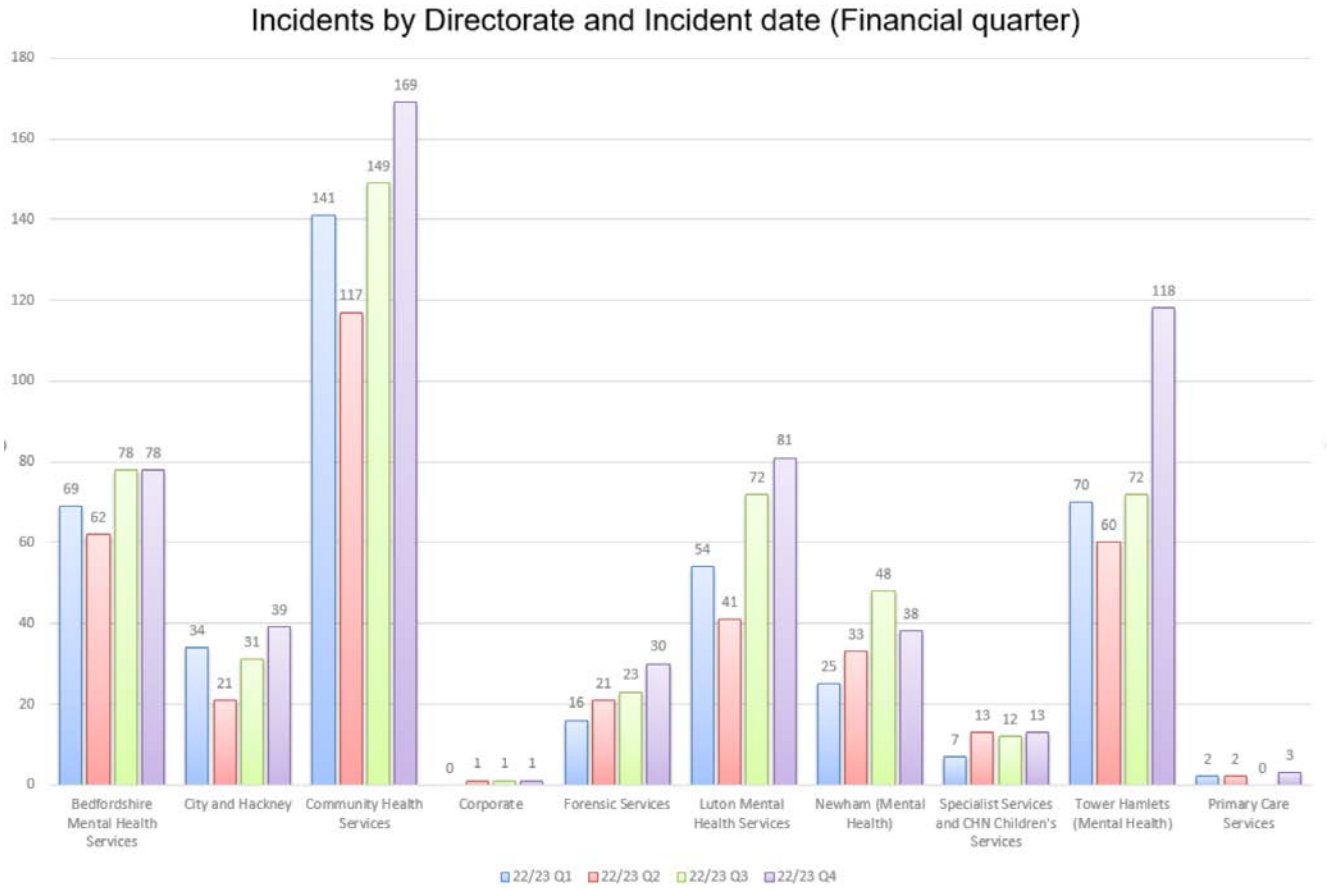
9.8 On 28th November 2022, a one day Domestic Abuse awareness was held across the trust in recognition of the 16 days of action against Domestic Abuse. A number of eminent speaks spoke about the subject and the information was well received by the staff.

10.0 DATIX reported incidents (2022-23)

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.

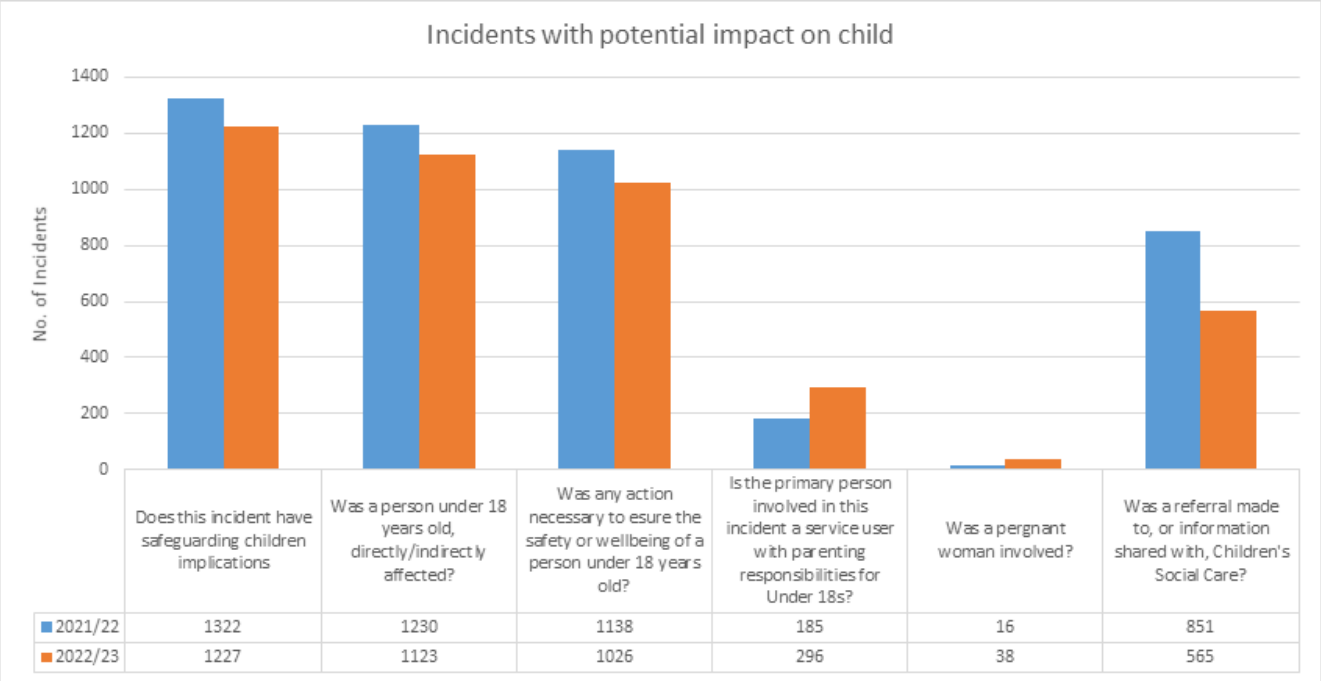


10.3 There were 1845 safeguarding adult incidents raised by the trust staff in 2022-23 compared to 1072 incidents raised in 2021 -22 and 993 in 2019-20. The Trust has seen a 40% increase in datix reporting in 2022-23. In the last three years the trust has seen an increase in the number of incidents being raised by staff and this could be due to increased awareness of Safeguarding issues and improved datix reporting.

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

10.5 The Trust has seen an increase in reporting of patient on patient abuse since last year as the safeguarding team have been raising awareness about this in light of the section 42 and SAR learnings across the country.

10.6 During the reporting year a total of 1277 ticked one or more of the safeguarding children fields, a decrease of 7.7% from 1322 in the previous year.



	Does this incident have safeguarding children implications	Was a person under 18 years old, directly/indirectly affected?	Was any action necessary to esure the safety or wellbeing 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 pergnant woman involved?	Was a referral made to, or information shared with, Children's Social Care?
2021/22	1322	1230	1138	185	16	851
2022/23	1227	1123	1026	296	38	565

10.7 The three most reported concerns for safeguarding children were self harm at 274 incidents, treatment and procedure at 185 incidents and actual physical attack at 139 incidents. The number of treatment and procedure incidents are predominantly incidents relating to the Coborn unit which account for 161 of the reported incidents. In 2023, the Evergreen unit, a new CAMHS inpatient unit opened in Luton. It is anticipated that there may be an increased number of datix incidents in 2023-2024 due to the opening of the new unit and the safeguarding children team will be monitoring this.

10.8 Of the 1277 incidents which showed that a child could have been affected 162 were made with the primary category of children at risk. This figure is a 12% decrease on the previous year of 185.

10.9 There was an increase of incidents reported involving services users with parenting responsibilities for under 18's. This was from 185 incidents in 2021/22 to 296 incidents in 2022/23, a 60% increase. The safeguarding children team have been undertaking extensive work across the trust with staff to improve the understanding of family composition and recording of family members within the household. This may be linked to this increase in recording of incidents where service users have parenting responsibilities.

10.10 There has been a decrease in the number of datix reports that answered yes to the question, was a referral made to, or information shared with children's social care. In the previous reporting year this was 851 and in this reporting year there were 565. The named professionals review all datix incidents that have safeguarding children implications. Where a referral to children's social care is indicated, the safeguarding named professionals respond via the datix incident to request confirmation that this has been done.

10.11 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 Adults Review and SAR In- Rapid -Time

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 What is a SAR In –rapid- Time?

A SAR in Rapid Time aims to turn-around learning in an approximately 3–6-week timeframe, following the set-up meeting. The set-up meeting is held after the decision has been made to progress with a review. An outline of the process is depicted below.
The learning produced through a SAR in Rapid Time concentrates on 'systems findings. Systems findings identify social and organisational factors that make it harder or easier for practitioners to do a good job day-to-day, within and between agencies. Standardised processes and templates support an analysis of a case within this framework.

11.3 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.

11.4 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.

11.5 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

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

11.7 During 2022-23 ELFT was involved in 20 SAR's. The SAR's are at different stages of progress.

The learnings from completed SARs are as follows:

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

12.0 Safeguarding Children Practice Reviews

12.1 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 categories 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.

12.2 During 2022-2023 the ELFT Safeguarding Children Team contributed to 24 new reviews involving 28 children. Two children were looked after children, and of these one was an asylum seeker. The case reviews included:

- 15 rapid reviews
- 4 child safeguarding practice reviews
- 2 learning reviews
- 2 domestic homicide reviews
- 1 joint children and adult partnership review

12.3 There were also 15 ongoing reviews from previous years at varying stages of progress, which the safeguarding children team continued to contribute too.

12.4 Where any immediate learning has been identified this has been actioned at the time. Learning from published reviews is included within level 3 training, as well as disseminated to staff groups via the named professional, included in the safeguarding quarterly newsletter and through targeted work with specific teams.

12.5 The safeguarding children contributed to 9 serious incidents during the reporting period, 3 in relation to children and 6 in relation to adults with children.

12.6 The primary learning from published case reviews were as follows:
Importance of information sharing Think family including:

- wider family demographics
- impact of family ill health
- learning from myth of invisible men and recording fathers/significant others details in the records
- Documentation
- Impact of diversity and intersectionality
- Importance of planning for transitions
- Trio of vulnerability
- Professional curiosity

12.7 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.

12.8 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.

13.0 Allegations against staff

13.1 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.

13.2 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.

13.3 Within the reporting period, a total of 21 referrals were made to the LADO. Of these referrals, 19 were made to the Newham LADO due to the large volume of allegations arising from the Coborn Centre for Adolescent Mental Health. 1 of the 19 Coborn referrals was for a non-ELFT member of staff. It is foreseen that there may be an increased number of LADO referrals in 2023-2024 due to the opening of the new Evergreen CAMHS inpatient unit.

14.0 Safeguarding Audits

14.1Safeguarding Adults Audit

The safeguarding adult team undertakes case audits, section 42 audits and thematic audits on a quarterly basis and reports their findings to the Trust Safeguarding Committee.

The audits helps to identify good practice and areas of improvement and helps the safeguarding team to address themes, trends and risks in supervision and trainings.

The team has completed the following audits:

- Safeguarding Concerns audit
- Domestic Abuse Audit
- Self- Neglect Audit
- Section 42 Enquiry Audit
- Making Safeguarding Personal Audit

The key findings of the audits are as follows:

Areas of good practice:

- Good adherence to Making Safeguarding Personal
- Consideration of advocacy
- Timely completion of enquiry
- Good partnership working and information sharing

Areas of Improvement

- Routine Enquiry not considered
- Poor adherence to MCA
- Legal literacy knowledge to work with complex cases

14.2 Safeguarding Children Audits

The ELFT safeguarding Children team has a duty to ensure there are systems in place to equip and support all staff to fulfil their responsibilities for safeguarding and promoting the welfare of children confidently, safely and effectively. The safeguarding children team has an annual audit cycle undertaking audits of training, supervision and professional practice, as well as participation in multi-agency audits across the partner areas.

The team completed the following audits:

Supervision dip sample audit
Professional practice audit
Multi-agency audits

14.3 Supervision Audit

A dip sample supervision audit was undertaken in August 2022, following the more comprehensive supervision audit in January 2022. The purpose of this audit was to monitor the effectiveness of safeguarding children supervision arrangements within the trust and develop and implement a SMART action plan to address identified areas for improvement.

The dip sample audit showed significant improvement in uploading of safeguarding supervision discussions and action plans to the clinical record, as well as the completion of agreed action plans

14.4 Professional Practice Audit

Due to significant staffing challenges within the safeguarding children team completion of the professional practice audit was delayed. The final audit was completed in February 2023.

Evidence of improvement in practice since previous audit:

- Use of the Continuum of Need/ Threshold document-with 80% of clinicians referencing it in their safeguarding referral. .
- 74% of case conferences were attended by a practitioner, which was a 24% improvement on previous audit.
- There was a 70% increase in safeguarding plan being discussed and recorded on RIO compared to previous audit in 2021.
- From previous audit there was a 40% increase in amount of practitioners evidencing discussion with partner agencies

The following areas were identified for improvement with action plans formulated:

- Sharing of case conference reports with family. Whilst this has improved compared to previous audit, further work at embedding this in practice is still required.

- Documenting within progress notes when a safeguarding children referral has been submitted.
- Additionally safeguarding children referrals are not being uploaded onto RIO. This is currently being explored in a Quality Improvement project.
- Capturing the voice of the child when submitting safeguarding children referrals especially in demonstrating impact of parental mental health on the child.

15.0 The Learning from Lives and Deaths of people with Learning Disabilities and Autistic people

15.1 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.

15.2 Key findings from the fifth annual LeDer report, and the first to be published by Kings College London, were:-

- The median age of death for a person with a learning disability was 62, in comparison to that of 82.7 in the general population.
- The most frequent reported long terms conditions were cardiovascular disease, sensory impairment, dysphagia, mental health conditions and epilepsy.
- Over 50% of people who dies, lived in areas that were rated as some of the most deprived
- Deaths due to pneumonia are falling
- The top five groupings for causes of death are COVID19, diseases of the circulatory system, respiratory disease, cancers, and diseases of the nervous system

15.3 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, and LeDeR has a quarterly slot at the Patient Safety Forum. 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.

15.4 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

15.5 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. To date, we have seen one review for the death of an autistic person

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

16.0 Domestic Homicide Review

16.1 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.

16.2 In 2022-23 the Trust was involved in 31 DHR's compared to 8 DHR's in the previous year. The sharp increase in DHR referrals shows that domestic abuse is an endemic that needs addressing at every level of the society.

16.3 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.

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

16.5 The trust "Domestic Abuse Steering" group meets twice a year 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.

16.6 The Associate Director for Adult Safeguarding represents the Trust at the Domestic Abuse Strategic group and contributes to its work plan

16.7 The safeguarding team have incorporated the learning from the completed DHR's in the level 3 safeguarding training, quarterly safeguarding trainings and in the annual safeguarding newsletter.

17.0 Complaints

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

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

17.3 During 2022-23 the trust received 2 complaints related directly to safeguarding team.

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

18.0 Workforce

18.1 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 98.98%.

19.0 Looked After Children

19.1 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.

19.2 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.

19.3 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.

19.4 The total number of children looked after by Newham as of March 2022, was 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. The current concluded figure for 2023 is not available at the time of writing this report.

19.5 There were 207 children entered into care. This is an increase of 13 children from 2021-2022 .

19.6 64% of Initial health assessments were completed in the 20 working days' time frame. This remains the same from 2020-2021. The expected national average per annual % of IHAs completed is 88%.

19.7 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.

The main reasons for breaches are:

- Child's paperwork was received from Social worker on or after breach date, no slot available in clinic to book earlier and carer's request later appointment.

19.8 Under 5yr Review Health Assessments:

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

- 78% of under 5's Review Health Assessments (RHA) were completed in the set time frame, a decrease of 3% from 2021-2022

19.9 5yr- 18yr Review Health Assessments:

80% of over 5's were completed in the set time frame. This is an increase of 11% from 2021-2022. The national average is 88%. The main reason why reviews have not been completed are:

- Child's appointment cancelled by carer
- Young Person refusing
- No consent received for child from Social worker
- All cases of reviews not being completed are fed back to the child / young person's social worker.

19.10 Care Leavers Health Summary:

ELFT LAC ensure that all Children and young people leaving care aged 18 years have a completed Care Leaver's health summary

- 100% of children and young people leaving care have a completed Care Leavers health summary in 2022-2023

19.11 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 ICB.
- The clinical team undertakes quarterly essential audits in record keeping and infection control

20.0 Key achievements and challenges

20.01 The following are the key achievements of the safeguarding team in 2022-2023:

- The safeguarding team has trained over 2650 staff members across the trust
- The Named Professionals and oiperational teams are chairing and inputing to the Safeguarding Boards/partnership sub-groups.
- 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.
- Improved data collection systems to identify safeguarding themes and demographic data of the safeguarding cohort
- Positive feedback regarding the quality of safeguarding supervision and training.

.

20.02 Challenges:

- The safeguarding children team were not staffed to full establishment for a significant proportion of 2022-2023 due to issues recruiting new members of staff, we are now fully staffed.
- 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, which is addressed in our yearly planning.
- Knowledge and application of the Mental Capacity Act (MCA) poses a challenge and staff will be offered training to understand MCA and its application in Safeguarding, this is being addressed through supervision and MCA teaching packages.
- 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.
- Knowledge and 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.

20.03 Key Priorities 2022-23:

- To 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 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 training
- To ensure that the Trust 'Think Family' ethos and professional curiosity is embedded into everyday practice
- Continue to embed organisational learning from serious incidents and adult/child reviews
- Making safeguarding personal and the demonstrating the voice of the child has been considered.

- Corporate Safeguarding Adults and Children team to deliver ‘Intergenerational’ and ‘Intersectional’ Safeguarding training for staff.

20.04. Recommendations

- During 2020-21, the safeguarding team made progress with the safeguarding strategic objectives and work plan underpinned by the Trust’s core values.
- 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.
- 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.
- The work plan will ensure the Trust drives forward the safeguarding agenda across the organisation .

21.0 Action being requested

21.1 The Board/Committee is asked to:

a) **RECEIVE** and **NOTE** the report
b) **NOTE** the assurance provided and **CONSIDER** if further sources of assurance are required

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**
2b	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 coproduction 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	SGA/SGC NPs and ADs	2022-24	• Feedback from training sessions and the content of material provided • Reviewing, developing and designing training packages, leaflets,	

		system improvement and action plan.				
		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	

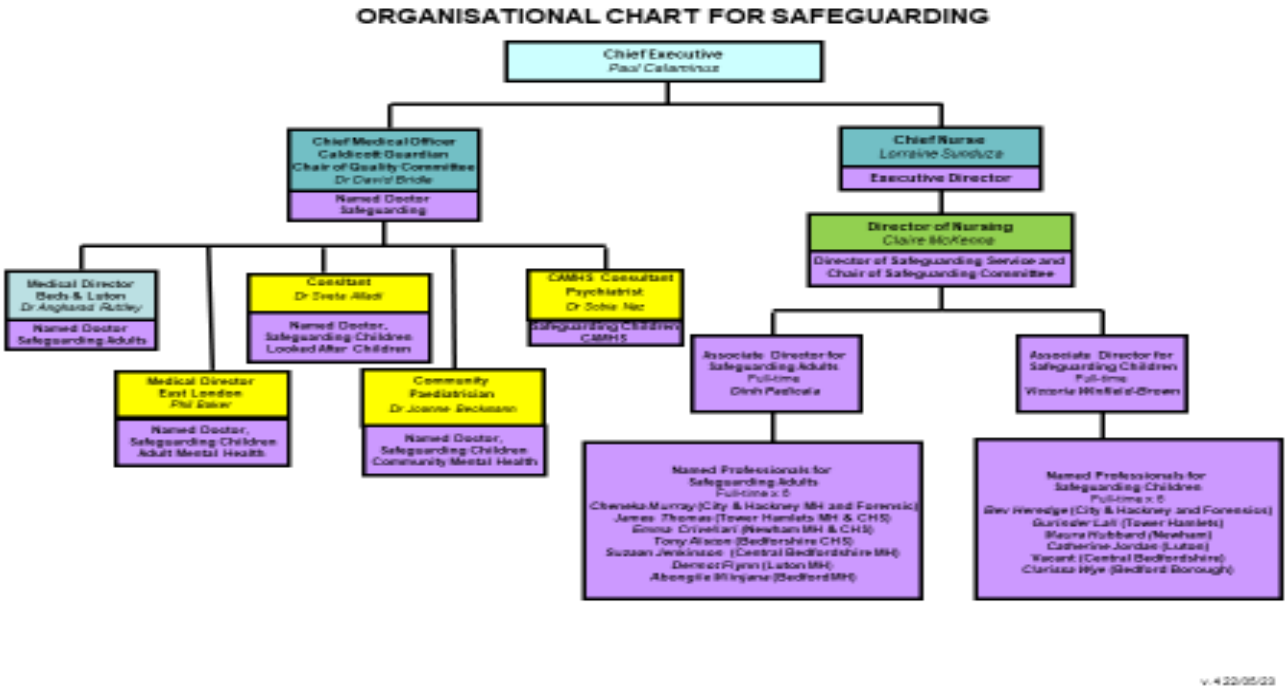
	learning mediums to promote awareness.	Raising awareness of the new forms of abuse and neglect and developing the knowledge to tackle these concerns at an early stage.	SGA/SGC NPs and ADs	Ongoing	By delivering training and good practice workshops to raise the awareness of Safeguarding issues. Ensure 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 intergenerational 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	

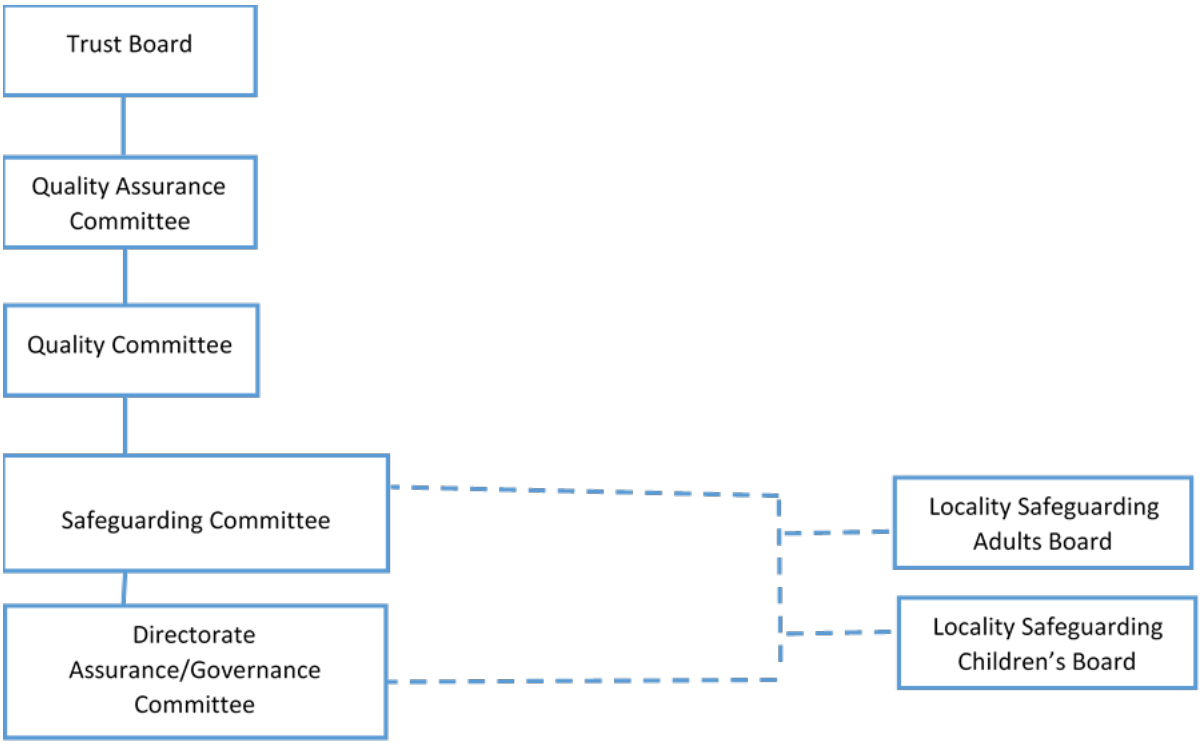
Appendix list

1. **Appendix 1** - Organisational Chart for Safeguarding
2. **Appendix 2** - Assurance Structure
3. **Appendix 3 –** Learning from SARs
4. **Appendix 4 -** Learning from CSPRs

Appendix 1


ORGANISATIONAL CHART FOR SAFEGUARDING
Chief Executive
Paul Calaminos
Chief Medical Officer
Caldicott Guardian
Chair of Quality Committee
Dr David Bridle
Named Doctor
Safeguarding
Chief Nurse
Lorraine Sunduza
Executive Director
Director of Nursing
Claire McKeogh
Director of Safeguarding Service and
Chair of Safeguarding Committee
Medical Director
Beds & Luton
Dr Arghavad Ashley
Named Doctor
Safeguarding Adults
Consultant
Dr Sveta Allaf
Named Doctor,
Safeguarding Children
Looked After Children
CAMHS Consultant
Psychiatrist
Dr Sofia Nic
Safeguarding Children
CAMHS
Medical Director
East London
Phil Baker
Named Doctor,
Safeguarding Children
Adult Mental Health
Community
Paediatrician
Dr Joanne Beckmann
Named Doctor,
Safeguarding Children
Community Mental Health
Associate Director for
Safeguarding Adults
Full-time
Dinh Pasicolo
Associate Director for
Safeguarding Children
Full-time
Victoria Winfield-Brown
Named Professionals for
Safeguarding Adults
Full-time x 6
Cheneka Murray (City & Hackney MH and Forensic)
James Thomas (Tower Hamlets MH & CHS)
Emma Crivellari (Newham MH & CHS)
Tony Alcock (Bedfordshire CHS)
Susan Jenkinson (Central Bedfordshire MH)
Dermot Flynn (Luton MH)
Abongile Mkhize (Bedford MH)
Named Professionals for
Safeguarding Children
Full-time x 6
Bev Heredge (City & Hackney and Forensic)
Gurinder Lall (Tower Hamlets)
Maura Hubbard (Newham)
Catherine Jordan (Luton)
Vacant (Central Bedfordshire)
Clarissa Hye (Bedford Borough)
v.4 22/05/23

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 and not assessing executive capacity
- Explore and respond to the impact of **domestic abuse** in family situations.
- **"Think Family**" and consider the needs of clients and of their household and family. Identify how you can work with family and friends to meet your client's needs.
- **Do not rely on substance use** as the explanation for a person's presentation, consider and respond to **care and support needs** and **menta**l and **physical health** needs too.
- Services should identify how to make **joint assessments** of people who have mental health needs and are substance dependent.

Organisational factors that influence practice;

- **Legal literacy** – insufficient organisational attention to considering legal powers and duties
- Identify how to avoid '**discharge to no service'** when, for example, someone that agencies struggle to engage with has not attended appointments. These include management review and approval before case closure of people who are seen as 'hard to engage' and the use of flagging systems on electronic client databases to alert practitioners and managers to the need to do this.
- Formalise the procedures for **authorising, monitoring and supporting** mental health patients who are granted leave during a hospital admission, whether pursuant to section 17 of the Mental Health Act 1983 or voluntary patients.
- Ensure there is a **robust transition policy** and audit process
- Employing **transition specialists** in Neurodiversity teams.
- **Multi-agency strategy meetings** and review in cases where accommodation is unsuitable.
- Ensure appropriate **risk forums** are in place and utilised.
- Strengthen an **integrated approach** between hospital mental health teams and the wider professional network.
- Strengthen **the role of the care coordinator** in complex cases.

- Strengthen **ICT systems** to aid information sharing.
- Provide more extensive information and guidance about the **Transitional Safeguarding needs** of care experienced young people
- Strengthen an **integrated approach** between hospital mental health teams and the wider professional network.

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
- Ensure there are good mechanisms for **dispute resolution and escalation** where there are disagreements on who should take the lead on a case.
- Strengthen **training programmes** for children's social workers and personal advisors in respect of mental capacity, executive capacity and fluctuating capacity.
- Publicise the **multi-agency exploitation strategy** widely
- Develop a **housing pathway and protocol** for vulnerable adolescents and young adults.

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/helpfor-adults/partnership-boards/safeguarding-partnership-board/

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

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

Appendix 4 – Learning from CSPRs the primary learning from published case reviews were as follows:

Think Family

- Role of father
- Other household members
- Family members with additional needs
- Wider support network
- Impact of family ill health
- Recording of fathers, family members, significant others in the records

Information Sharing

Documentation

Impact of diversity and intersectionality

Importance of planning for transitions

Trio of vulnerability

Professional curiosity

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-andcommunity/children-young-people/safeguarding-children-board/serious-casereviews/

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

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

NHS
East London
NHS Foundation Trust

Infection Prevention & Control Annual Report
1st April 2022 – 31st March 2023

Title	Infection Prevention and Control (IPC)
Author	Rana Begum – Trust-wide Lead Infection Prevention & Control Nurse
	The author would like to thank the following individuals and department in developing the annual report: • Lorraine Sunduza – Chief Nurse/ Director of Infection Prevention & Control /Deputy CEO • Ruth Bradley –Director of Community Health Services London • Bernadette Kinsella – Deputy Director of Infection Prevention & Control / Physical Health Lead Nurse • Dr Giovanni Satta – Consultant Microbiologist / Infection Control Doctor • Harriet Ddungu – Trust-wide Deputy Lead Infection Prevention & Control Nurse • Verity Honu – Interim IPC Specialist Nurse • Rebecca Clancy – IPC Nurse • Valrie Burgess – IPC Nurse • Siobhan Fensom – IPC Nurse • Angie In – IPC Nurse • Serakoule Traore – IPC Nurse • Nichole Reid – IPC Nurse • Monsur Gabr – Infection Prevention & Control Administrator • Jasmin Manjdadria – IPC Data Administrator • Shahidur Rahman – Infection Prevention & Control Administrator • Estates and Facilities Department • Occupational Health Department – TP Health • People and Culture Department • Pharmacy Department • Medical Devices Department • Fit Testing Department • Vaccinations Department
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 at all times 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 2022-23:

- The IPC Team (IPCT) continues to maintain a high level of awareness within the Trust and engagement from frontline staff. This has been achieved through proactive and reactive work including the use of social media and national awareness campaigns.
- The IPCT remain vigilant in closing the loop on the audit programme pursuing assurance until they are provided and audits can be signed off as compliant.
- The Trust shares best practice and findings from audits, Root cause analysis (RCAs) and post infection reviews (PIRs).
- The IPC policies, procedures and resources have been reviewed, updated and ratified to support staff and offer sources of guidance.
- Good communication with system-wide providers and United Kingdom Security and Health Agency (UKSHA) continue to reap the benefits through ensuring that timely information, regarding Health Care Associated Infection (HCAI), is passed from one organisation to another.
- The IPCT have also attended system-wide economy meetings across the integrated care systems and have received positive feedback regarding their engagement.
- There were no serious incidents raised in relation to IPC during 2022-23.
- The Care Quality Commission (CQC) visit identified areas of good practice of infection prevention and control during visits.
- During 2022-23 the Trust Water Safety Group (WSG) continued to provide assurance on water hygiene compliance.
- During 2022-23 the Trust Antimicrobial Stewardship Group continued to support national agendas of antimicrobial stewardship.
- During 2022-23 the Trust Ventilation Safety Group (VSG) was established to provide assurance on ventilation compliance in line with national guidance.
- During 2022-23 there were no patient related deaths pertaining to IPC infections.
- Successful Trust-wide reflection event was held in June 2022 on outbreaks & to capture learning in a dynamic way and to look at applying the learning in practice on a local basis across the organisation. This was well attended by staff from all areas of the Trust. Staff were able to share best practice / innovations of practice around outbreak management.
- Successful awareness campaigns held for World Hand Hygiene Day and National Infection Prevention and Control Week.
- Successful implementation of system-wide North East London (NEL) urinary catheter passport.
- Launch of Quality Improvement (QI) project on Gram Negative Blood Stream Infections on Catheter Reduction at Fothergill Ward.
- Launch of Quality improvement project on Sustainability and Glove Usage in Luton and Bedford Inpatient Wards.
- Two members of the IPC Team completed their postgraduate Infection Prevention & Control specialty training.
- At the time of writing, two members of the IPC team are completing their postgraduate

Infection Prevention & Control specialty training at Master's level.

- A joint collaboration with Cambridge University Hospital on Air Cleaning Study at Fountains Court, Bedfordshire is currently being undertaken, at the time of writing report.

Healthcare Associated Infection Surveillance

- There was zero MRSA bacteraemia reported in 2022-23.
- There was no C.diff toxin positive cases reported 2022-23.
- There was no Gram negative rod blood stream infections reported in 2022-23.
- There were 508 COVID-19 infections reported in 2022-23. This is a decrease from 2021-22.
- There were 399 COVID-19 healthcare onset infections reported in 2022-23. This is a decrease from 2021-22.
- The IPC team responded to 633 general enquires during 2022-2023.
- The IPC team responded to 767 COVID-19 enquires during 2022-2023.

Notifiable Diseases

- In 2022-23 490 notifiable diseases of infections were reported to UK Security and Health Agency (UKSHA).

Outbreaks & Incidents

- There were a total of 99 Covid-19 Outbreaks notified to UKSHA during 2022-2023. This is a decrease on the number of COVID-19 outbreaks reported in the previous year.
- There were 2 *Influenza A* outbreaks notified to UKSHA in 2022-2023.
- There were 2 incidents related to pulmonary TB in 2022-2023. Please refer to Section 15 of the report for further information.
- There were 2 incidents related to IGAS infection in 2022-2023. Please refer to Section 15 of the report for further information.

Coronavirus (COVID-19) Pandemic:

- There were regular meetings where service leads and nominated COVID-19 leads have an opportunity to feedback issues with relation to IPC.
- The IPC service has been operating 9am-5pm Monday to Friday with an on-call service should it be required.
- 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.
- The IPC team have developed various communication leaflets in light of new guidance changes and updates.
- Outbreak Management meetings have been held across the Trust to support services/wards with COVID-19 outbreak management in line with Trust policy and UKSHA guidelines.
- IPC have created and delivered several COVID-19 / IPC training presentation and webinars.
- Fit Testing service continues to roll out services across the Trust. Joint working between IPCT and Fit testing team across Tower Hamlets and Newham Mental Health Services in response to Staff-side union inspection conducted in Q4 (2021-2022).
- Communications continually updated in line with emerging evidence for COVID-19 and IPC issues for staff and patients.
- IPC Policy Manual resources on the Intranet for staff.
- A Respiratory Pathways Policy was developed including the management of COVID-19 infections.
- Work Place Risk Assessment (WPRA) tool updated in collaboration with Staff-side union representatives.
- Regular weekly meetings with senior staff and IPC Doctor/ Consultant Microbiologist to discuss COVID-19 advice as the pandemic evidence emerged in relation to ELFT service needs and respond appropriate as required.

- 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.

- Track and Trace systems and processes in place across the Trust. During 2022-23 Q2 this was discontinued in light of UKSHA guidance changes.
- Medical Device Lead continues to procure extra equipment for patient monitoring.
- The IPC Service was flexible and responsive ensuring adaption to the latest evidence and guidance in terms of 'Quality Care'.
- CQC 'Floor to Board' assurance document was regularly updated.
- For National Infection Prevention & Control Week, the IPCT team facilitated and promoted infection control practices across the Trust, including corporate teams. This was well attended and well evaluated by staff and services-users participating on the roadshows.

Lassa Fever

- During 2022-23 Q1, the IPC team provided support to staff in Calnwood Court, Bedfordshire on the safe management of a patient who was recently discharged from the National High Level Isolation Unit with Lassa Fever infection. The Trust's senior nurses & ICPT worked in-conjunction with external providers (The High Consequence Infectious Disease Network) to ensure the patient, staff and visitors were supported in an environment that was IPC safe, mitigated IPC risk and prevented further onward transmission of Lassa fever. Face-to-face visits were conducted by IPC Nurses on alternative days to ensure staff were supported and felt confident in caring for an individual with a category 4 pathogen.

M-pox (Previously called Monkeypox)

- During 2022-23 Q1, there was an increase of M-pox infections across the UK. As a response measure, the IPCT developed an M-Pox standard operating procedure (SOP) guiding staff on how to manage a suspected/confirmed case within ELFT services. An M-pox Information Sheet was also developed, providing easy to read information & answering common questions about M-pox. The Chief Nurse / Director of IPC / Deputy CEO wrote to all staff about the emerging threat of M-Pox and concerns staff members may have. During 2022-23 on-going communications regarding M-Pox have been disseminated to staff via the Trust Communications Bulletin on a weekly basis or when national guidance has been updated. A local system was developed for reporting sit-rep data of M-Pox positive service users to NHS England. During 2022-23 Q2, updated guidance was disseminated in line with national guidance changes. The IPCT have supported with system wide implementation of the M-Pox vaccination and the use of inter-dermol vaccination.

Influenza

- During 2022-23, there were 2 Influenza outbreaks across the Trust in the winter period.
- Guidance developed on the management of Influenza cases.
- A SOP was also produced for admitting to wards with Active Influenza Outbreaks.
- Emergency supplies of Tamiflu were stocked, in response to the 2 Influenza outbreaks that occurred during Q3.

Group A Step

- In light of increased prevalence of Group A strep during 2022-23, guidance was developed on the management of Group A Strep infections.
- A factsheet was also produced and circulated to staff regarding frequently asked questions.
- A CAS alert for Strep A was also circulated to inform staff of symptoms and those at risk of Strep A infections given that there was a national increase in Group A Strep / Scarlett Fever infections in 2022-23.
- There were 2 reported Invasive Group A infections reported in Community Health Services.

Quality Review Meeting with Trust Executive Team

- During 2022-23 Q2, the ELFT Executive team met with the some members of the IPCT to review the quality of the IPC service. Highlights were presented on the successful management of COVID-19 Outbreaks at the peak of the Omicron wave in Q4. The hand-hygiene roadshow was also presented showcasing how the IPCT are working on engaging all staff, service-users and visitors in embedding IPC as everyone's responsibility. The IPCT were praised for their prompt responsiveness & support on the management of the Lassa Fever case.

Risk Register

During 2022-23 the following items were reported on the IPC Risk Register:

- On-going risk remains regarding adequate ventilation in some clinical areas (Treatment rooms). This is monitored at the Trust Ventilation Safety Group (VSG). Please refer to section 39 of this report for further information.
- On-going risk regarding staff awareness of waste management systems and process across the Trust due to the new waste management system implemented in April 2022. Please refer to section 39 of this report for further information.
- New risk added during Q4, regarding staffing capacity issues due to sickness & vacancy of specialist IPC Nurses, due to high service demand for IPC support and expert advice required. Please refer to section 39 of this report for further information.

Cleanliness of the Environment

- The cleaning scores at 95.9% suggest that cleanliness standards across the Trust are on par with the national average of 95%.
- Please refer to page 79 to see cleaning scores for 2022-23
- Due to the continued COVID-19 situation, all cleaning processes have been maintained using the SOP agreed with IPC and new standardised terminology for cleaning. Enhanced cleaning of patient bedrooms daily and communal areas and high-touch point cleaning three times daily using a chlorine-based product is in place and being maintained across the service to help reduce the microbial burden in the environment.
- There have been a few cleaning issues reported in Newham. Estate works are in progress in Newham with a cleaning plan in place which is been monitored by Estates and Facilities (E&F) and Newham Health and Safety Committee.
- New cleaning contractors OCS commenced on 1st April 2022.
- Due to the continued COVID-19 situation, all cleaning processes were maintained until August 2022 when national COVID-19 guidance recommended cleaning should return to pre-pandemic levels. As a result of this guidance, a joint business case by IPC and Estates was produced for enhance cleaning during outbreaks.
- Since August 2022, during outbreaks, enhanced cleaning is implemented & includes daily cleaning of patient bedrooms with communal areas & high-touch points both cleaned 3 times a day. All cleaning is completed using a chlorine-based product to help reduce the microbial burden in the environment.
- The new NHS cleaning standards, risk categories & standards for functional areas & 'stars on door' ratings commenced in November 2022.
- During Q3, the IPC team supported the Trust-wide PLACE inspections.
- The FR rating tables for individual wards are agreed, with the exception of Newham where further discussions with IPC and the Service continue to ensure we are managing the correct risks.

Staff Health

- There were 30 sharps injuries recorded on the Datix system during 2022. This is a decrease from previous year whereby 48 sharps injuries were reported.

- During Q1, there was a sharps incident relating to an insulin device in Tower Hamlets. As a result joint working between IPCT and the Diabetic Nurse took place. Any unsafe diabetic devices found were removed. The joint visit with the Diabetic Nurse identified gaps in communication around management of Care Sense Lancet. A pathway was developed on the management of non-safety diabetic devices brought by patients to the ward. Please refer to page 84 for further breakdown of sharps injuries.
- Safer sharps devices are ready available for staff when providing care.
- Occupational Health Provided by TP health

Fit testing

- In line with UKSHA and the 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.
- At the end of 2023, fit testing compliance was recorded at 48%.
- The compliance figures have decreased from the previous year due to a higher number of staff required to be re-tested as the 2-year cycle has lapsed & also due to new staff joining the Trust that require fit testing. Further work to improve fit testing compliance continues by the fit testing team.

Seasonal influenza vaccination

- In line with the National strategy ELFT has being promoting and delivering Immunisation to protect staff & service users from Influenza and COVID-19.
- The seasonal influenza vaccination uptake of frontline healthcare staff for 2022-23 was 62.3%.

Water Safety

- Rydon's have taken over responsibility for John Howard Centre (JHC), Wolfson House, The Lodge and Trust Head Quarters at Alie Street as of 1st April 2022.
- There was a newly appointed Authorised Engineer who provides a services to ensure ELFT remains compliant with water safety legalisation. The authorising engineer works collaboratively with the IPCT and contractors reporting to the Trust's Water Safety Group (WSG).
- During Q1, there was an incident regarding the management of Legionella at East Ham Care Centre (EHCC) in Newham. External contractors did not notify ELFT's Estates & Facilities Team nor IPCT of the positive legionella results in timely manner. The IPCT facilitated a lessons learnt reflection meeting to look at current systems and processes for reviewing water testing. As a result, monthly water safety sub-group meetings were arranged to review water testing results. A flowchart has been developed to ensure all WSG members and Contractors are aware of the process for reporting results.
- Monthly Water Safety Sub-group meetings are held to monitor water issues.
- During 2022-23 14 sites had positive samples of legionella detected. Sites were resampled and the tests were negative for legionella.
- Water tank disinfection and showerheads and hoses were dismantled, cleaned and chemically descaled, flushed with fresh water and returned to normal service continued as per work programme during 2022-23. All site visits and certifications are available to view via contractor portals.
- During 2022-23, the IPC team procured water management training for IPCT and Estates members.

Ventilation Safety

- The IPCT continue to provide support at Trust VSG meetings. During 2022-23, an alert has been communicated to turn off air-conditioning units that circulate the same air and do not

bring in fresh air for adequate air exchange on wards. These are mainly in medication/treatment rooms. Ventilation is discussed at all outbreak meetings and risks identified and management plans in place in line with the hierarchy of controls. FFP3 mask wearing is promoted where there is inadequate ventilation to reduce risks from COVID-19. A ventilation policy has been approved. In Q1, the IPCT supported with writing an options paper in-conjunction with E&F & Health and Safety (H&S) departments on the use of re-circulating portable fans/air conditioning units, during extreme heat waves.

- During 2022-23 the IPCT, Estates and the Luton and Bedfordshire Mental Health Clinical teams are participating in a study led by Cambridge University Hospitals Trust (CUH) – *the Addenbrookes Air Disinfection Study – Implementation of air disinfection to prevent hospital acquired infections on inpatient wards for older people: A pragmatic controlled before and after study*. The IPCT have provided support on the design of the air cleaning units ensuring they comply with ligature and health and safety requirements for use in an inpatient mental health setting. At the time of writing, the study is in progress and air cleaning units are being installed. The IPCT, air cleaning supplier & Dr Matthew Butler from CUH, have also presented the study at the recent IPC Knowlex Conference.

Waste

- During 2022-2023 Q1, the trust rolled out a new waste system in light of the wider NHS net Zero agenda. Due to the changes of the new waste system there was ongoing risk regarding staff awareness of the new waste management systems and processes across the Trust, as a result the IPCT updated their IPC Statutory & Mandatory training sessions. A Clinical Waste Compliance Audit was conducted by Sharpsmart (new clinical waste contractor) for baseline audit data.
- During Q2, a new waste matters email was launched & signage was sent out to all sites to help clarify the waste streams.
- During Q3, there was a period of non-collection of waste at East Ham Care Centre and Primrose Resource Centre. Both sites have been rectified and the problems resolved.
- During Q4, there was a period of non-collection of waste at Three Colts Lane and at Passmore Edwards. Both sites have since been rectified and the problems resolved.
- At the time of writing, a furniture disposing SOP in Forensics is due to be piloted by a new contractor called Reyooz at John Howard Centre.
- During Q4, a re-usable sharps pilot project at Newham Centre for Mental Health is underway. The Waste Matters team are leading on this project and are working directly with clinical staff to ensure the pilot is successful.

Complaints

- During Q1, the IPCT received a formal complaint from a service user on Jade ward, Luton. This complaint was related to the management of the service user during a COVID-19 outbreak. The service user was a contact of a positive COVID-19 case and was denied leave to attend a hospital appointment. The ELFT legal team supported the IPCT in responding to the complaint and apologised to the patient for any undue harm caused. There were several learning points identified for the IPC Team. These are:
- IPCT members are to keep abreast of latest guidance on management of COVID-19.
- IPCT member's knowledge & awareness on handling complaints process and following Trust polices when handling complaints.
- To address learning for this compliant:
- IPCT members have completed the Trust compliant training.
- Policy and guidance changes related to COVID-19 are communicated to all team members on daily huddles meetings by Lead IPC Nurses.

Information Governance – GDPR Breach

- During Q3, Patient-related information was shared on a section of the Respiratory Policy

related to RiO documentation. At the time of writing, Duty of Candour is in process to notify the patient of the GDPR breach. Learning from this GDPR breach has been followed-up with all IPC Team members at Team Meetings & at individual supervision meetings. All IPC Team members have also had refresher training on information Governance.

Work Plan 2023-2024

- 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 Rod Blood Stream Infection Reduction ambition
- Continue further work on sustainability and glove usage reduction.
- Further collaborative work with patient participation team.
- See Appendix 1 – Driver diagram of IPC workplan for 2023-2024

Strategic priorities this paper supports

Improved population health outcomes	☒	The information provided in the Infection Prevention and Control 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.
Improved experience of care	☒	
Improved staff experience	☒	
Improved value	☒	

Committees/meetings where this item has been considered

Date	Committee/Meeting
27th April 2023	Infection Prevention & Control Committee
3rd May 2023	Quality Committee

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 though improved access to facilities for hand washing from capital funds.
Quality	Providing quality care and continuously improving the environment

Supporting documents and research material

a. Driver Diagram of IPC Workplan 2023-2024
b. IPC Workplan for 2022-2023

Glossary

Abbreviation	**In full**
IPC	Infection Prevention & Control
IPCT	Infection Prevention & Control Team
VSG	Ventilation Safety Group
E&F	Estates & Facilities
H&S	Health & Safety
EHCC	East Ham Care Centre
JHC	John Howard Centre

NHS
East London
NHS Foundation Trust

Infection Prevention and Control Annual Report 2022-2023

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	NSI
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

Red, Amber, Green (RAG) Ratings		
Green	85=100%	Compliance
Amber	60-84%	Partial compliance
Red	0-59%	Minimal Compliance

1.0 Executive Summary

This annual report provides an overview of the Infection Prevention & 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. 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 for 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.

2.0 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 IPC standards and risks within the organisation.

It will also provide assurance of the progress made against The Health and Social Care Act: *Code of Practice for the prevention and control of infection* and related guidance (July 2015) and the Care Quality Commission (CQC) standards over the last twelve months. The IPC driver diagram for the annual work programme for 2023-24 provides an overview of the priorities for the upcoming year (Appendix 1). The IPC annual work programme for 2022-2023 is attached to this report (Appendix 2).

At the end of the year 2022-2023, ELFT declared compliance in IPC practices. In the event that IPC non-compliance is demonstrated action plans, recommendations and timeframes are given to service lines to address IPC issues.

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.

3.0 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 (IPCC). The IPCC 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 (E&F) 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 IPC standards.

The DIPC devolves the day to day responsibilities and duties to the Deputy Director of Infection Prevention and Control (DDIPC). The Deputy Director of Infection Prevention and Control provides leadership and management for the IPC service.

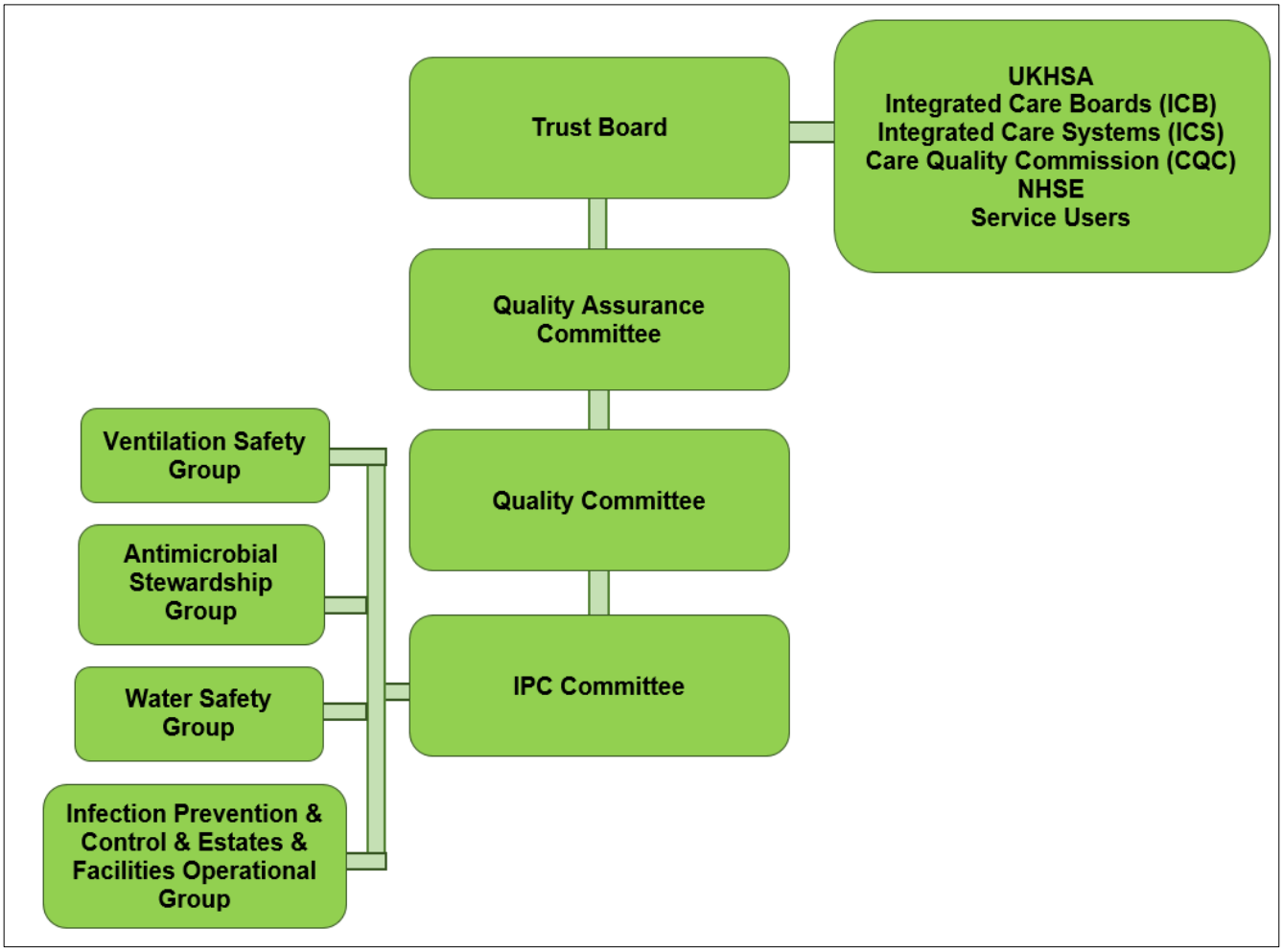
The Deputy Director of Infection Prevention and Control (DDIPC) has overall responsibility for:

- 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
- Ensuring robust arrangements are in place in line with national policy and relevant legislation, and creating an environment of continuous quality improvement and development
- Facilitating links and communication with all clinical areas
- Links with the wider health economy and representing the Trust at NHS London DIPC meetings and system-wide network forums.

The Trust Board is accountable for ensuring that there are effective IPC 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.

4.0 Governance Framework for Infection Prevention & Control Committee

***Figure 1**. below shows the Governance Framework for Infection Prevention and Control.*



5.0 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. During 2022-23, The IPCC met quarterly 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. This enabled capturing HCAI's alert organisms, outbreaks, IPC audit programme and scoring therefore comparable data can be analysed. In the absence of the DIPC, the meeting is chaired by the Director of Nursing/DDIPC. 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 Services
- 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
- Trust-wide Deputy Lead Infection Prevention and Control Nurse

- Infection Prevention and Control Nurses
- Infection Prevention and Control Administrators
- Lead IPC Nurses from Integrated Care Boards
- Occupational Health (Team Prevent)
- Head of Communications
- Expert attendees: UK Security & Health Agency (UKSHA) representatives

The Committees within the Trust's governance framework that have responsibilities/roles in relation to IPC are as follows: Quality Committee:

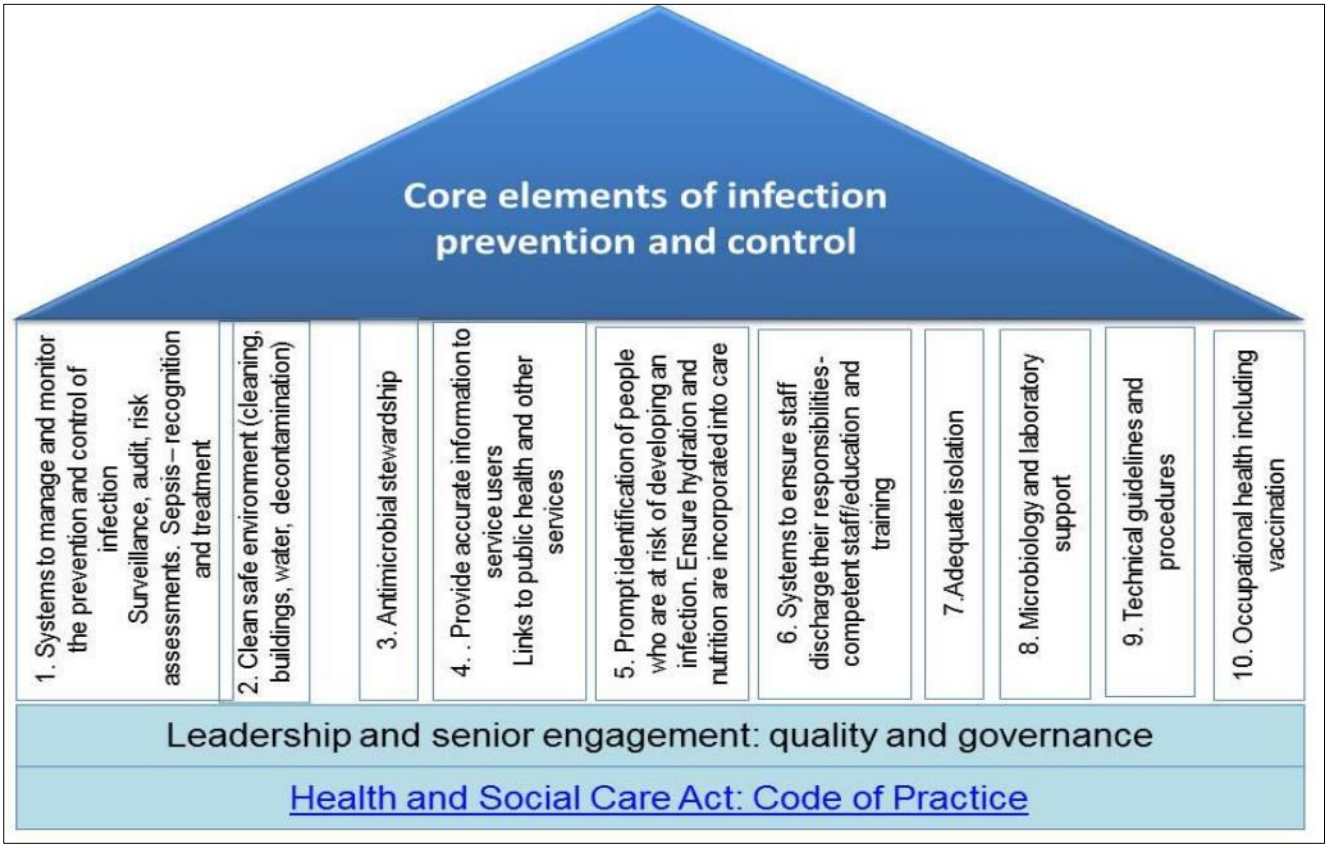
- The Quality Committee monitors the work of the Infection Prevention and Control Committee.
- The Quality Committee is chaired by the Chief Nurse and is attended by senior corporate staff and all clinical directors.
- The Quality Committee oversees clinical governance activity across the Trust.

5.1 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 3.

Trust microbiology services are provided by local acute hospitals via Bart's Health NHS Trust for London-based services and Bedfordshire Hospital NHS Foundation Trust for Luton and Bedford based-services.

***Figure 2**. below shows core elements of Infection Prevention & Control.*



6.0 Healthcare on-set Infections (HCOIs)

Healthcare on-set Infections (HCOIs) are infections that are acquired during care in hospitals and other healthcare facilities.

6.1 Surveillance of Healthcare Associated Infection (HCAI's)

The National Mandatory Data Capture System (DCS) was introduced by UK Security Health Agency (UKSHA) to monitor Healthcare 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 Section 11.3 of this report for a summary of lessons learnt from RCA'S.

6.2 Zero Tolerance Approach to Avoidable HCAI's (MRSA and C. diff)

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.

6.3 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.

***Figure 3**. Below shows zero MRSA Bacteraemia cases were reported across the Trust during 2022-2023.*

MRSA bacteraemia infections	Q1	Q2	Q3	Q4
Trust-wide	0	0	0	0

6.4 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.

***Figure 4**. below shows zero MSSA Bacteraemia cases were reported across the Trust during 2022-2023.*

MSSA bacteraemia Infections	Q1	Q2	Q3	Q4
Trust-wide	0	0	0	0

6.5 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.

***Figure 5**. below shows zero C.diff cases were reported across the Trust during 2022-2023.*

C.diff Infections	Q1	Q2	Q3	Q4
Trust-wide	0	0	0	0

6.6 Carbapenem-resistant Organisms (CRO)

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 CROs recorded across the Trust this year.

***Figure 6**. below shows zero CRO cases were reported across the Trust during 2022-2023.*

CROs Infections	Q1	Q2	Q3	Q4
Trust-wide	0	0	0	0

6.7 Gram-negative Rod Blood Stream Infections (GNRBSIs)

There are many different types of Gram-negative bacteria. Some live in the intestine harmlessly, while others may cause a variety of diseases. Bacteria that are normally harmless in their normal environment can cause problems if they grow in other parts of the body and can cause a range of infections with differing severity and associated mortality. One of the most serious infections Gram-negatives can cause is bloodstream infections.

Gram-negative bacteria such as *Escherichia coli, Klebsiella spp*. and *Pseudomonas aeruginosa* are the leading causes of healthcare associated bloodstream infections.

Gram-negative bacteria can be resistant to antibiotics and in some cases will be multi-resistant rendering most available antibiotics useless. Some of the antibiotic resistance mechanisms are on mobile genetic elements, such as plasmids, which allow the genes that encode resistance to spread more easily, and importantly, between different bacterial species.

Figure 7*. below shows zero GNRBSI cases were reported across the Trust during 2022-2023.*

GNRBSIs	Q1	Q2	Q3	Q4
Trust-wide	0	0	0	0

6.8 Surveillance: Other Alert Organism: (all reported in East Ham Care Centre post 48 hours of admission)

Figure 8*. below shows there were no alert organisms reported across the Trust during 2022-2023.*

Alert Organism Infections	Q1	Q2	Q3	Q4
East Ham Care Centre – Fothergill ward	0	0	0	0

7.0 Coronavirus Disease 2019 (COVID-19)

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China. On 9 January 2020, it was announced that a novel coronavirus had been identified in samples obtained from these cases and initial analysis of virus genetic sequences suggested that this was the cause of the outbreak.

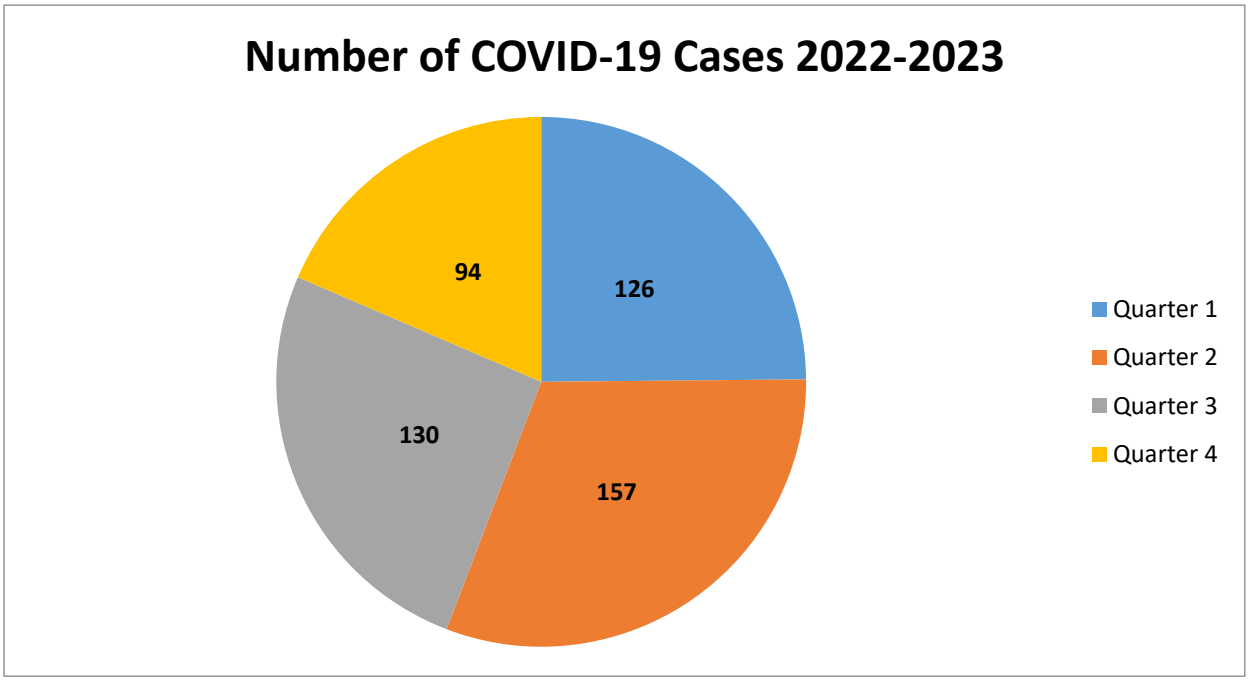
In February 2020 this new virus was formally named as SARS-CoV-2, and the disease caused by it was named Coronavirus 2019 (COVID-19), in line with best practice guidance. On 11 March 2020 WHO declared the COVID-19 outbreak a global pandemic due to the rapid spread and severity of cases around the world.

Scientific consensus is that SARS-CoV-2 is zoonotic in origin, however the source of the original outbreak is yet to be determined. An intermediate host between the source and introduction into humans has been considered to be ‘likely to very likely’, and investigations are ongoing.

8.0 COVID-19 Infections

During 2022-23 there were 507 COVID-19 infections reported, this is a decrease from the previous year where 514 COVID-19 cases were reported.

***Figure 9**. below displays the total number of COVID-19 cases during 2022-2023 broken down by quarter.*



During quarter 2, there was a significant increase in the number of confirmed positive cases across the Trust. This was a reflection of the national epidemiological increase of COVID-19 cases across the United Kingdom due to the Omicron BA.4 and BA.5 variant.

***Figure 10**. below displays the number of COVID-19 cases in April of Q1 by ward.*

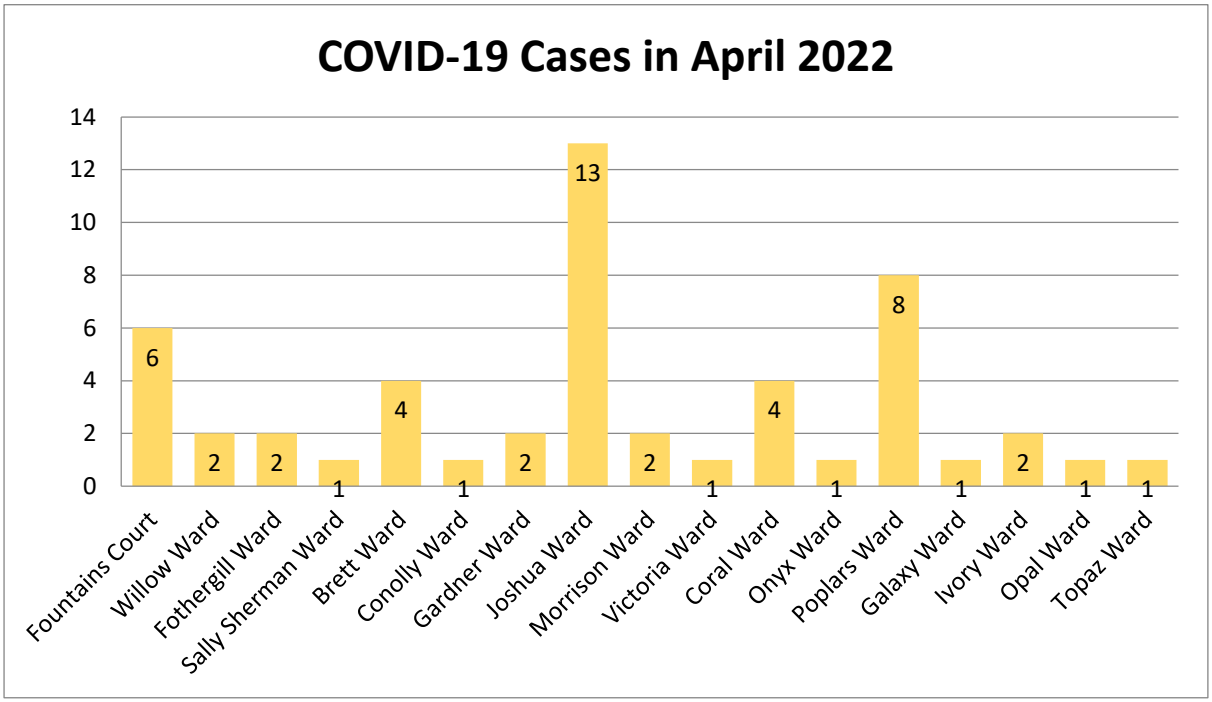


***Figure 11**. below displays the number of COVID-19 cases in May of Q1 by ward.*

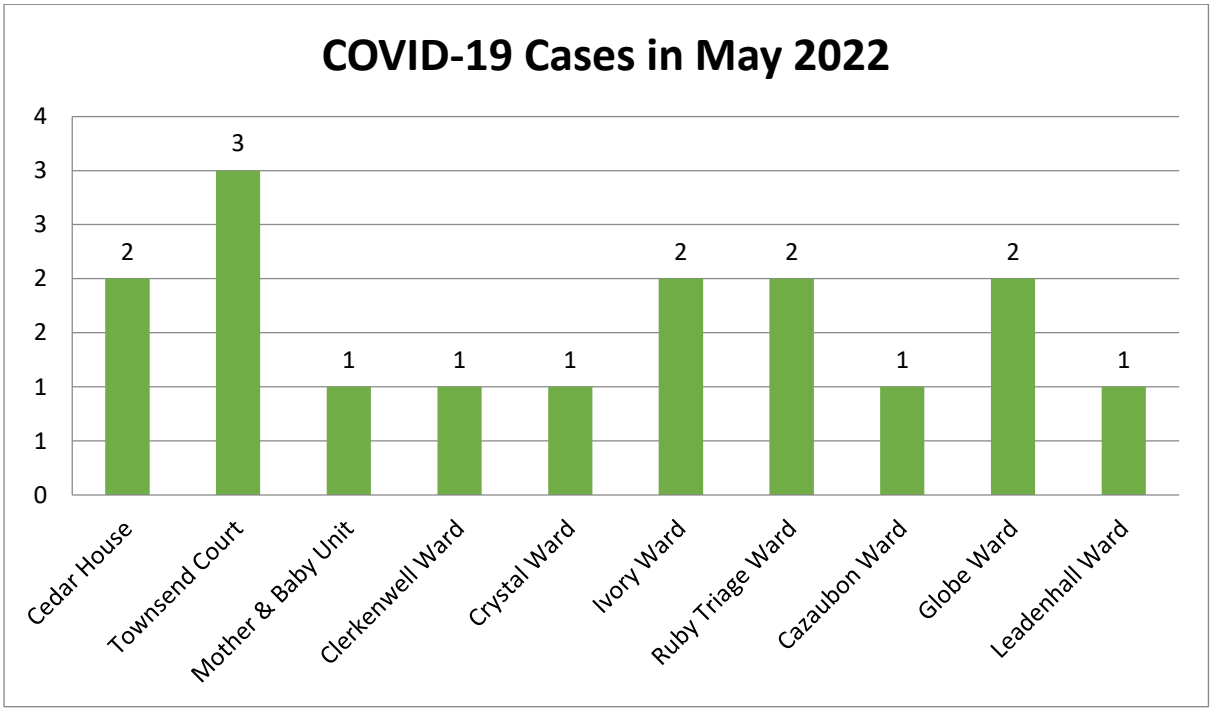
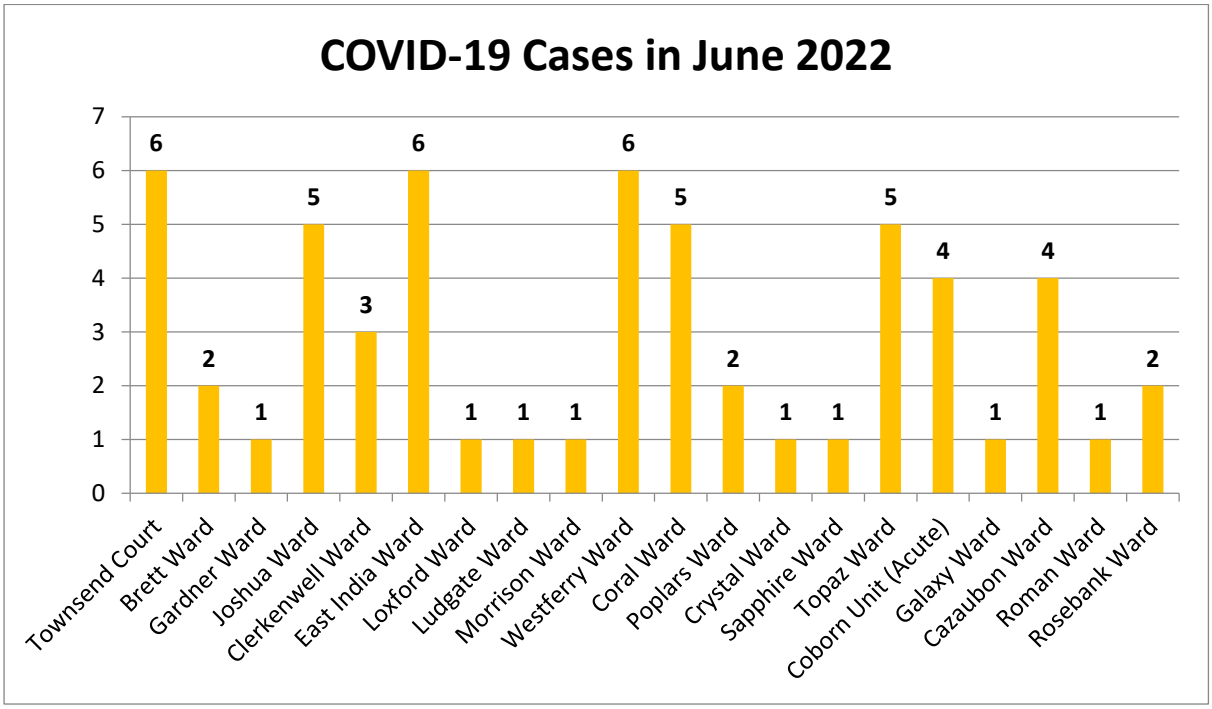
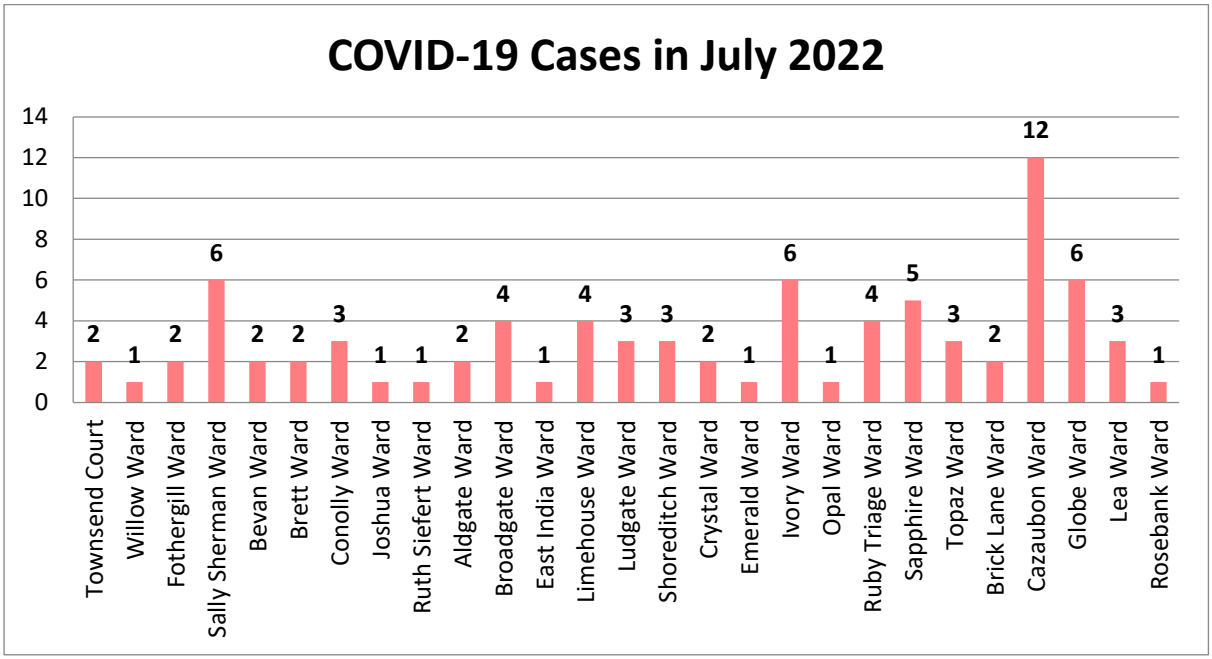


***Figure 12**. below displays the number of COVID-19 cases in June of Q1 by ward.*



During the month of June there was a significant increase in the number of confirmed positive cases across the Trust. This was a reflection of the national epidemiological increase of COVID-19 cases across the United Kingdom due to the Omicron BA.4 and BA.5 variant.

***Figure 13**. below displays the number of COVID-19 cases in July of Q2 by ward.*



During the month of July there was a significant increase in the number of confirmed positive cases across the Trust. This was a reflection of the national epidemiological increase of COVID-19 cases across the United Kingdom due to the Omicron BA.4 and BA.5 variant.

***Figure 14**. below displays the number of COVID-19 cases in August of Q2 by ward.*

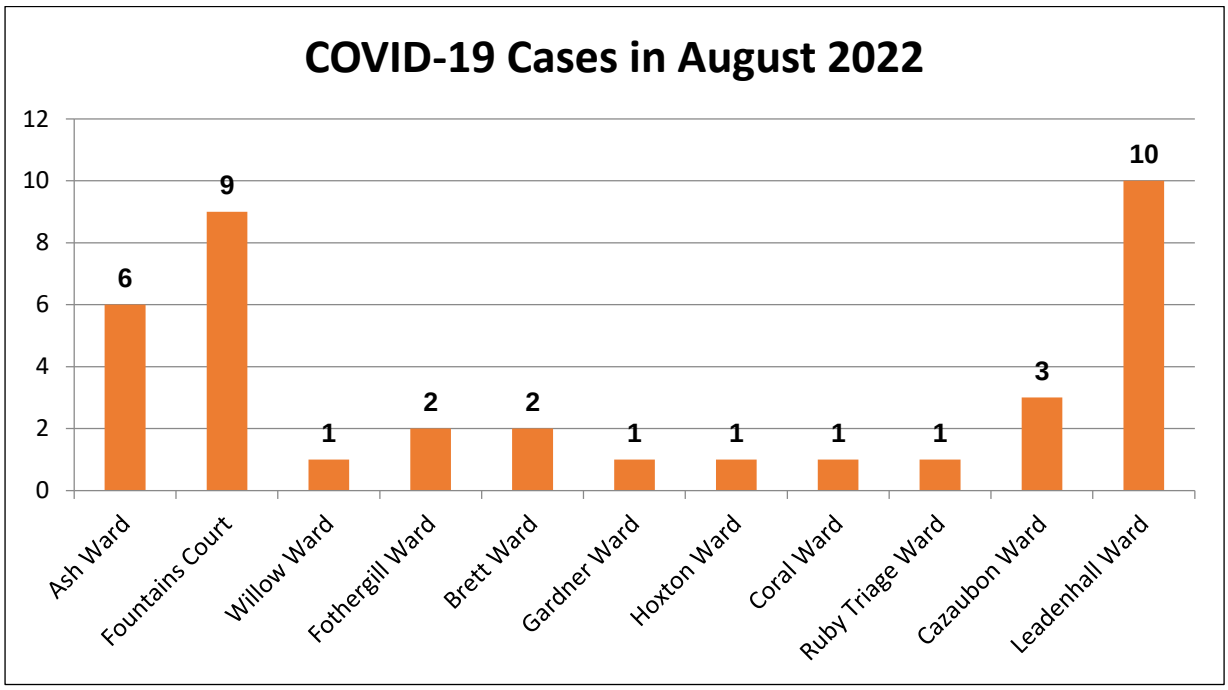


***Figure 15**. below displays the number of COVID-19 cases in September of Q2 by ward.*

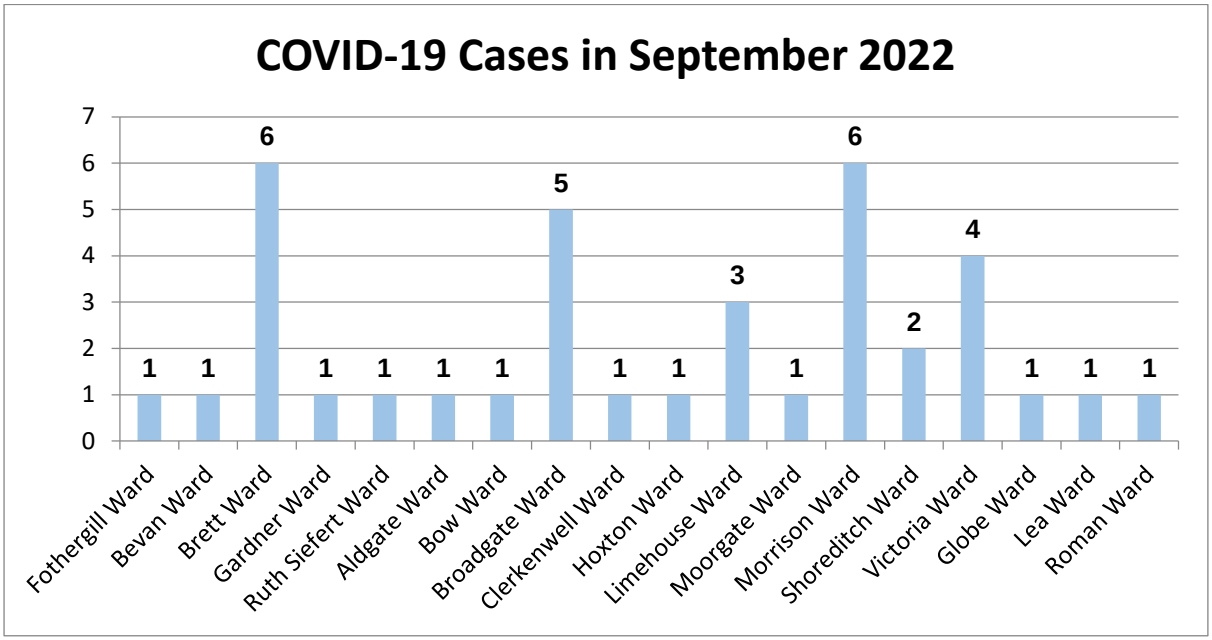


***Figure 16**. below displays the number of COVID-19 cases in October of Q3 by ward.*

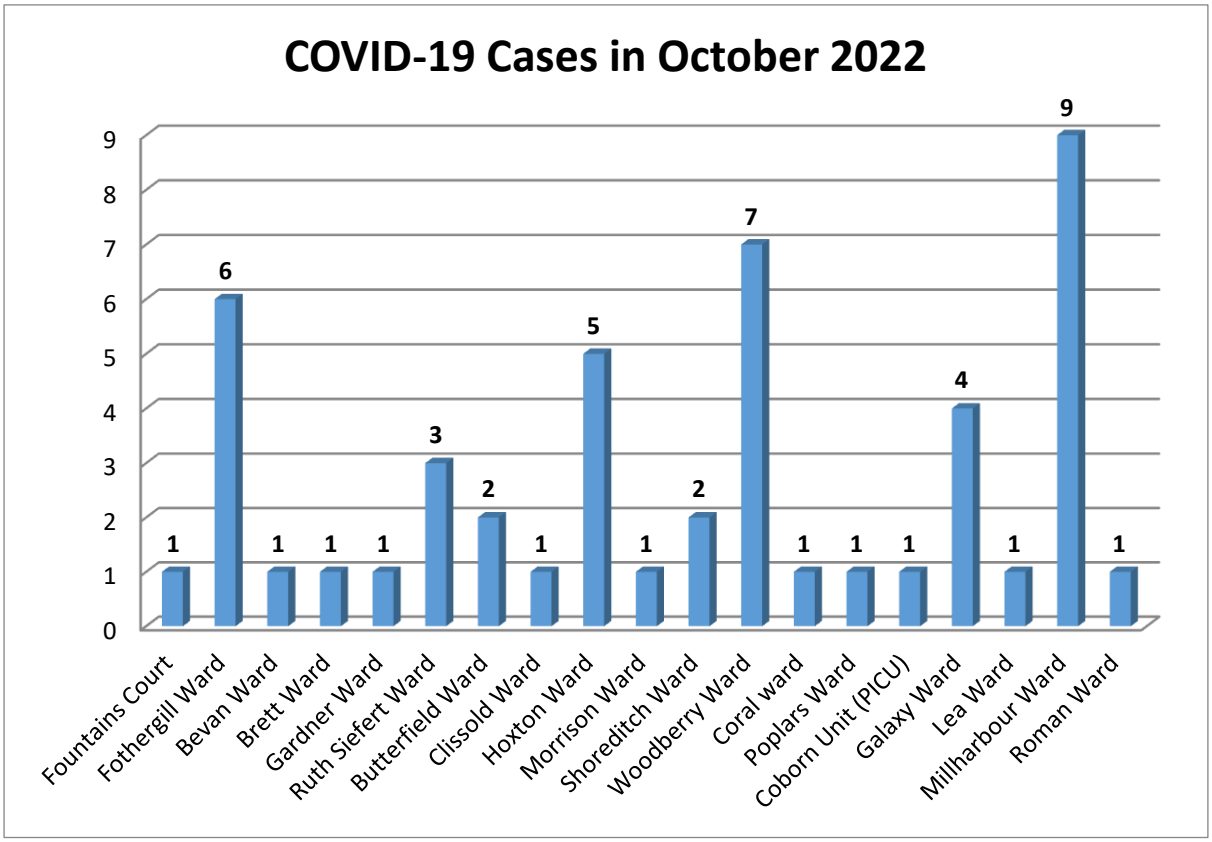


***Figure 17**. below displays the number of COVID-19 cases in November of Q3 by ward.*

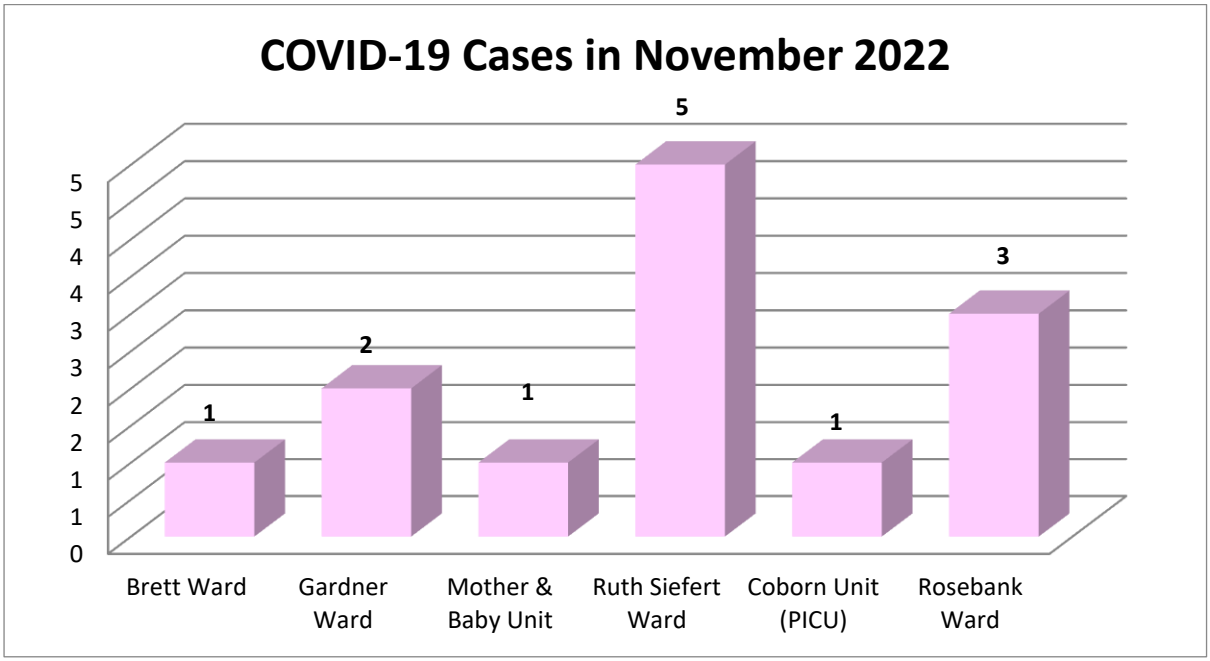
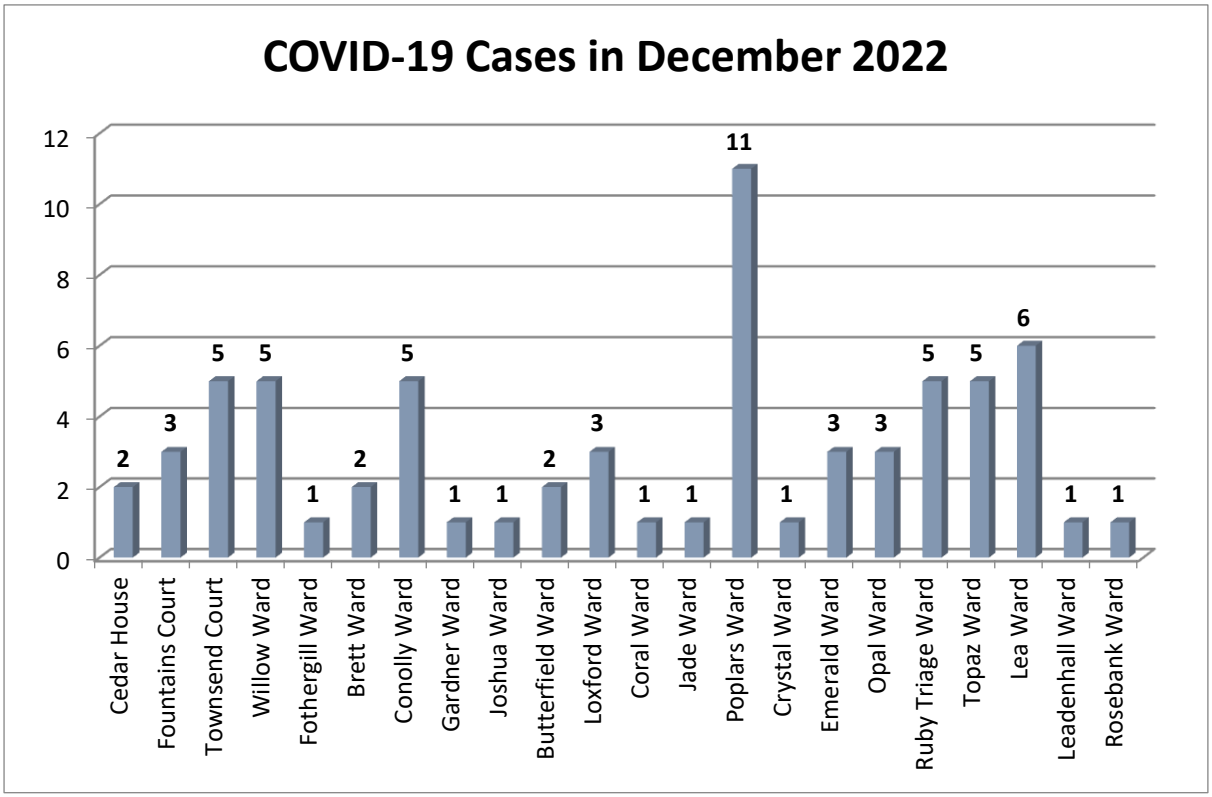


***Figure 18**. below displays the number of COVID-19 cases in December of Q3 by ward.*



During the month of December there was a significant increase in the number of confirmed positive cases across the Trust. This was a reflection of the national epidemiological increase of COVID-19 cases across the United Kingdom due to the emerging Omicron XBB.1.5 variant.

***Figure 19**. below displays the number of COVID-19 cases in January of Q4 by ward.*

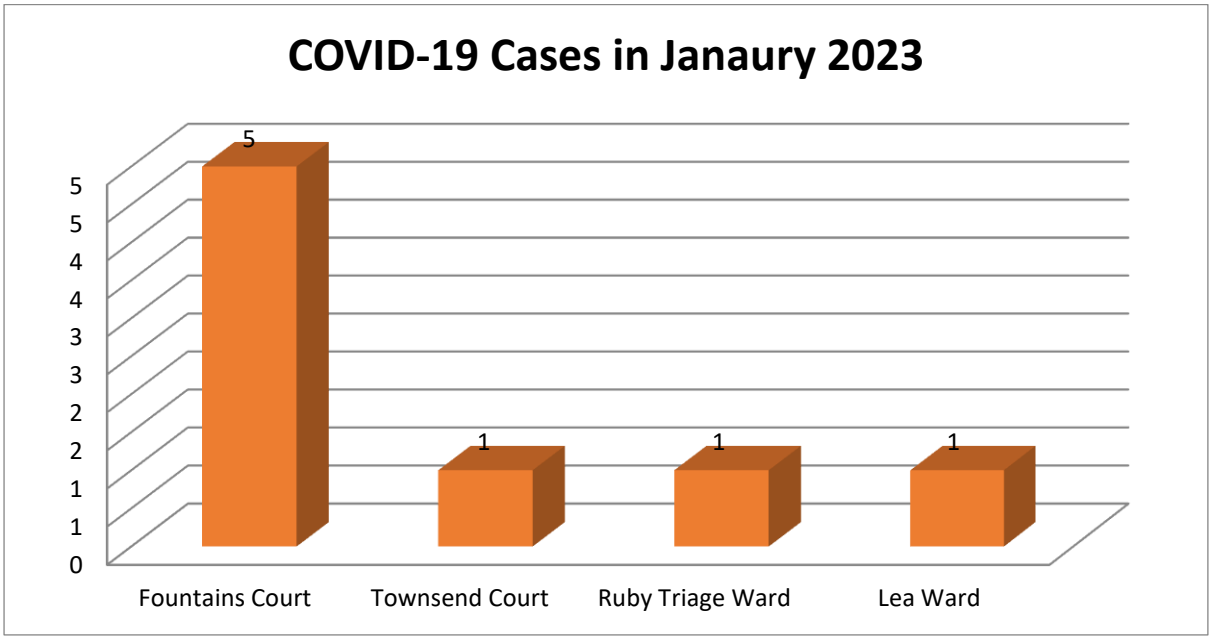
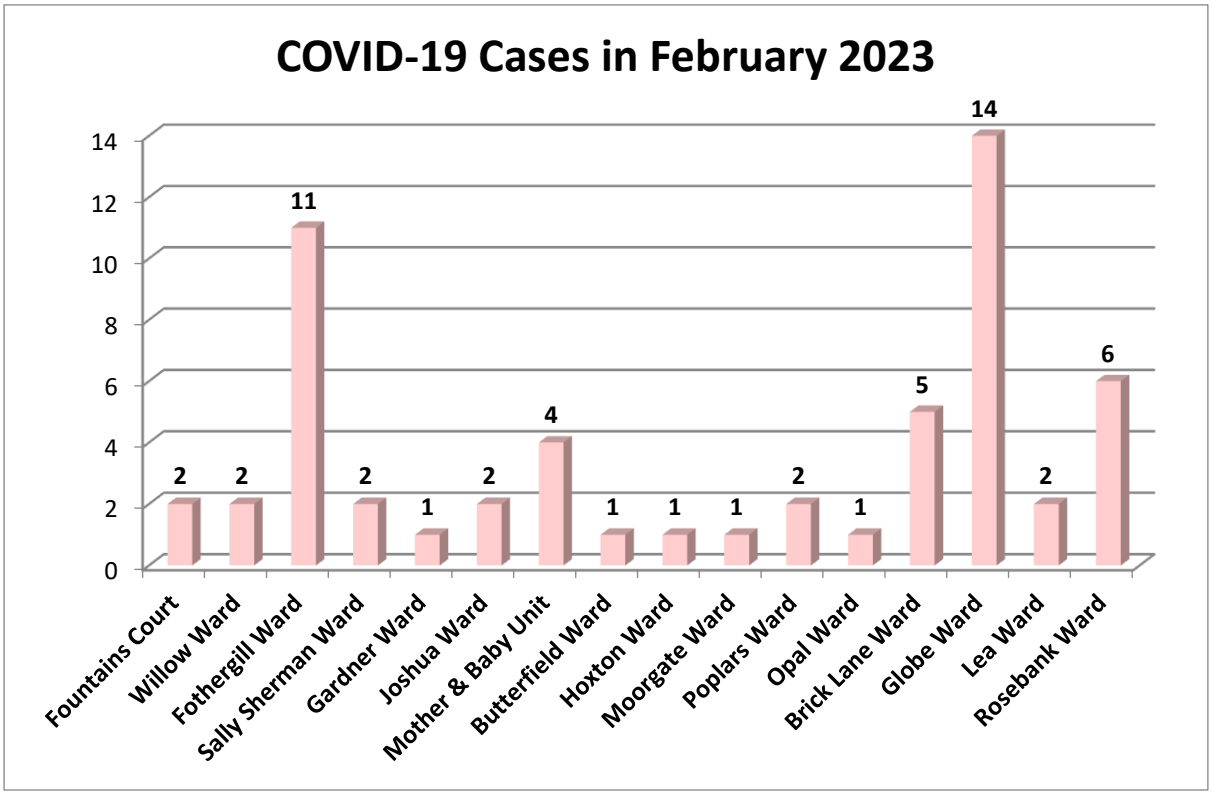
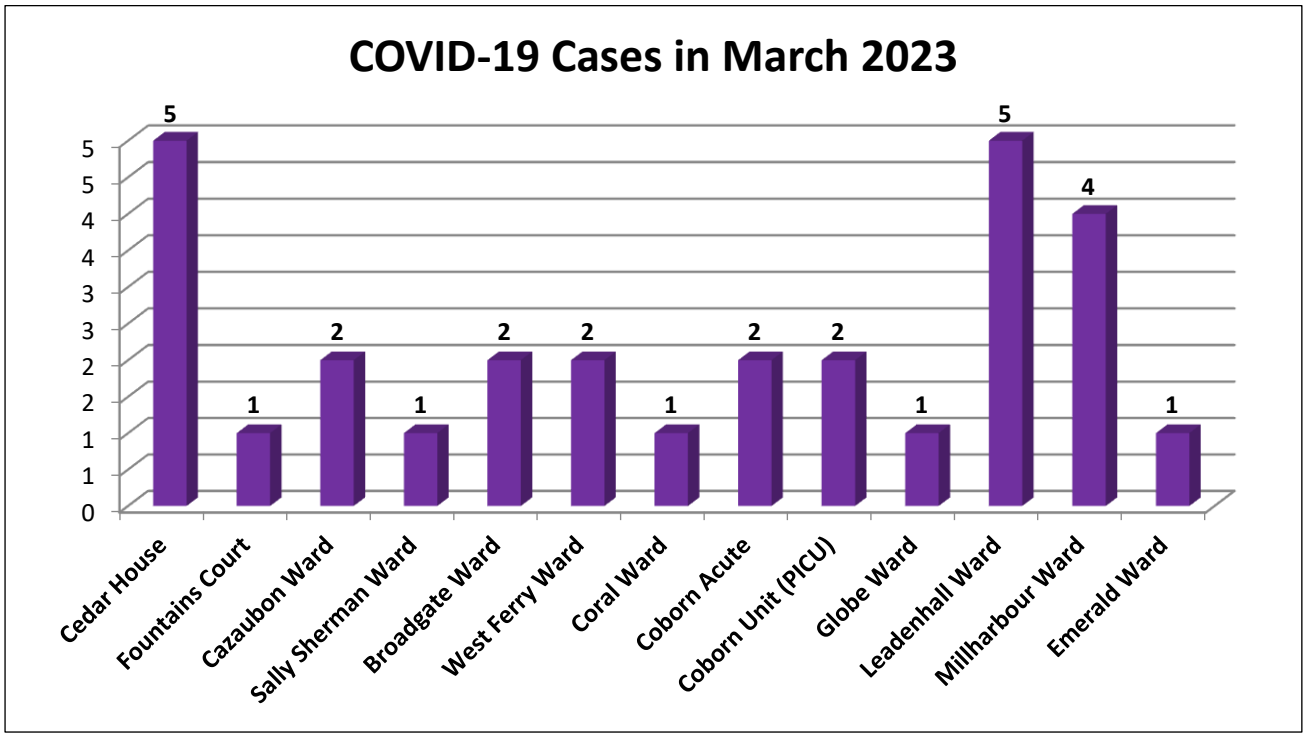


***Figure 20**. below displays the number of COVID-19 cases in February of Q4 by ward.*



During the month of February 2023 there was a significant increase in the number of confirmed COVID-19 positive cases across the Trust. This was a reflection of the national epidemiological increase of COVID-19 cases across the United Kingdom due to the emerging Omicron XBB.1.5 variant.

***Figure 21**. below displays the number of COVID-19 cases in March of Q4 by ward.*



9.0 Healthcare-onset COVID-19 Infections (HOCI)

Between 10 – 20% of COVID-19 infections are thought to occur as a result of healthcare. Healthcare onset COVID-19 infection (HOCI) are associated with increased harm and mortality and reducing these is a clear patient safety issue. Early identification of increased incidences of infection and outbreaks are key components in reducing HOCI and are central to understanding COVID-19 transmission within healthcare, providing transparency on performance and supporting a focus on the culture of continuous improvement.

9.1 The Definition of Healthcare-onset Infections (HCOIs)

***Figure 22**. below displays the types of number of Healthcare-onset Infections.*

Healthcare-onset of Infection Type	Definitions
Community-onset (CO)	Positive specimen date <=2 days after hospital admission or Hospital attendance.
Hospital-onset Indeterminate Healthcare-Associated	Positive specimen date 3-7 days after hospital admission.
Hospital-onset Probable Healthcare-Associated	Positive specimen date 8-14 days after hospital admission.
Hospital-onset Definite Healthcare-Associated	Positive specimen date 15 or more days after hospital admission.

Cases of COVID-19 acquired after 8 days of admission within ELFT services are reviewed. A Root Cause Analysis (RCA) is conducted for HOCIs to attempt to establish a causal link. The IPC Team have updated the RCA Template to include ventilation and levels of harm information as requested by the local Integrated Care Board.

***Figure 23**. below shows a breakdown of definite HOCIs (15 days+) during 2022-23.*

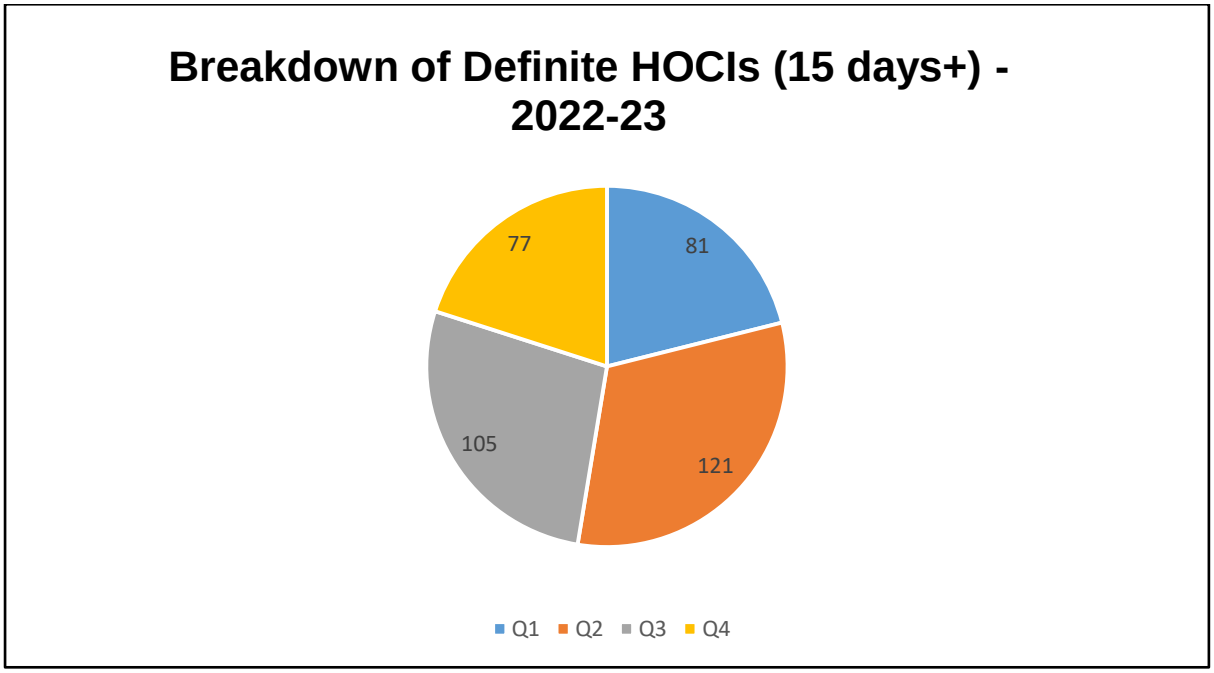


***Figure 24**. below shows a breakdown of probable HOCIs (7-14 days) during 2022-23.*

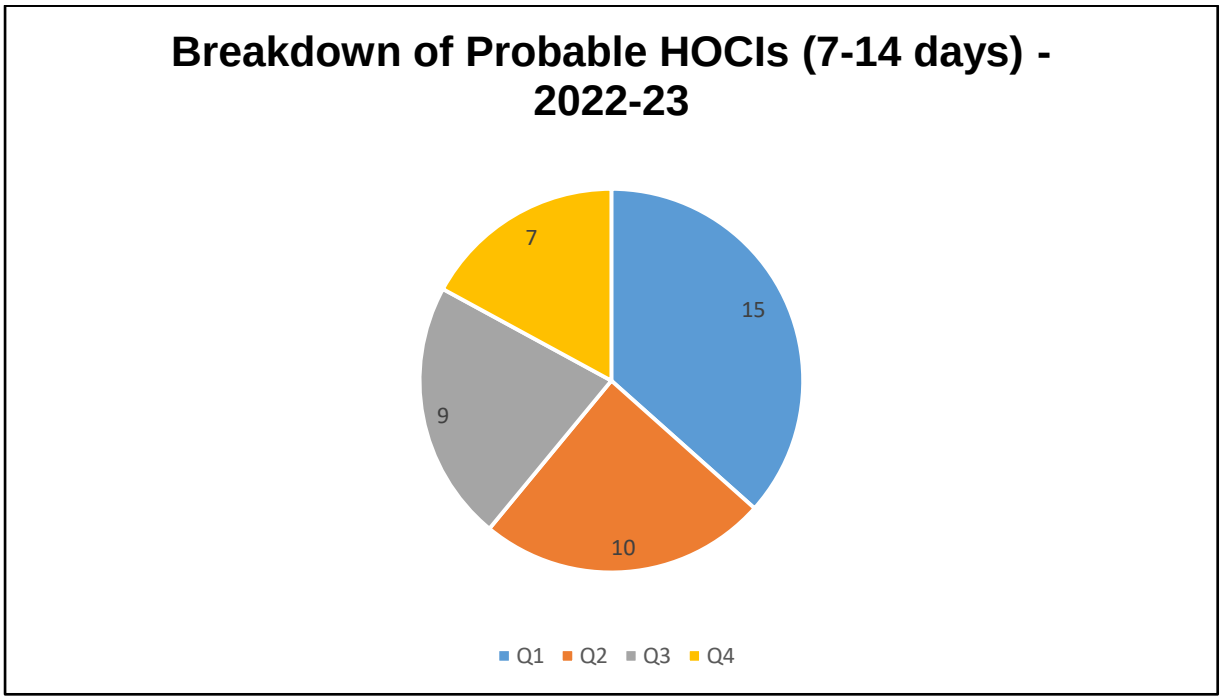
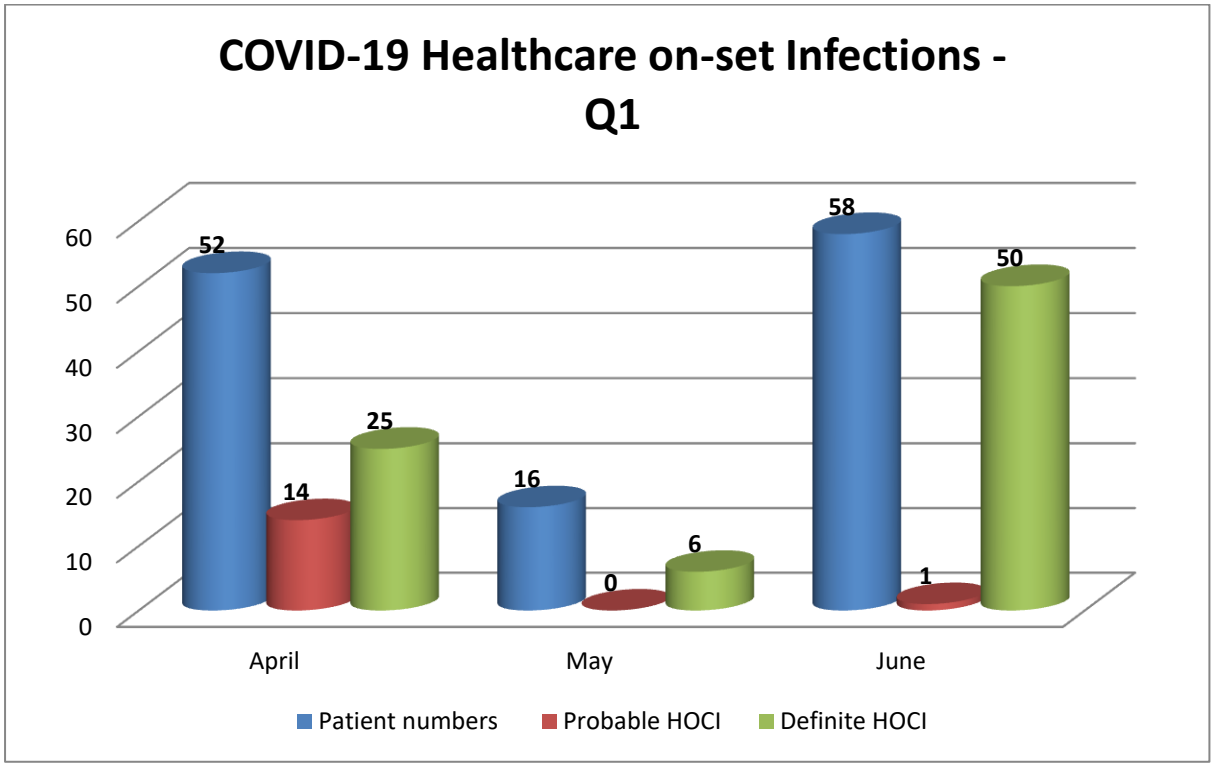
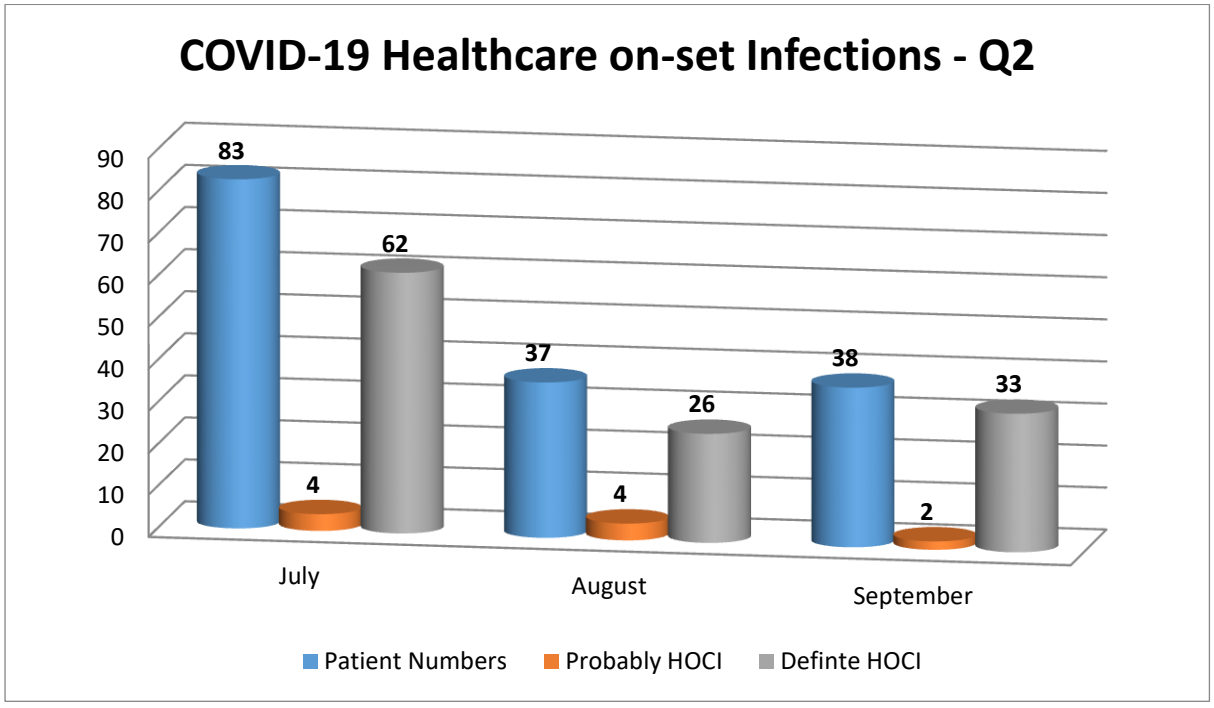


***Figure 25**. below shows a breakdown of HOCIs in Q1.*



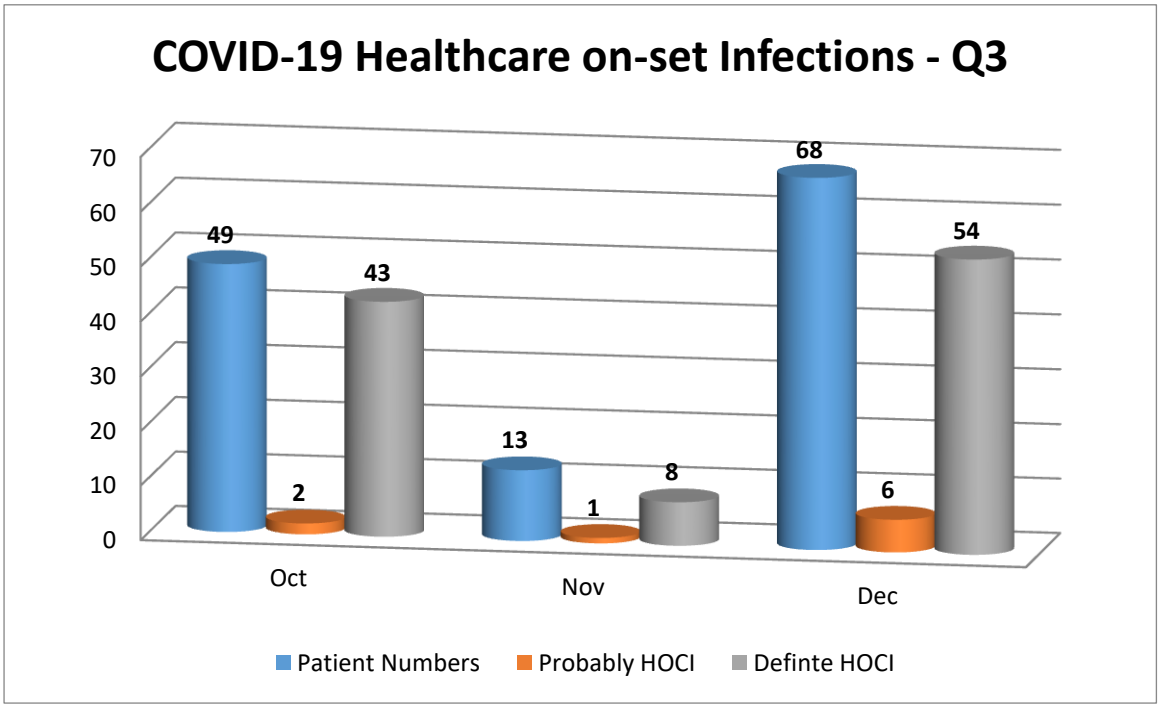
Q1, there were 81 definite HOCIs and 15 probable HOCIs reported during Q1.

***Figure 26.** below provides a breakdown of HOCIs in Q2:*



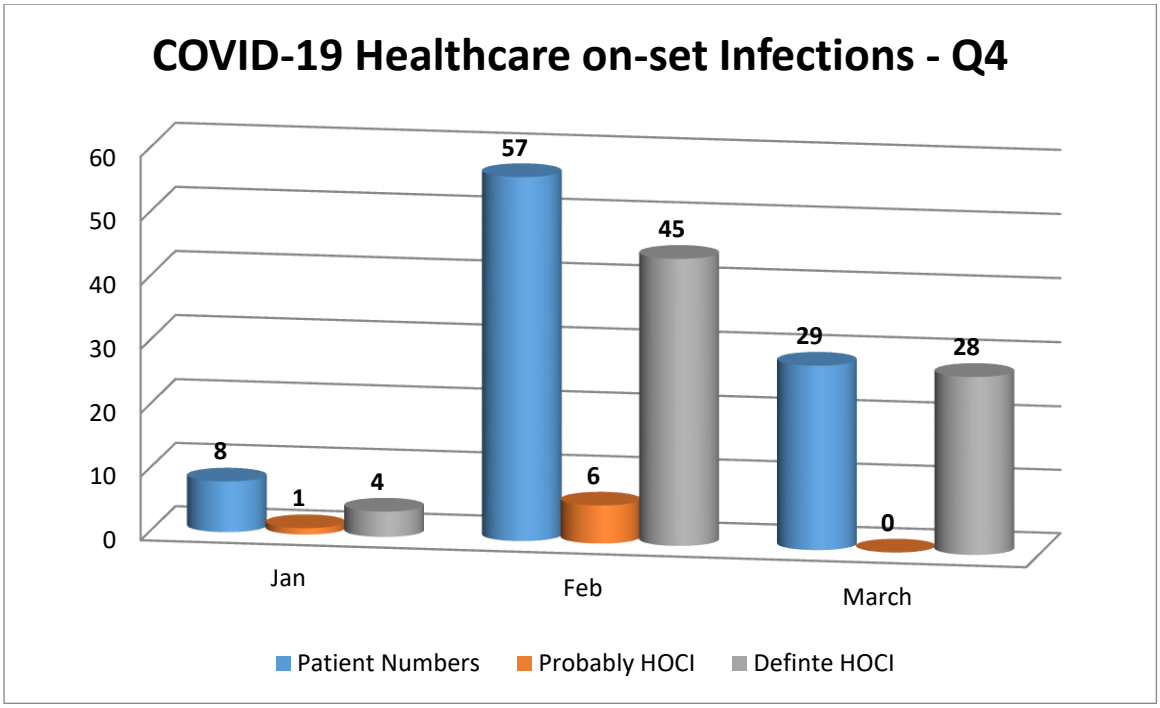
In Q2, there were 121 definite HOCIs. This is an increase from the previous quarter. In Q2, 10 probable HOCIs were reported, this is a decrease from Q1.

Figure 27. *below provides a breakdown of HOCIs in Q3.*



In Q3, there were 105 definite HOCIs. This is a decrease from the previous quarter where 121 definite HOCI cases were reported in Q2. In Q3, there were 9 probable HOCIs reported. This is a slight decrease from the previous quarter.

Figure 28. *below provides a breakdown of HOCIs in Q4.*



In Q4, there were 77 definite HOCIs. This is a decrease from the previous quarter, where 105 definite HOCI cases were reported. In Q3, there were 7 probable HOCIs reported. This is a decrease from the previous quarter.

Figure 29. *below illustrates the number of HOCI cases in April of Q1.*

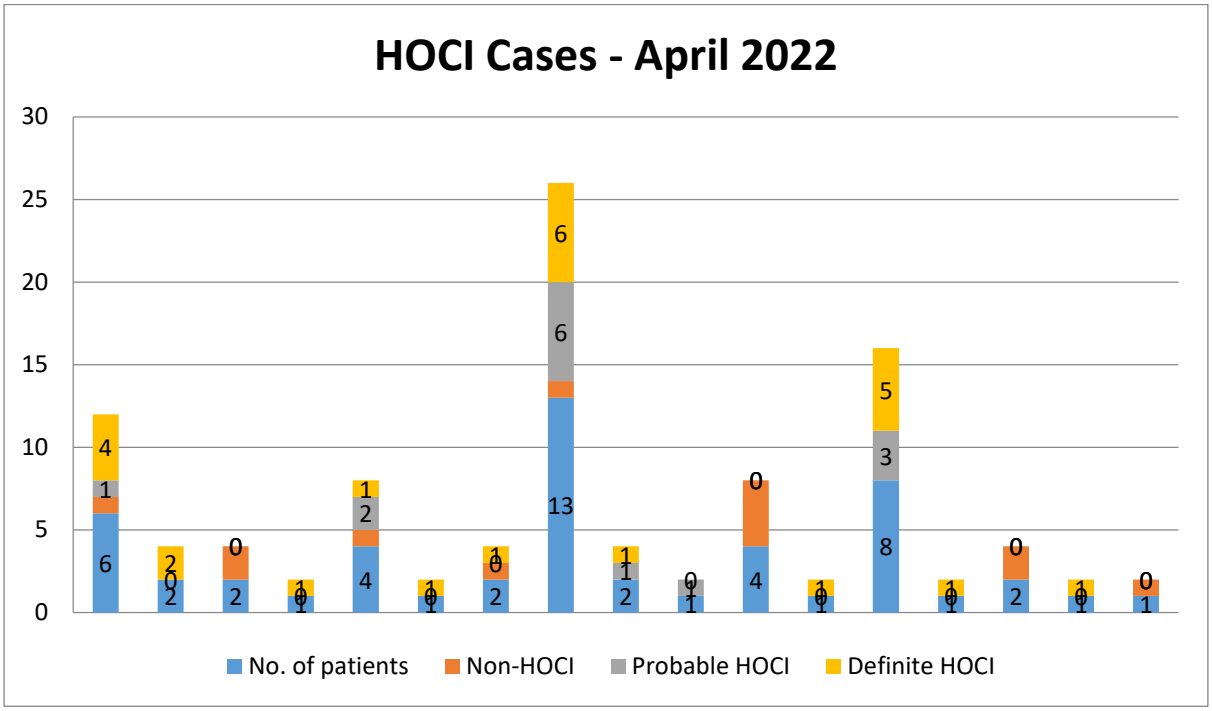


Figure 30. *below illustrates the number of HOCI cases in May of Q1.*

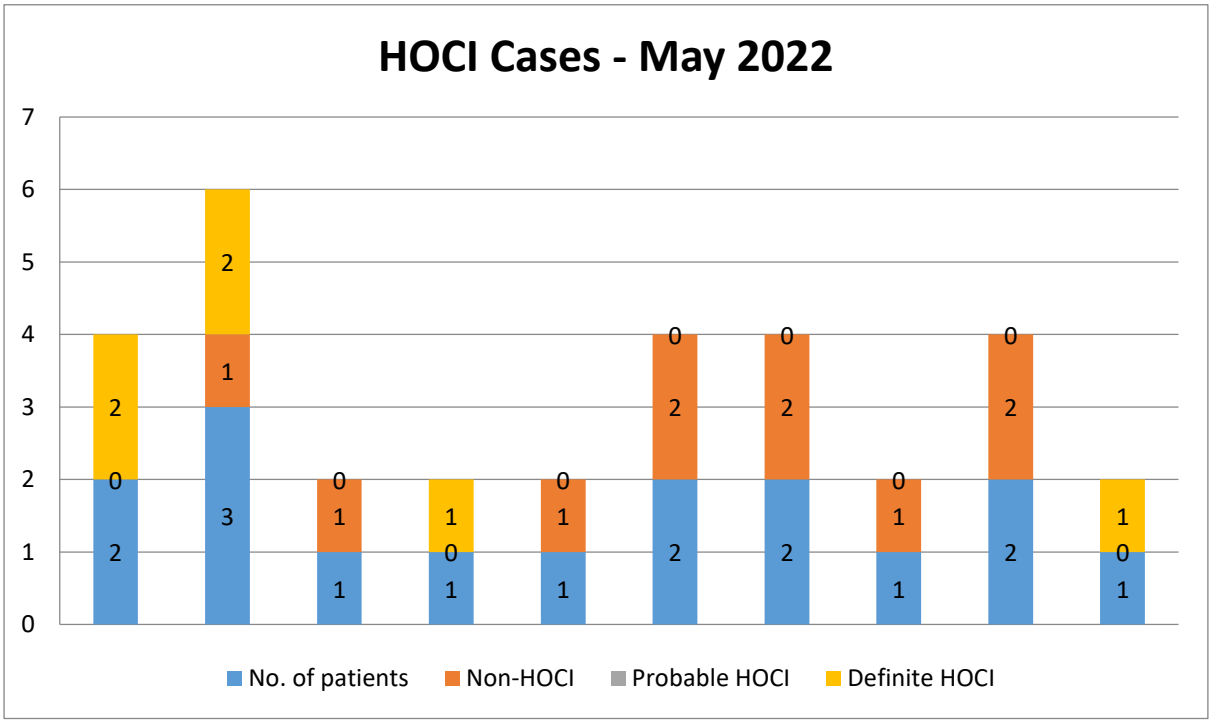


Figure 31. *below illustrates the number of HOCI cases in June of Q1.*

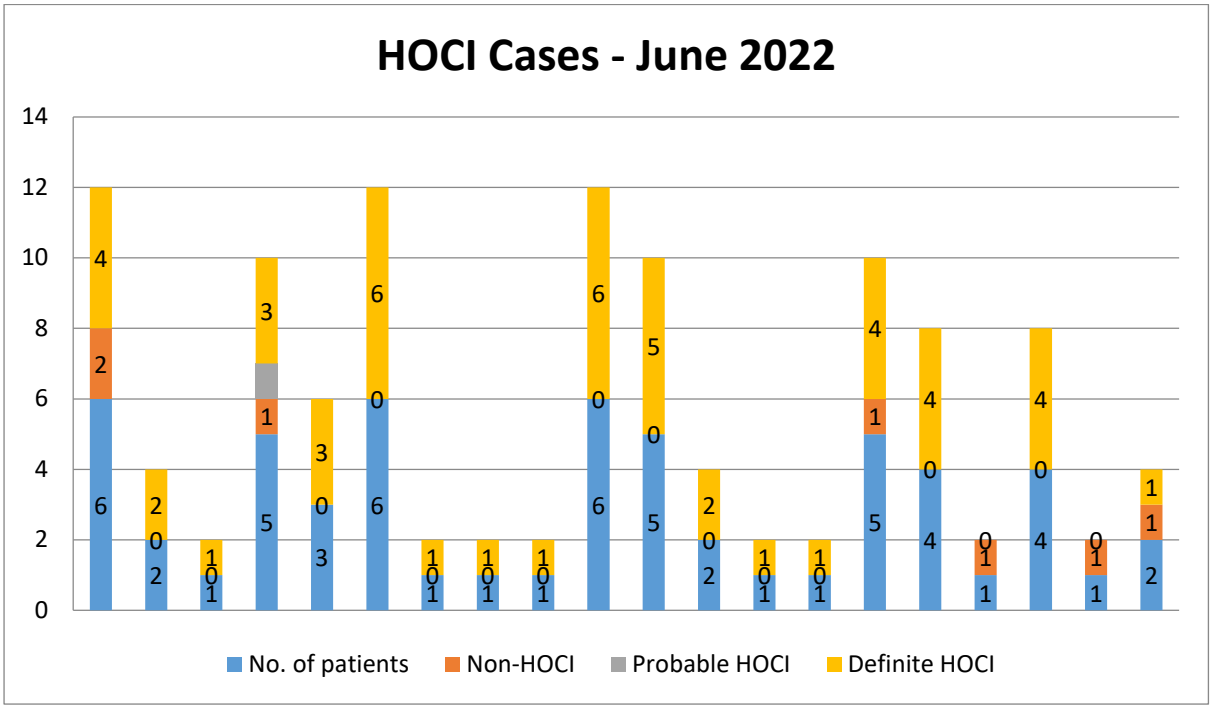
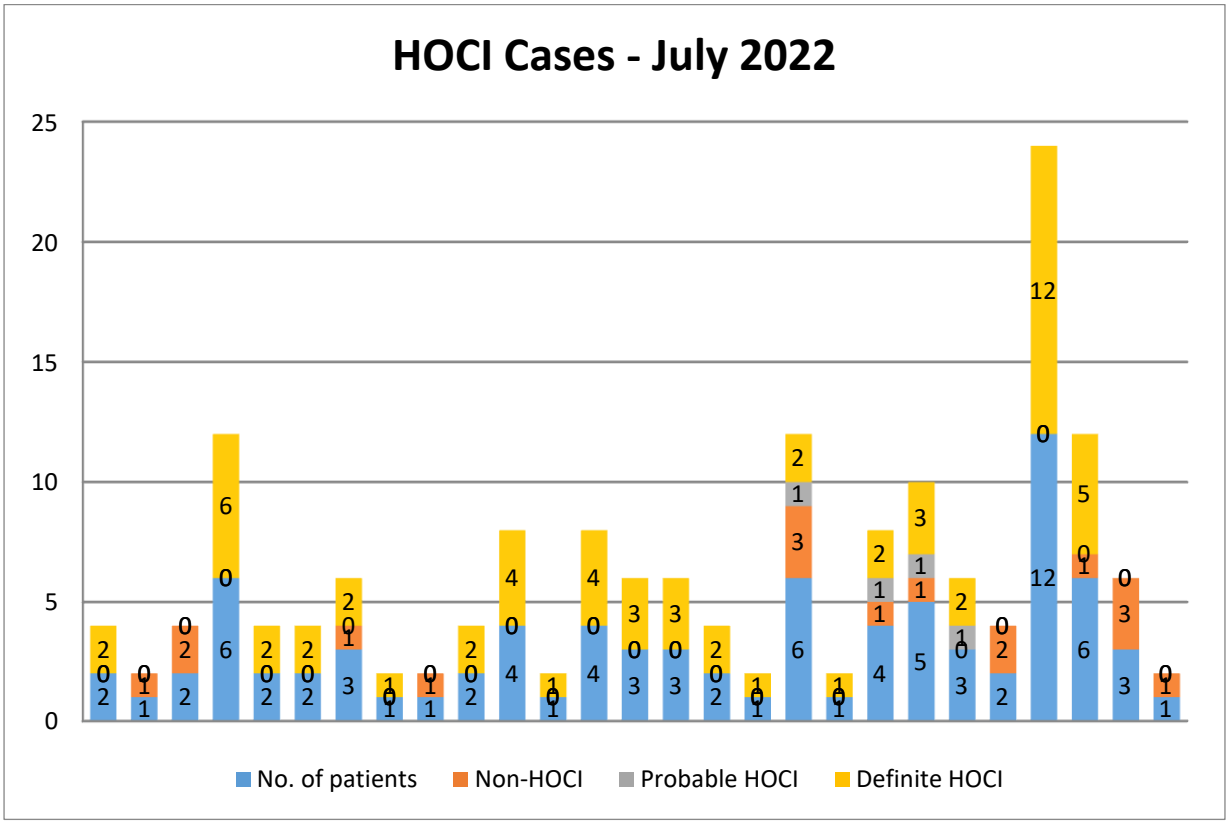


Figure 32. *below illustrates the number of HOCI cases in July of Q2.*



:

Figure 33. *below illustrates the number of HOCI cases in August of Q2.*

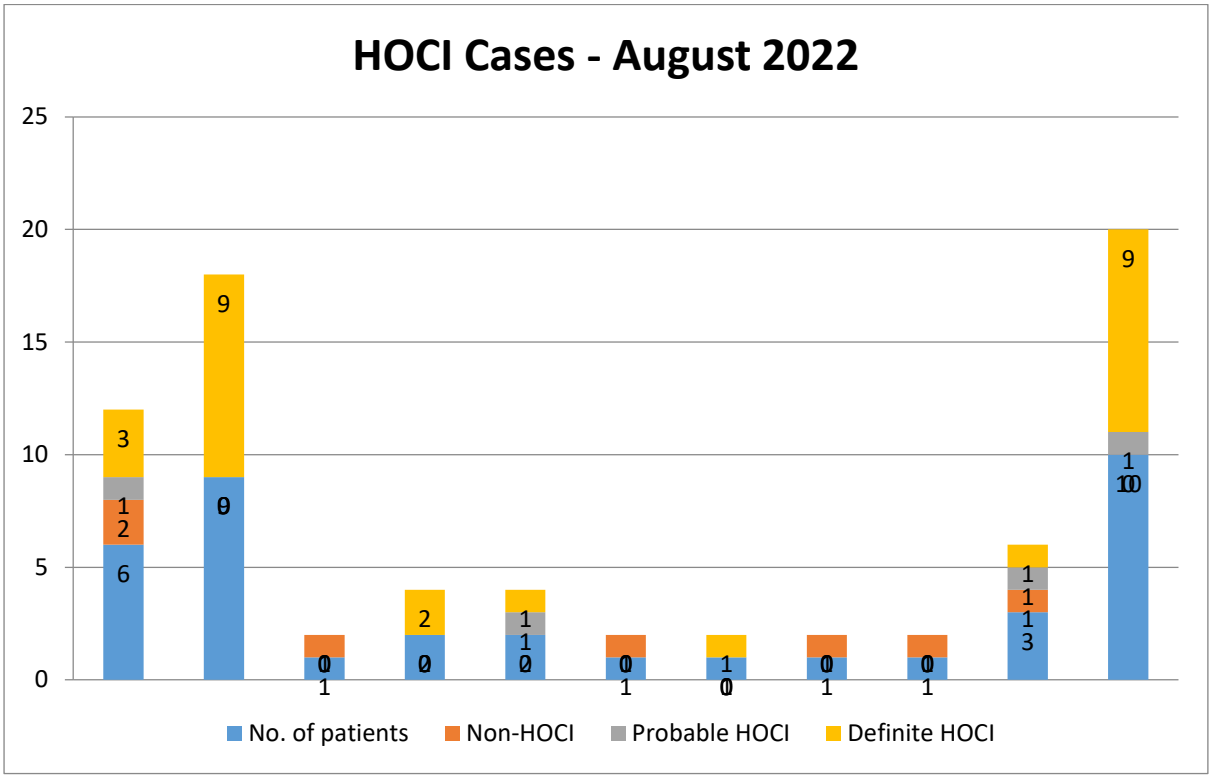


Figure 34. *below illustrates the number of HOCI cases in September of Q2.*

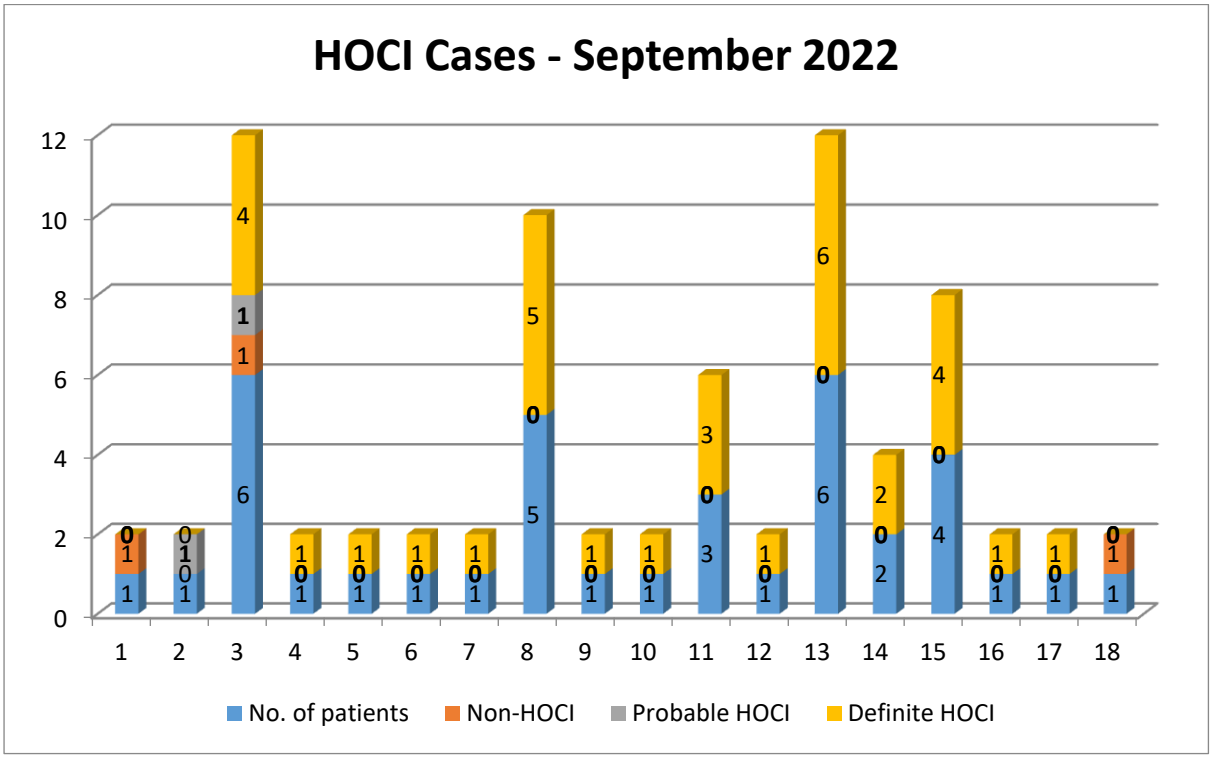


Figure 35. *below illustrates the number of HOCI cases in October of Q3.*

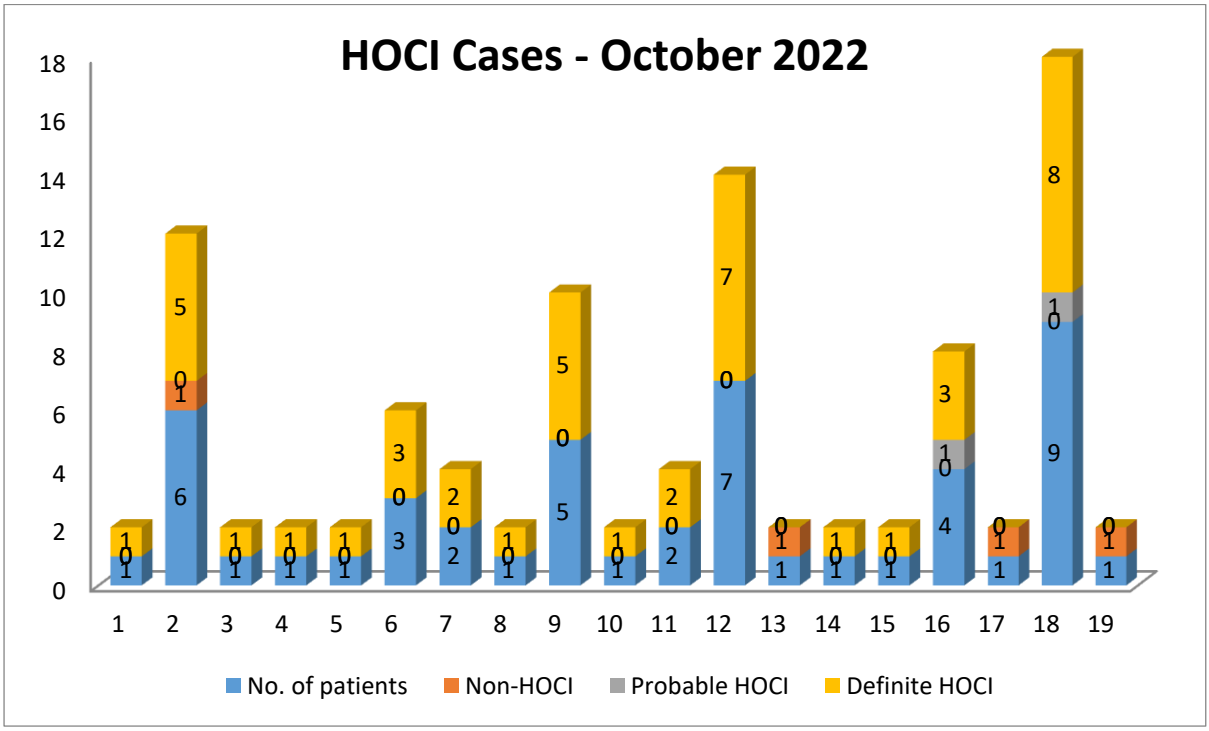


Figure 36. *below illustrates the number of HOCI cases in November of Q3.*

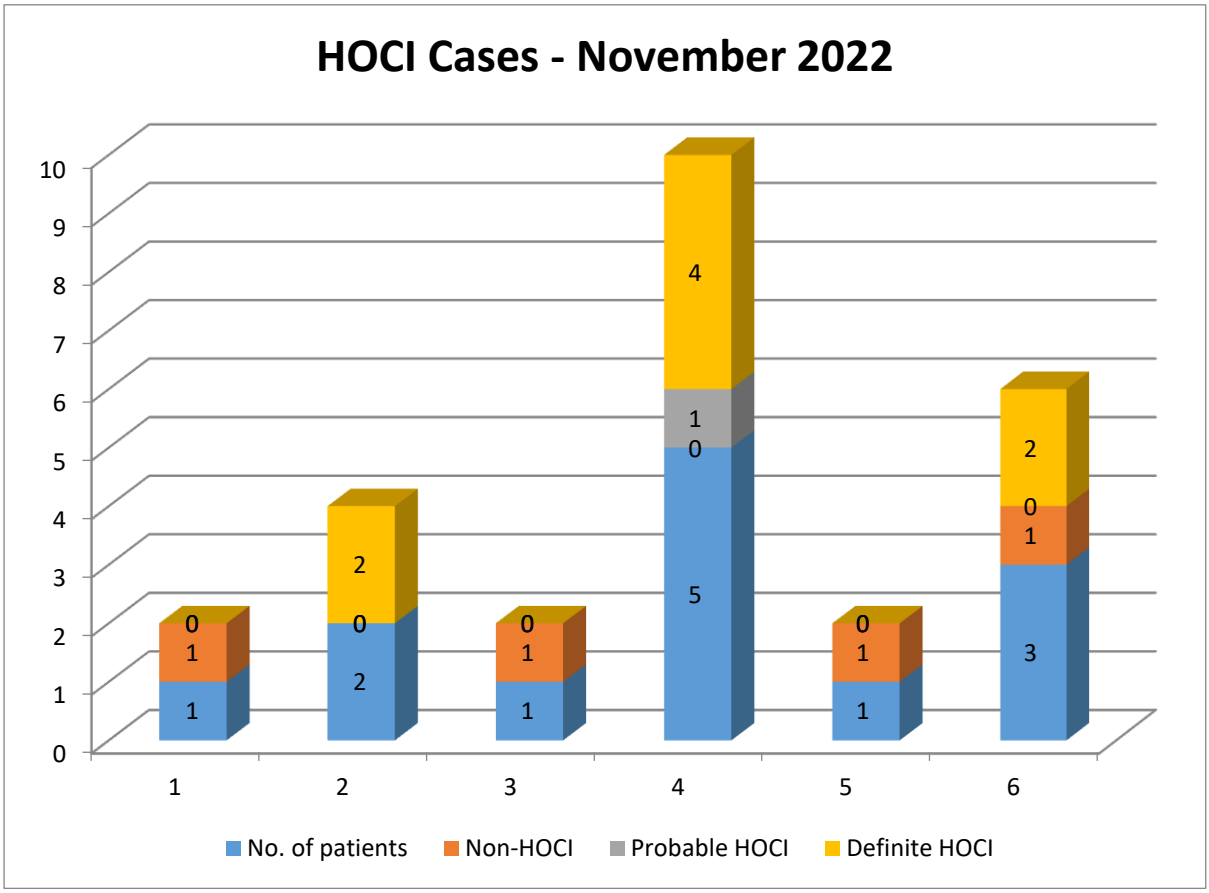


Figure 37. *below illustrates the number of HOCI cases in December of Q3.*

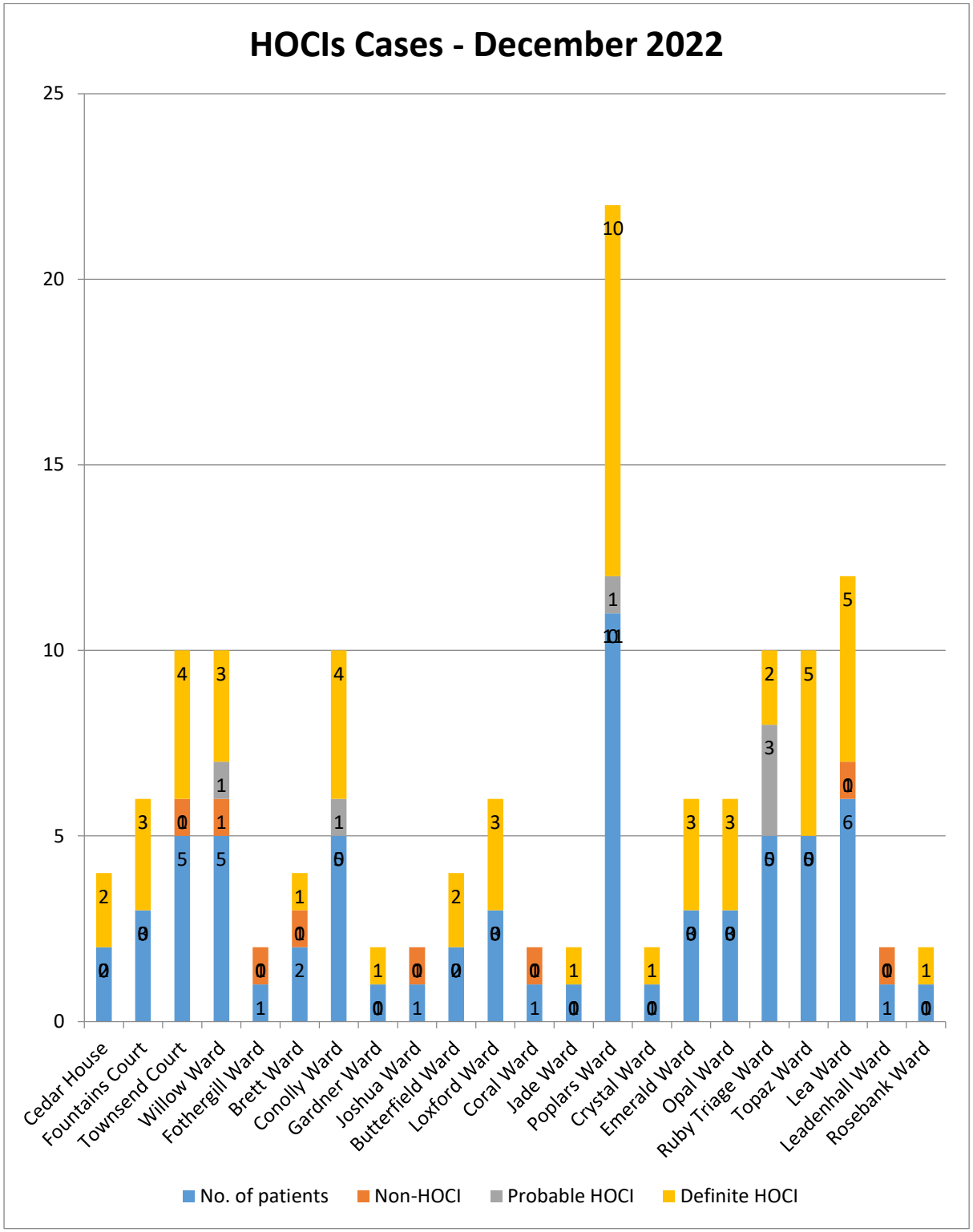


Figure 38. *below illustrates the number of HOCI cases in January of Q4.*

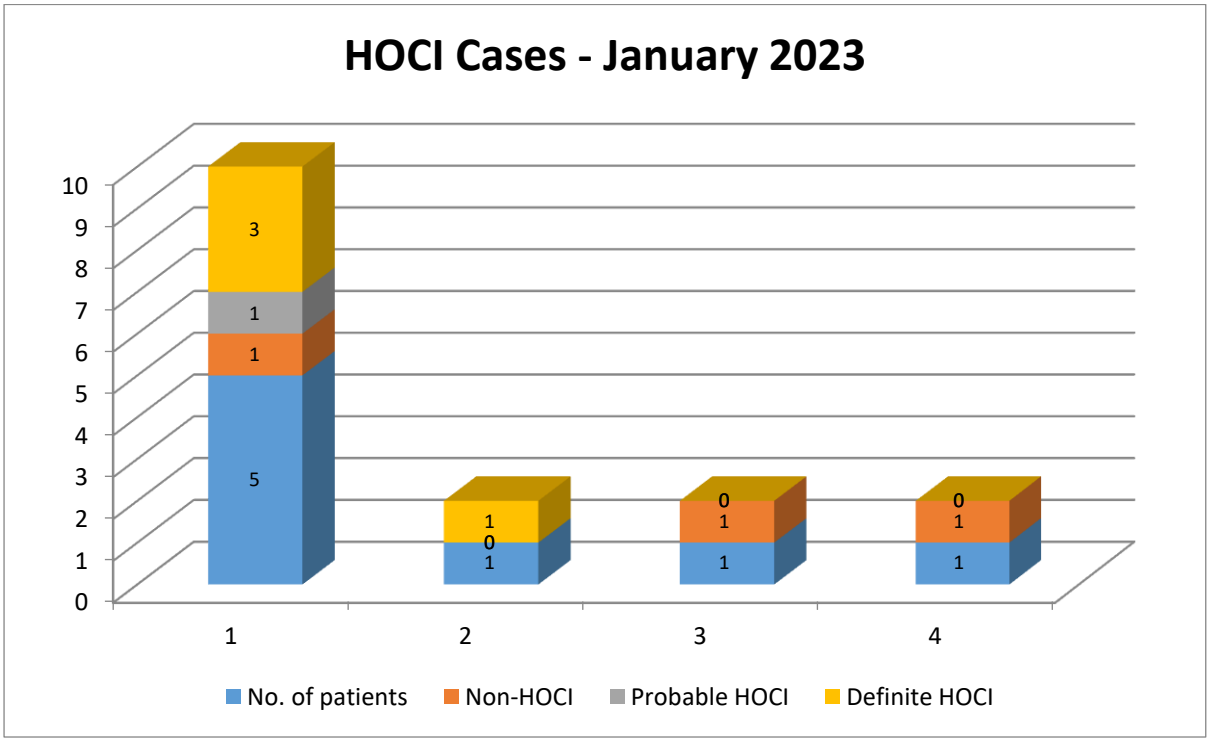


Figure 39. *below illustrates the number of HOCI cases in February of Q4.*

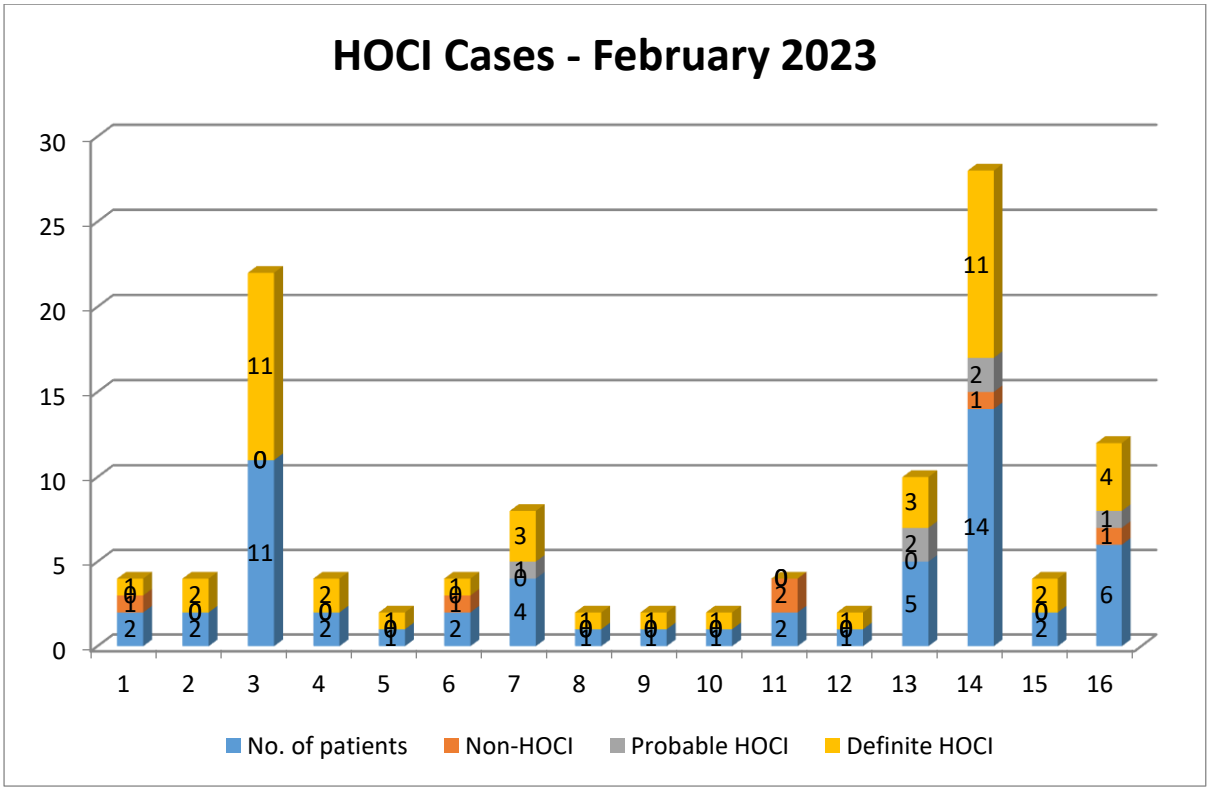


Figure 40. *below illustrates the number of HOCI cases in March of Q4.*

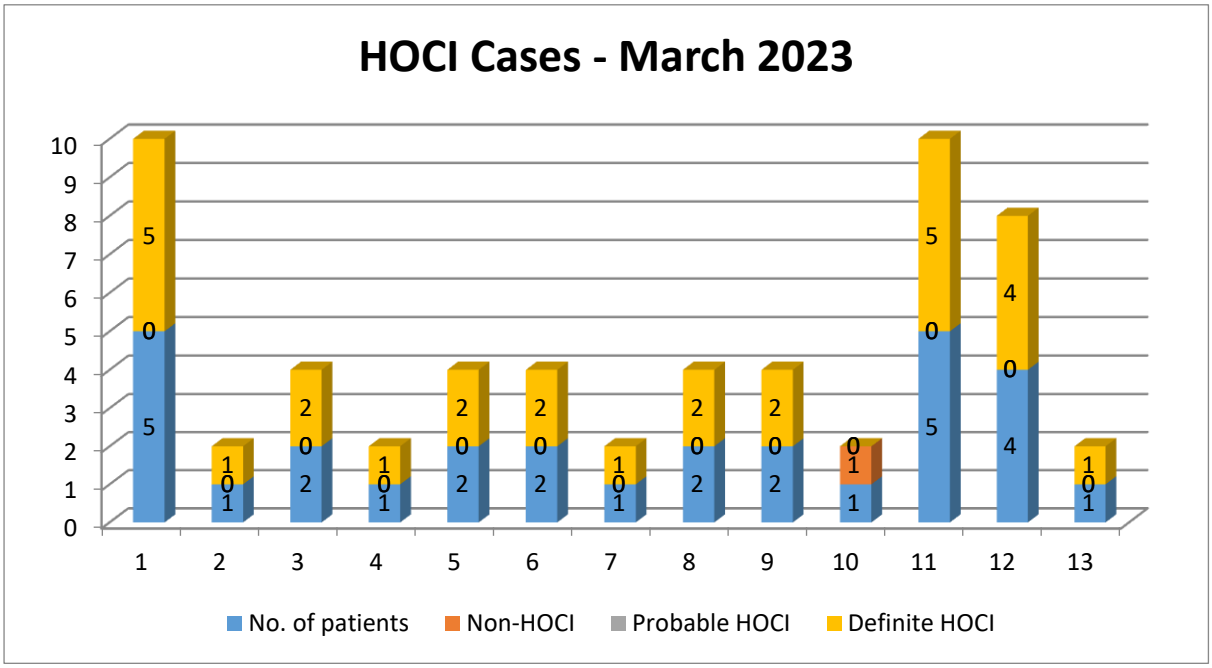


Figure 41. *below illustrates the number of Healthcare-onset COVID-19 Infections in Q1 in wards across the Trust.*

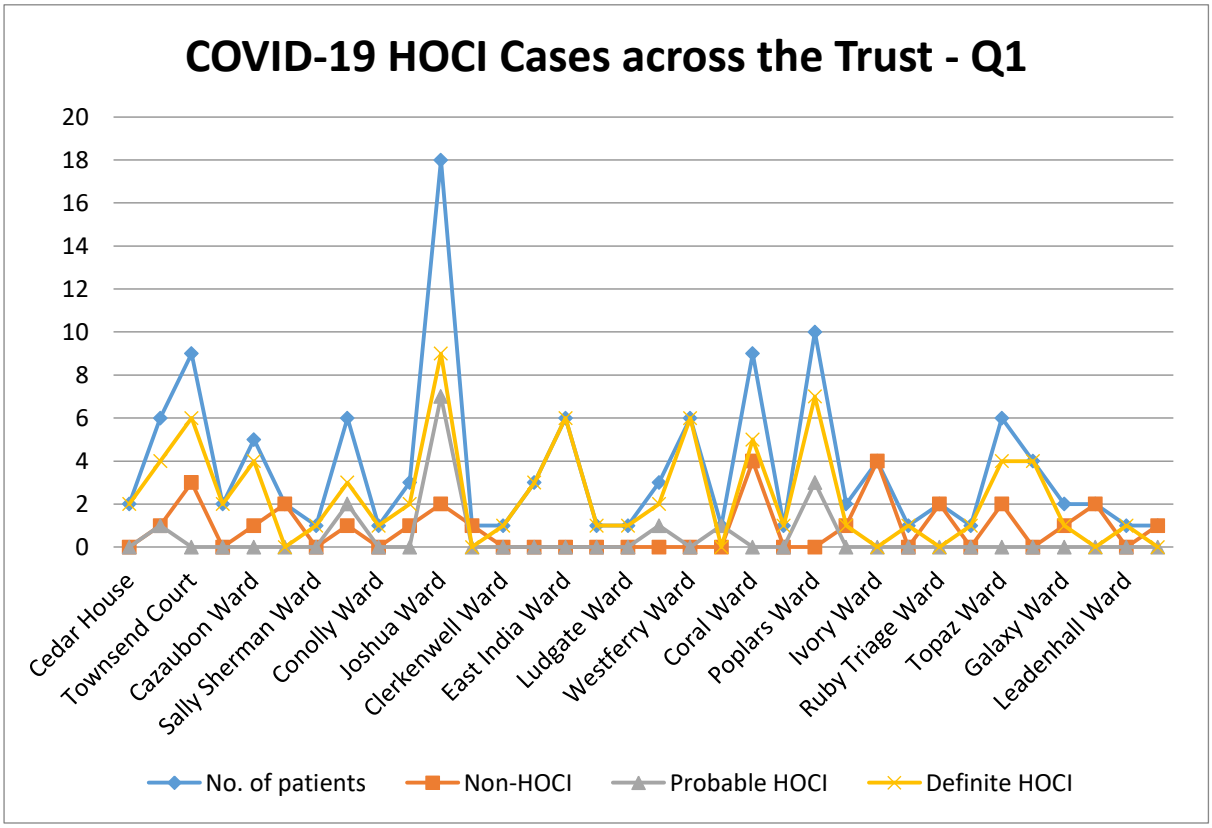


Figure 42. *below illustrates the number of Healthcare-onset COVID-19 Infections in Q2 in wards across the Trust.*

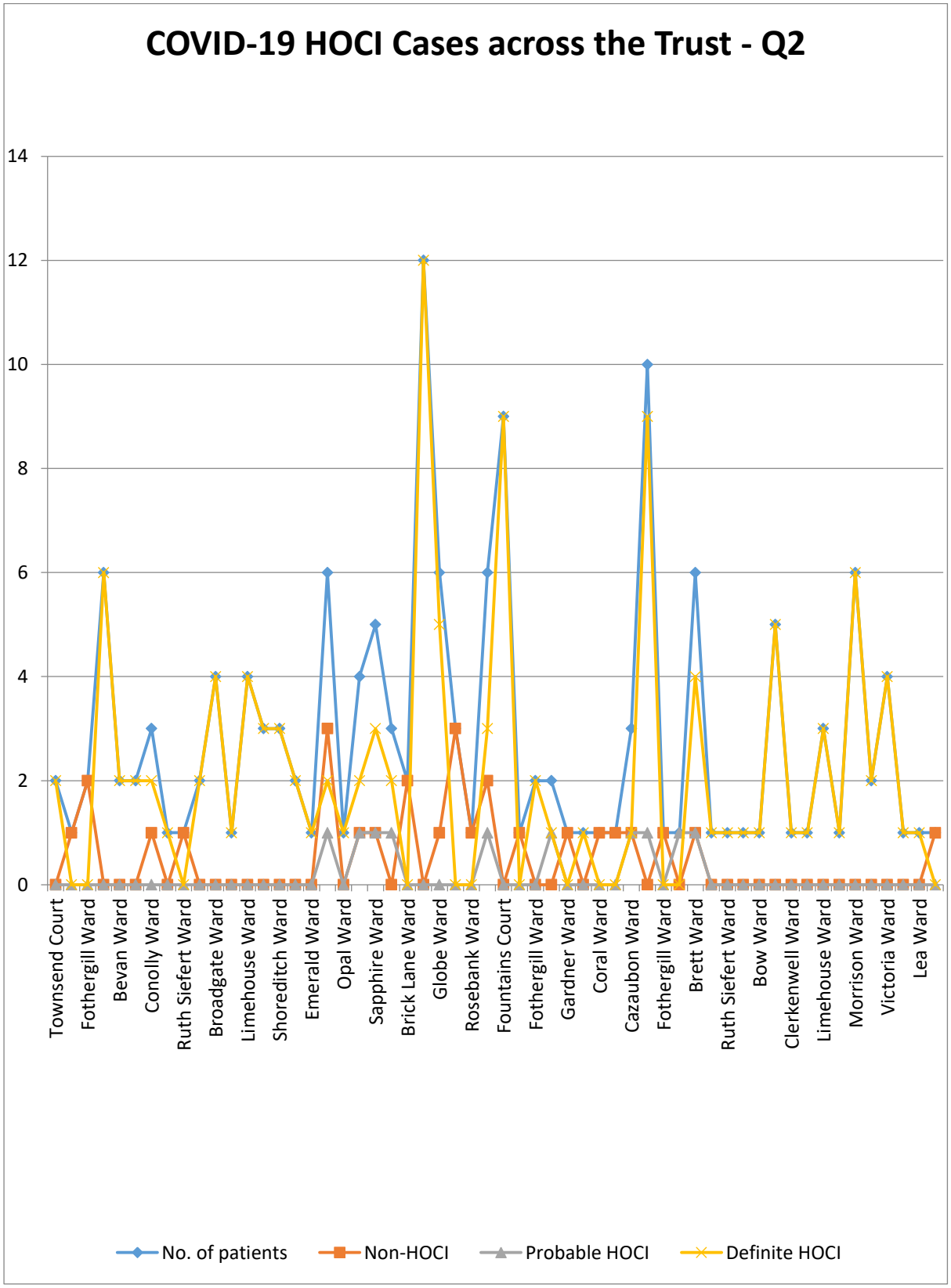


Figure 43. *below illustrates the number of Healthcare-onset COVID-19 Infections in Q3 in wards across the Trust.*

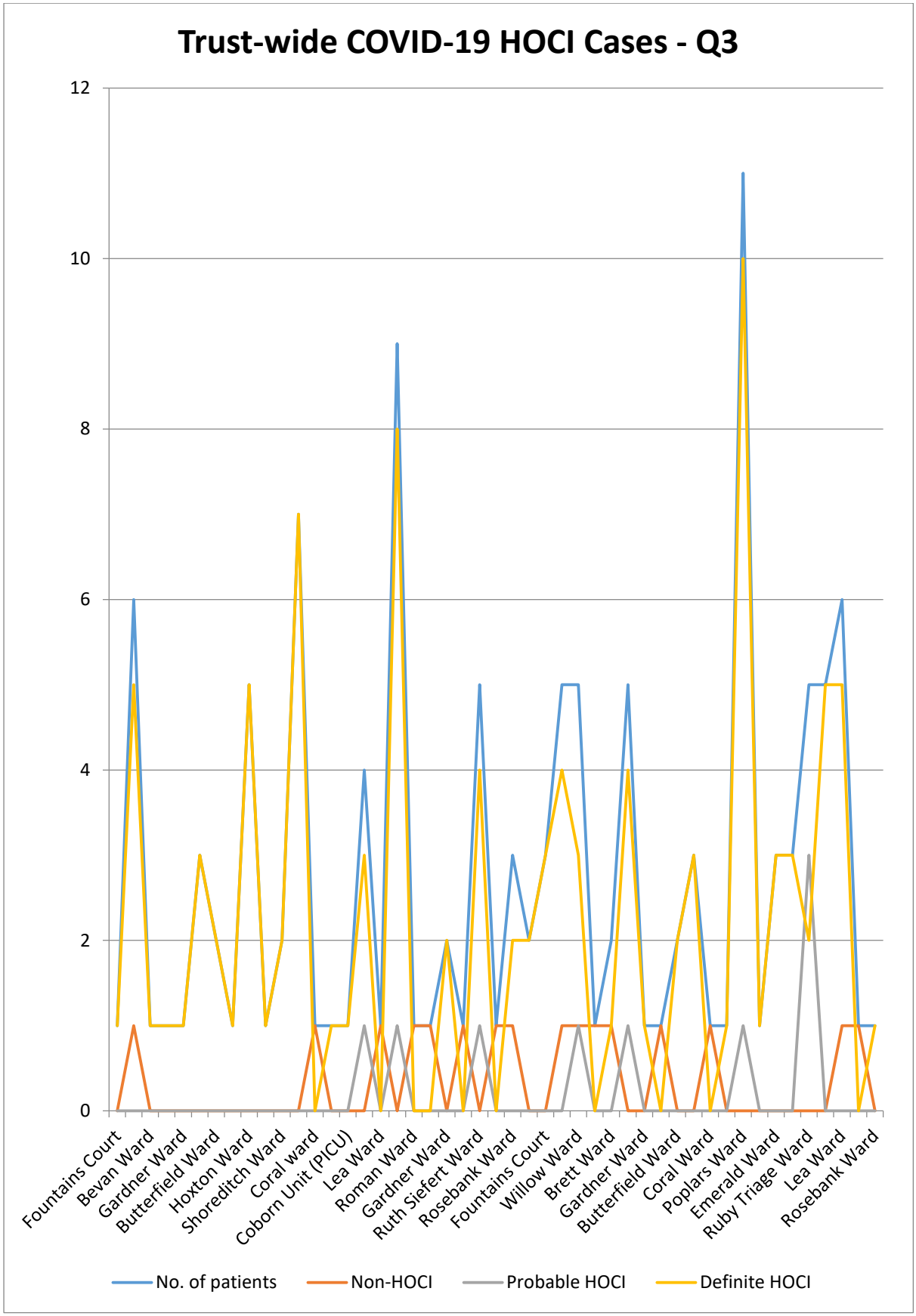


Figure 44. *below illustrates the number of Healthcare-onset COVID-19 Infections in Q4 in wards across the Trust.*

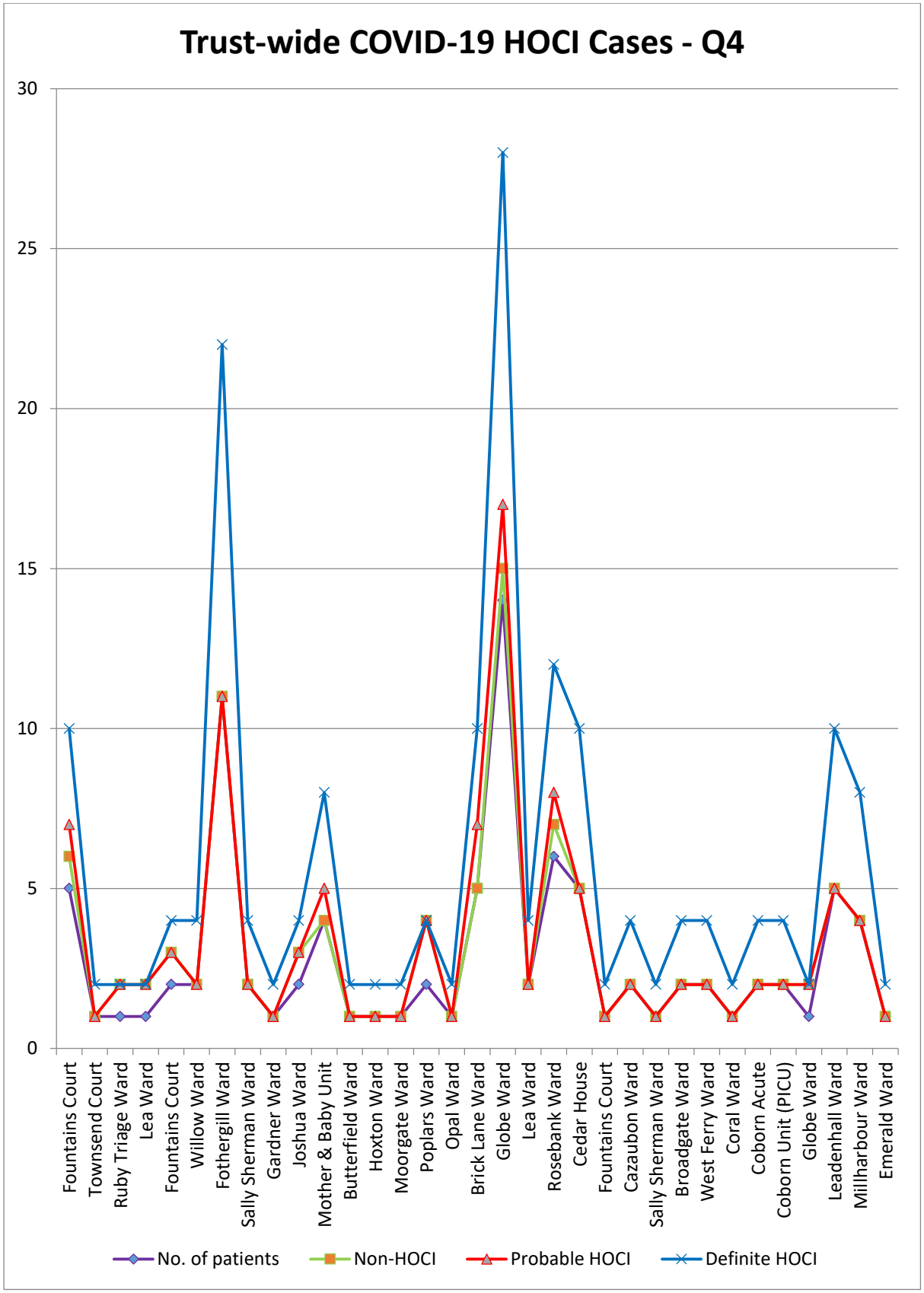
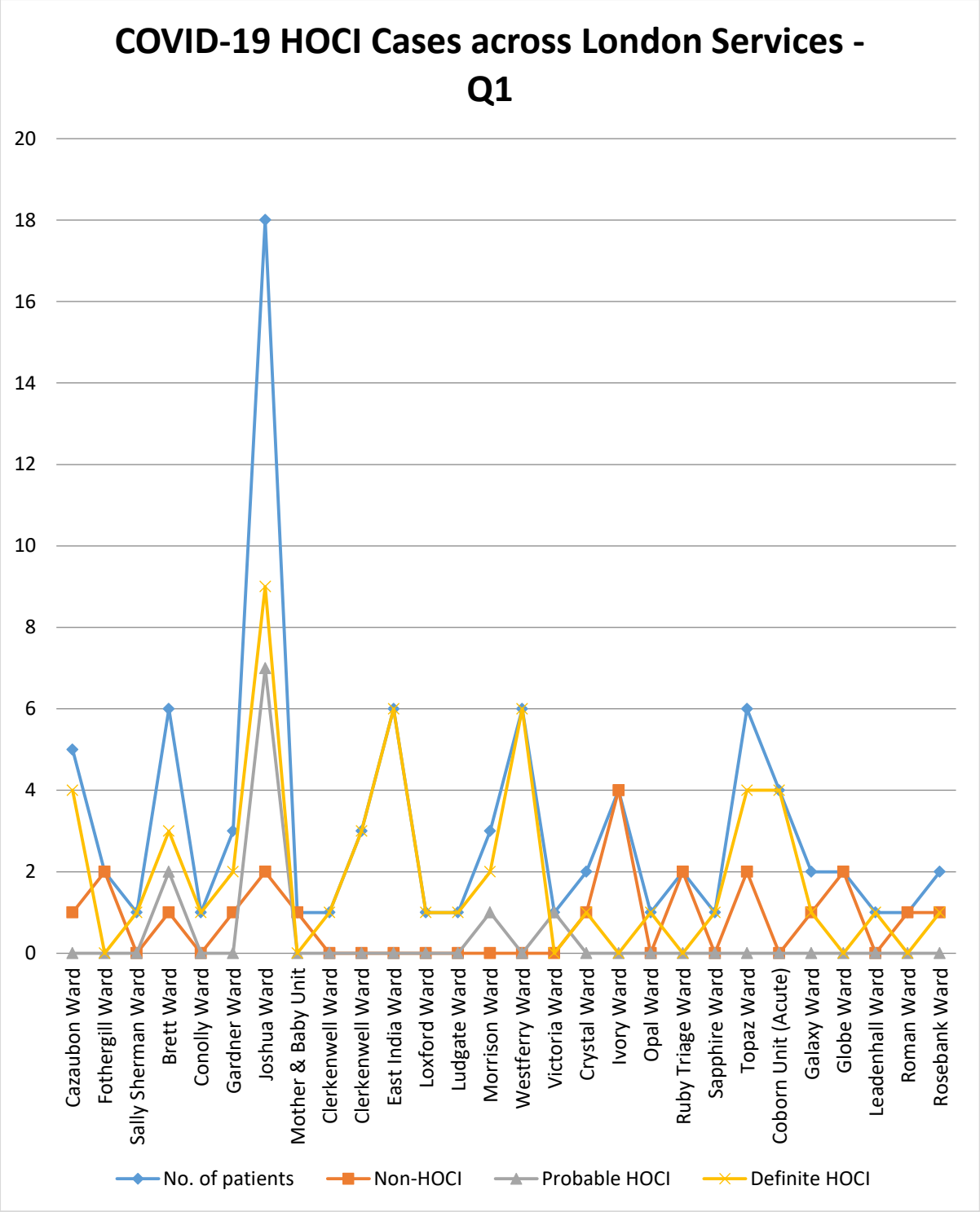
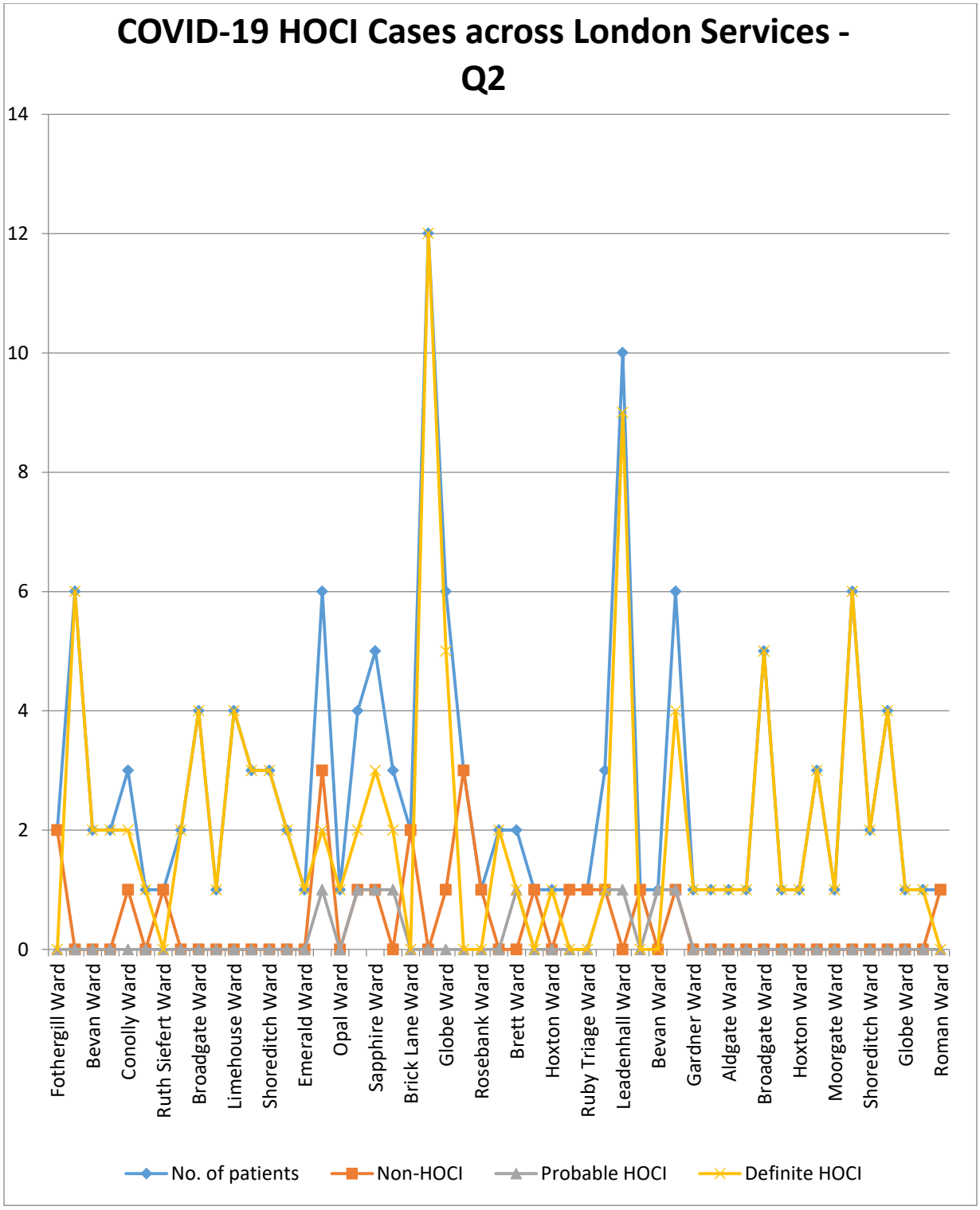


Figure 45. *below displays the number of Healthcare-onset COVID-19 Infections in wards across London Services in Q1.*



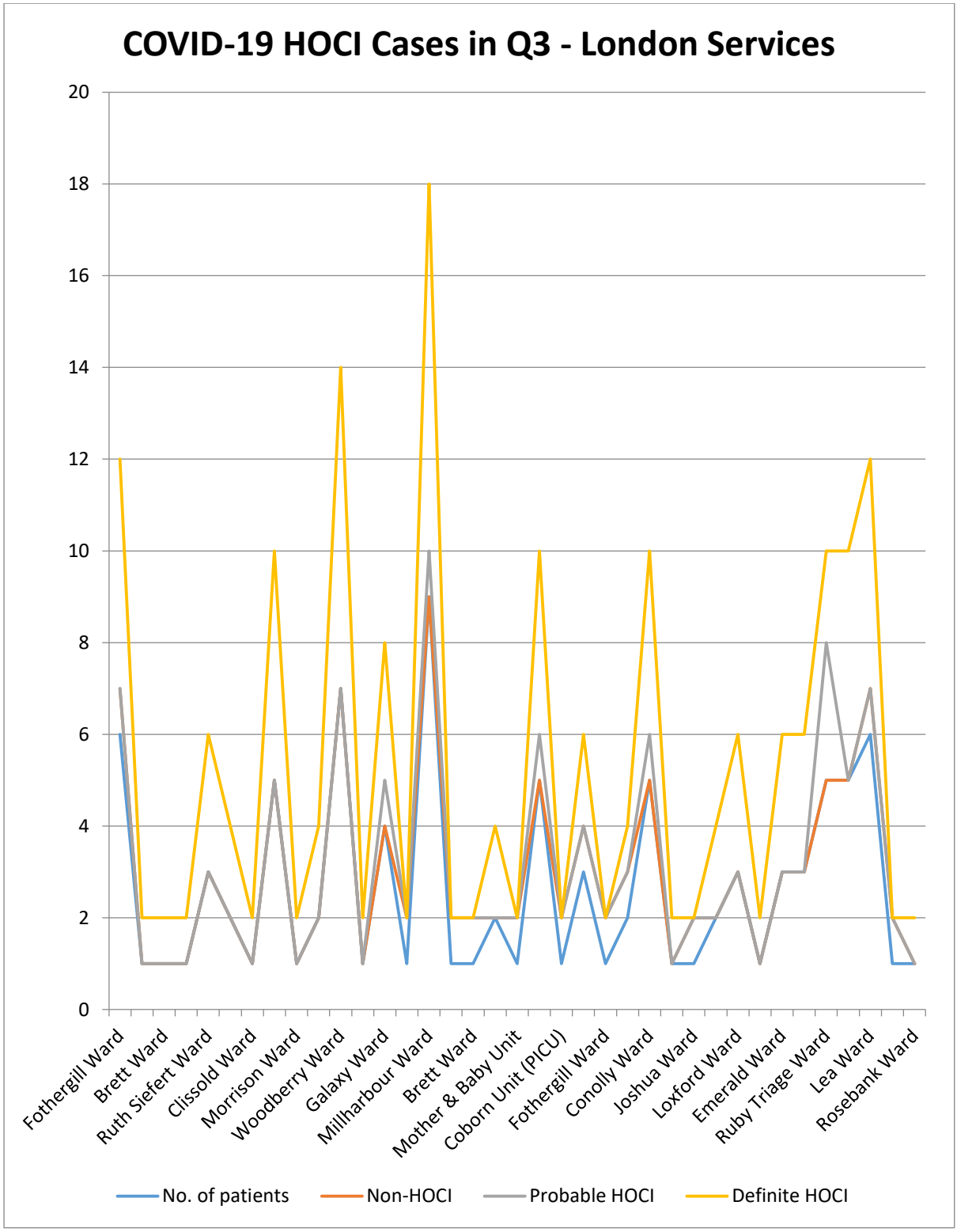
Joshua Ward in City and Hackney had the highest number of COVID-19 cases including the highest number of HOCI cases. This was due to a COVID-19 outbreak on Joshua Ward in April 2022

Figure 46. *below displays the number of Healthcare-onset COVID-19 Infections in wards across London Services in Q2.*



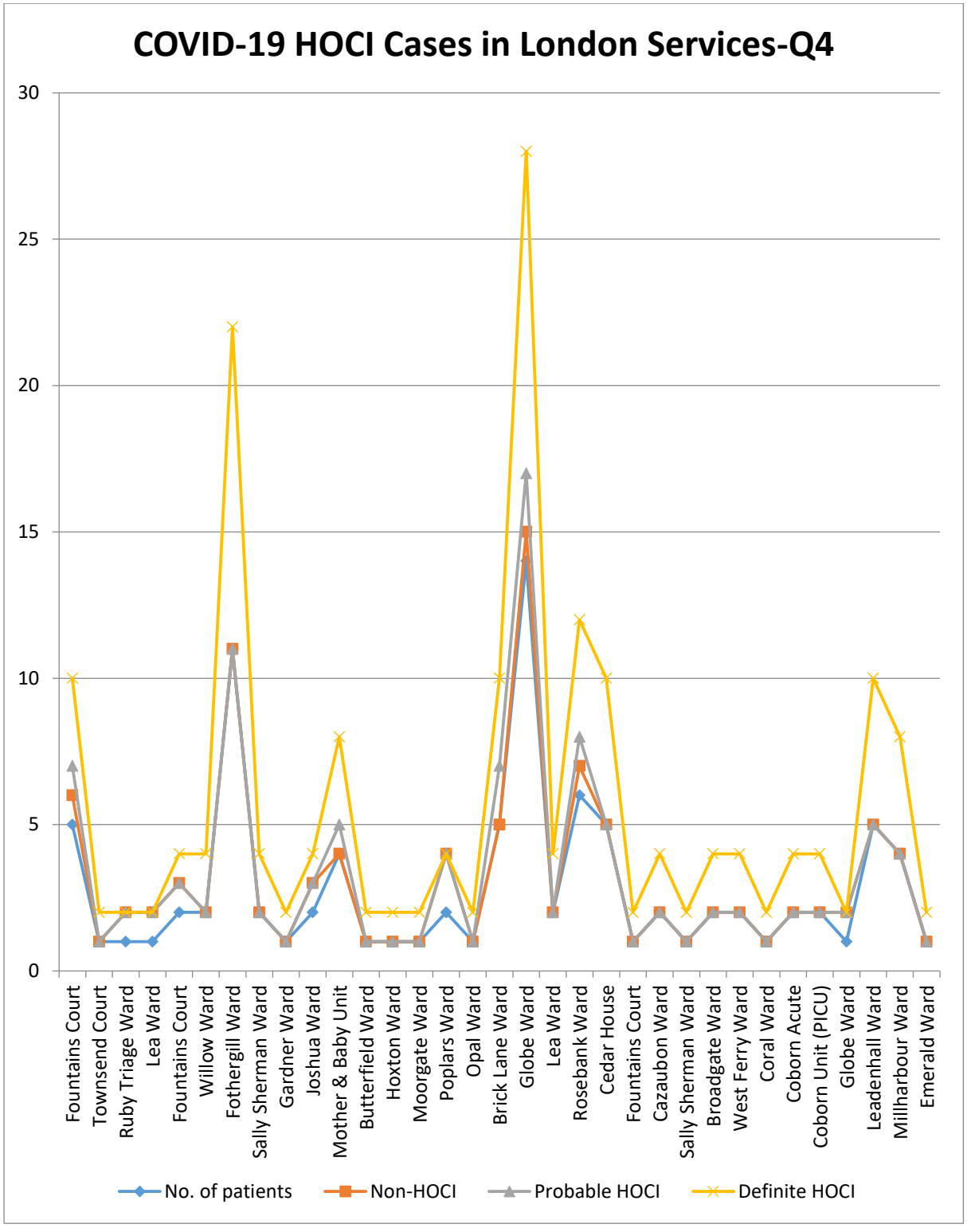
Cazaubon Ward & Leadenhall Ward in Tower Hamlets Directorate had the highest number of COVID-19 cases including the highest number of HOCI cases. This was due to a COVID-19 outbreak on Cazaubon Ward in July 2022 and COVID-19 outbreak on Leadenhall Ward in August 2022.

Figure 47. *below displays the number of Healthcare-onset COVID-19 Infections in wards across London Services in Q3.*



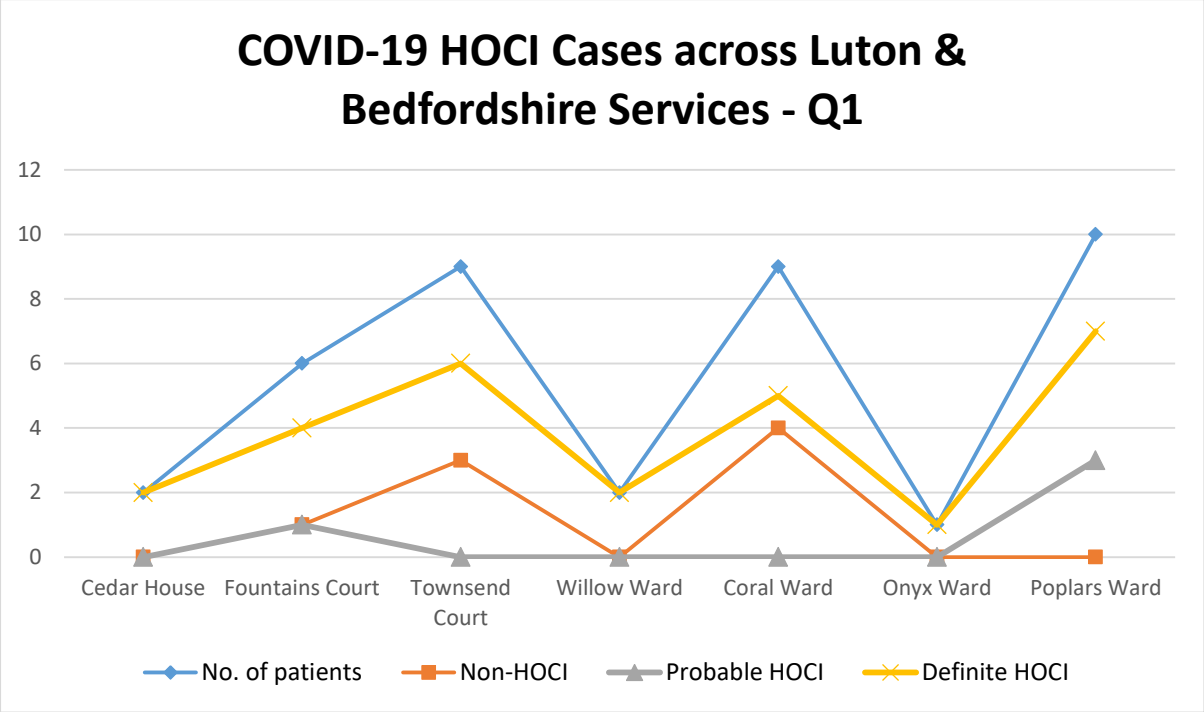
Millhabour Ward in Tower Hamlets Directorate had the highest number of COVID-19 cases including the highest number of HOCI cases. This was due to a COVID-19 outbreak on Millhabour Ward in October 2022.

Figure 48. *below displays the number of Healthcare-onset COVID-19 Infections in wards across London Services in Q4.*



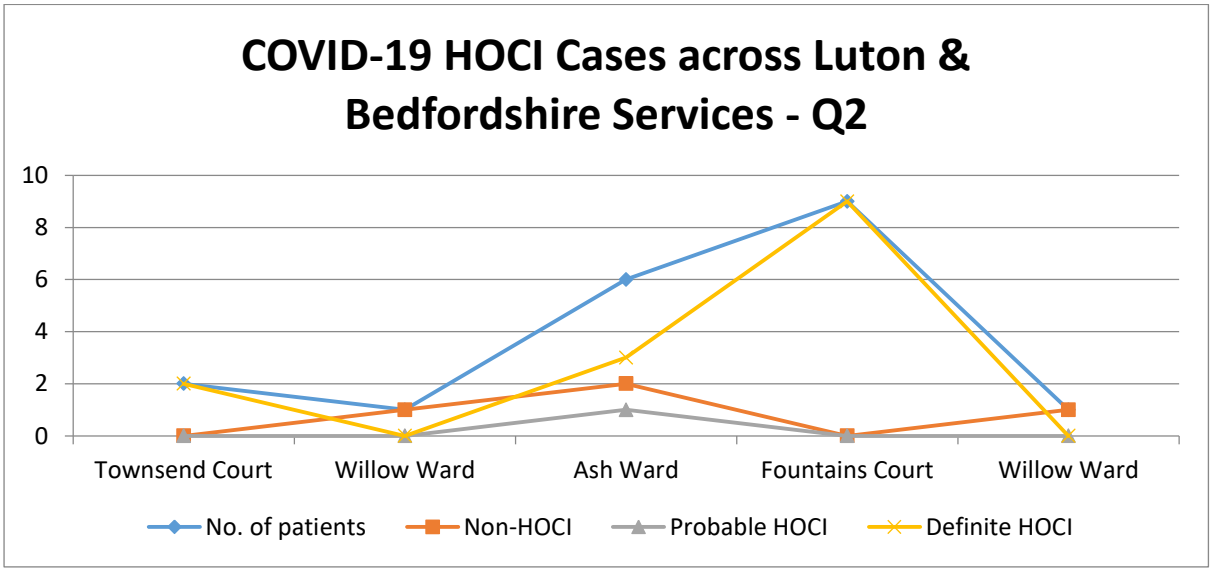
Globe Ward in Tower Hamlets Directorate had the highest number of COVID-19 cases including the highest number of HOCI cases. This was due to a COVID-19 outbreak on Globe Ward in February 2022.

Figure 49. *below displays the number of Healthcare-onset COVID-19 infections in wards across Luton & Bedfordshire in Q1.*



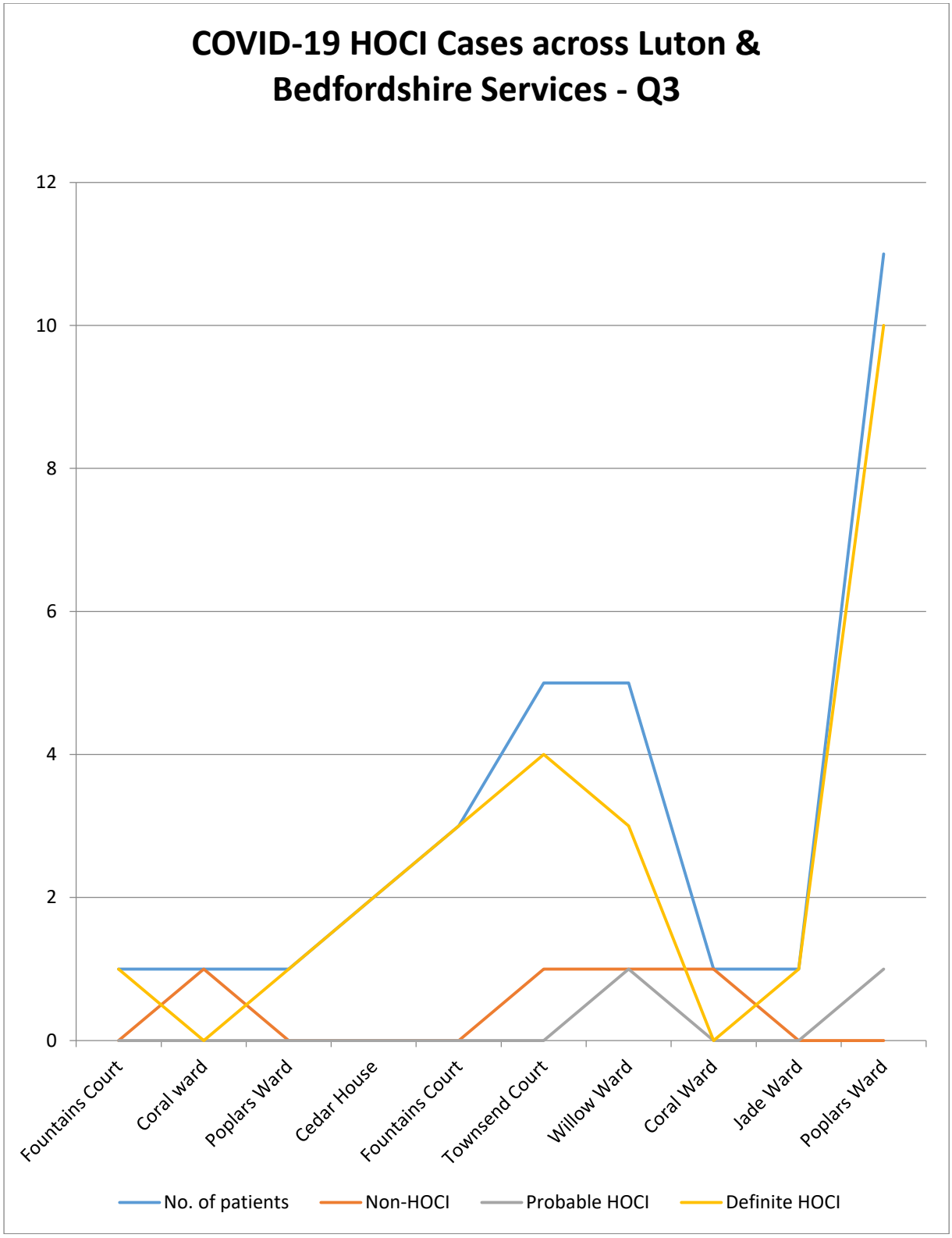
Townsend Court and Poplars Ward had the highest number of patients that were positive for COVID-19 infection including the highest number of HOCI cases. Both wards had two COVID-19 outbreaks within Q1.

Figure 50. *below displays the number of Healthcare-onset COVID-19 infections in wards across Luton & Bedfordshire in Q2.*



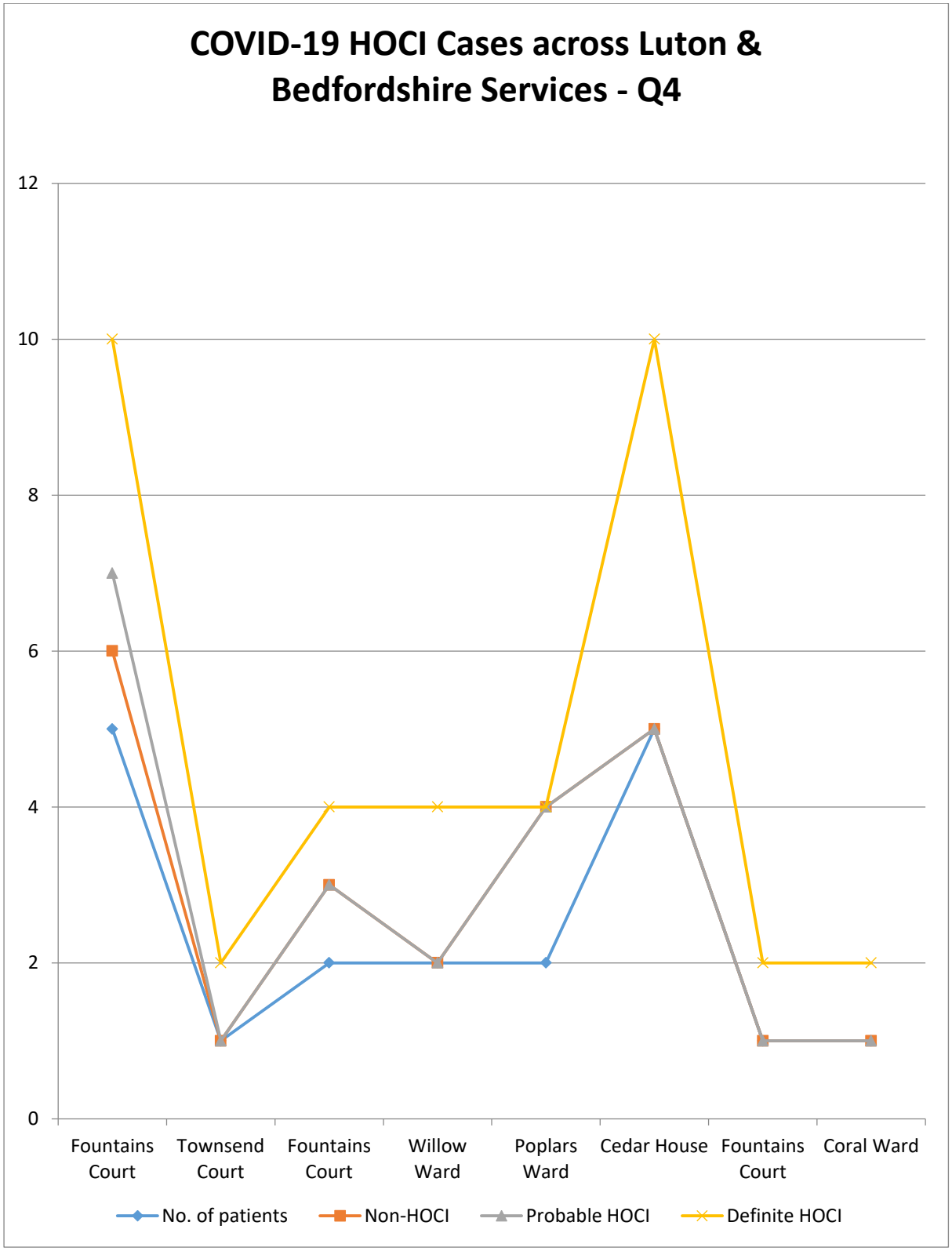
Ash Ward and Fountains Court had the highest number of patients that were positive for COVID-19 infection including the highest number of HOCI cases. Both wards had COVID-19 outbreaks within Q2.

Figure 51. *below displays the number of Healthcare-onset COVID-19 infections in wards across Luton & Bedfordshire in Q3.*



Poplars Ward had the highest number of patients that were positive for COVID-19 infection including the highest number of HOCI cases. This was due to a COVID-19 Outbreak in December.

Figure 52. *below displays the number of Healthcare-onset COVID-19 infections in wards across Luton & Bedfordshire in Q4.*



Fountains Court & Cedar House had the highest number of patients that were positive for COVID-19 infection including the highest number of HOCI cases. This was due to a COVID-19 Outbreak in February.

10.0 HOCI COVID-19 Cases – Levels of Harm

In September 2022, levels of harm monitoring was introduced. Levels of harm monitors if harm was caused to the patient/service-user. Harm is recorded at the onset of COVID-19 infection however due to the nature of COVID-19 infection those affected can go on to develop Long COVID which may not be apparent during the initial stages of COVID-19 infection.

Figure 53. *below displays the types of HOCI COVID-19 - Levels of Harm*

Level of Harm	*Definition criteria*
No Harm	Asymptomatic
Low Harm	Low level support - oxygen therapy
Medium Harm	Admitted to ITU
High Harm	Death due to COVID-19 on Death Certification

Figure 54. *shows the HOCI COVID-19 Cases - Levels of Harm for Q3.*

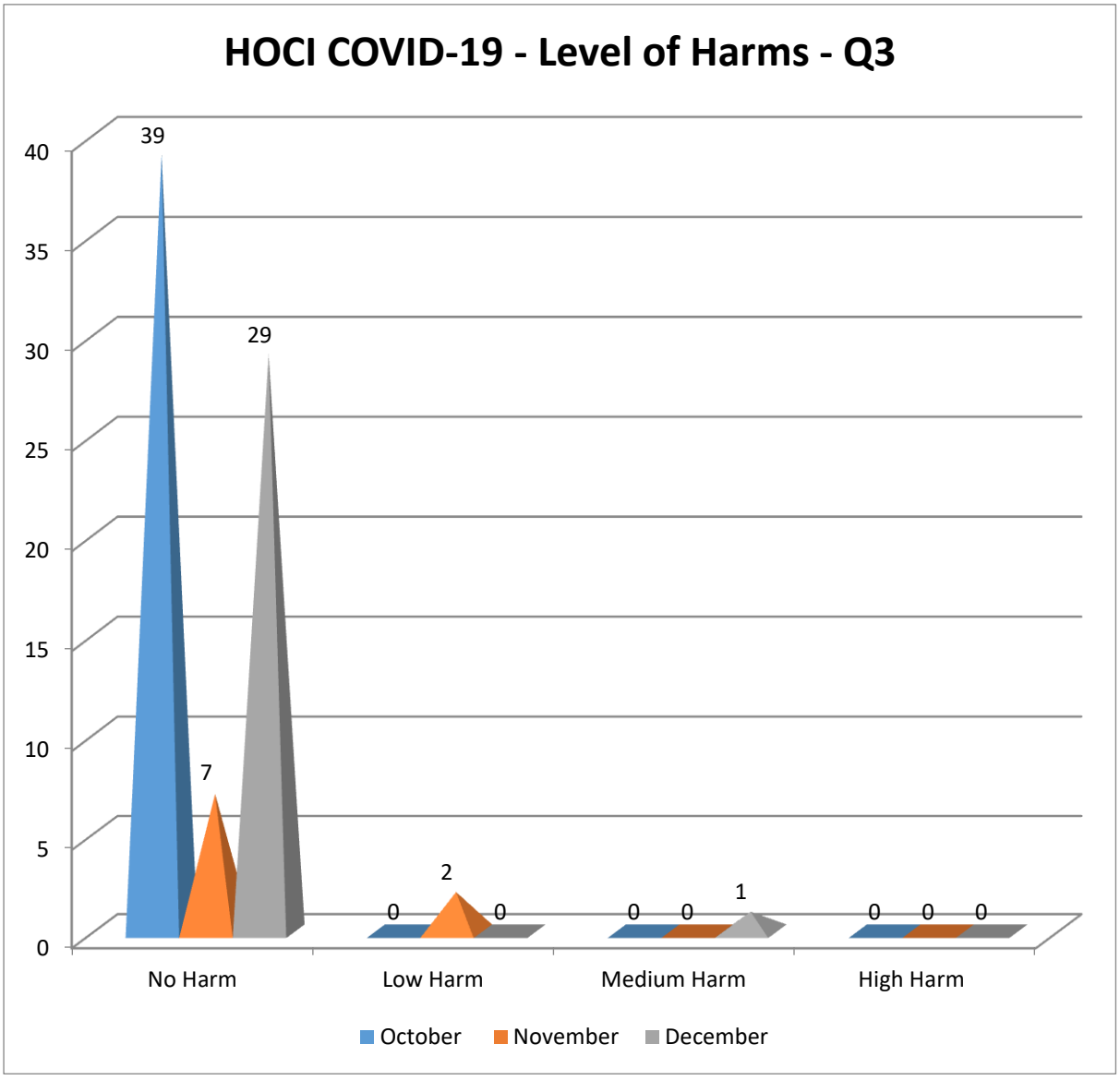


Figure 55. Shows *the HOCI COVID-19 Cases - Levels of Harm for Q4.*

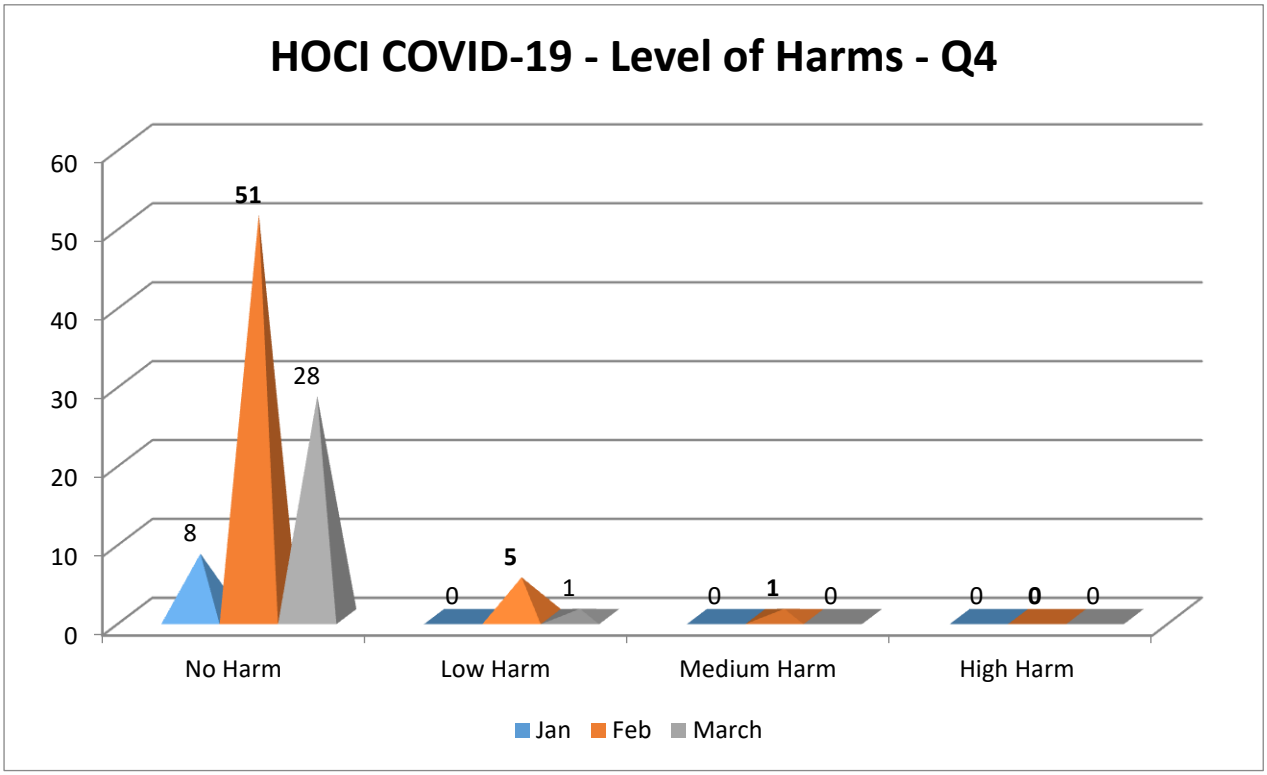


Figure 56. *Displays a breakdown of COVID-19 harm by ward for Q3.*

Month	***Ward***	***Level of harm***
November	Fountains Court	Low harm
	Fountains Court	Low harm
	Ruth Siefert Ward	Low harm
December	Rosebank Ward	Low harm
	Ruby Triage Ward	Low harm
	Ruby Triage Ward	Low harm
	Emerald Ward	Medium harm
	Poplars Ward	Low harm
	Poplars Ward	Low harm
	Willow Ward	Low harm
	Fountains Court	Low harm

Figure 57. *Displays a breakdown of COVID-19 harm by ward for Q4.*

Month	***Ward***	***Level of harm***
Febuaury	Brick Lane Ward	Low harm
	Fothergill Ward	Low harm
	Fothergill Ward	Low harm
	Fothergill Ward	Low harm
	Globe Ward	Medium harm
	Williow Ward	Low harm
March	Millharbour Ward	Low harm

During 2022-2023, there 16 instances of low harm & 2x instances of medium harm reported. All patients recovered successfully. During 2022-2023 there were no patient deaths related

to COVID-19 infection. This is a decrease from the previous year where 2 patient deaths were related to COVID-19 infection. The success of the vaccination programme, herd immunity and good IPC practice were all contributing factors to achieving zero patient's deaths from COVID-19 infection this year.

11.0 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 Trust intranet.

11.1 COVID-19 Outbreaks

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 UKSHA guidance. In addition, a post infection review or root cause 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 UKSHA Test and Trace processes (in case of COVID-19).

The Infection Prevention and Control Board Assurance Framework is completed for COVID-19 hospital transmissions and the Infection Prevention and Control Policy on Outbreak Management for COVID-19 is followed. A 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 UKSHA are completed on a regular basis.

This section of the report focuses on the reviews and findings from the outbreaks, the lessons learnt and changes made or measures reinforced 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.

Figure 58. *below illustrates a breakdown of COVID-19 Outbreaks across the Trust in 2022-2023 by quarter:*

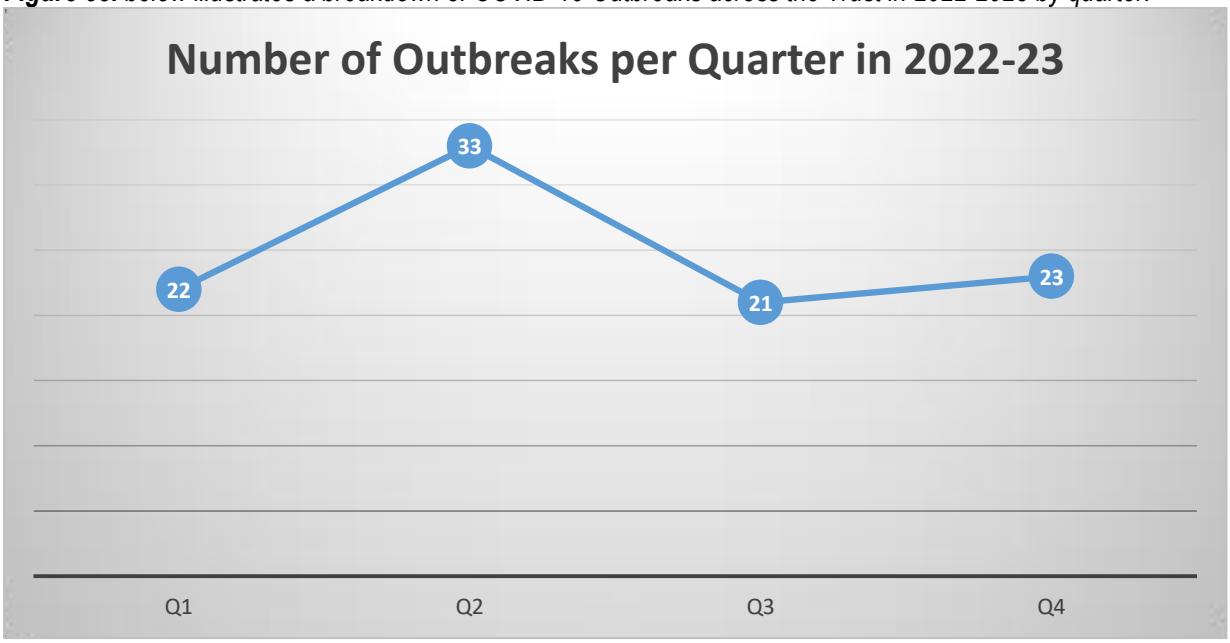
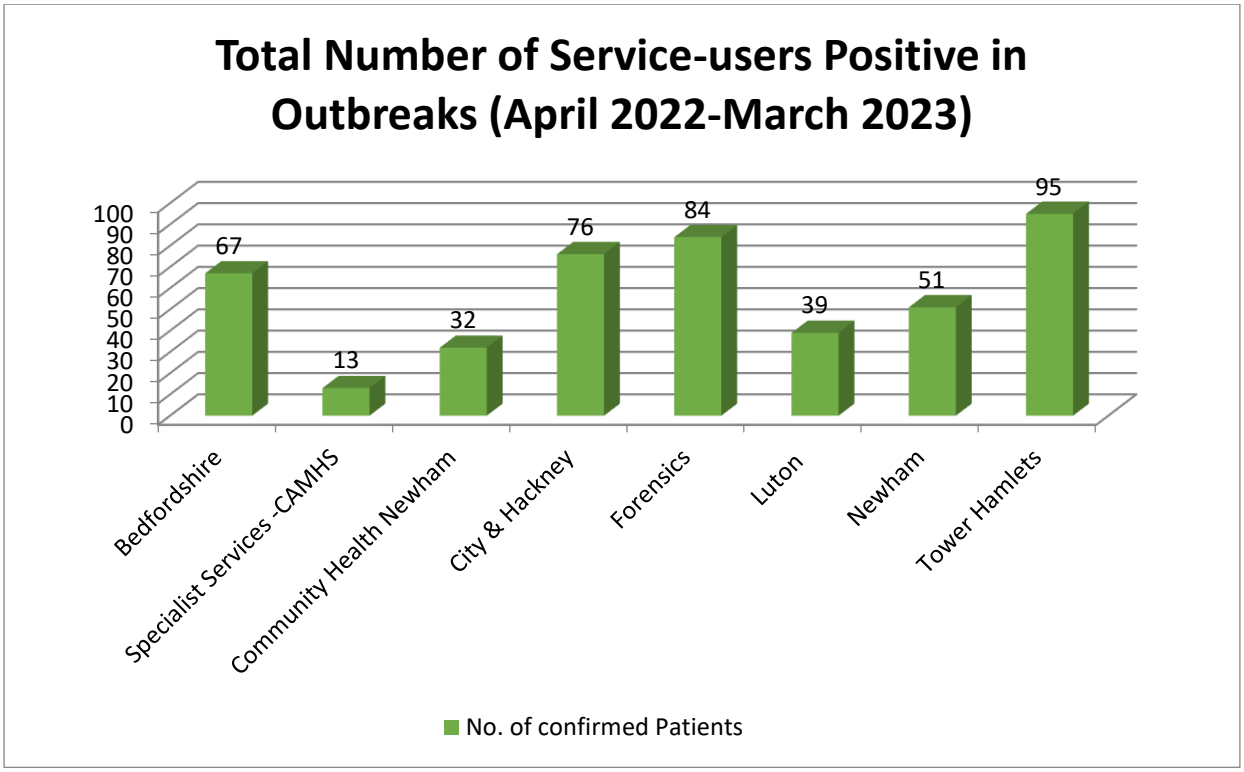


Figure 59. *below displays a breakdown of COVID-19 Outbreaks across the Trust in 2022-2023.*

Directorate	Ward	No. of confirmed Patients	No of confirmed Staff	HOCI 3-7 days	HOCI 8-14 days	HOCI 15 days +	Total cases	Date declared	Date closed
City & Hackney	Brett Ward	6	1	0	0	6	7	29/03/2022	28/04/2022
Newham	Opal Ward	7	1	0	0	7	8	29/03/2022	07/04/2022
Luton	Jade Ward	4	4	1	0	3	9	29/03/2022	08/04/2022
Luton	Onyx Ward	1	2	0	0	1	3	05/04/2022	14/04/2022
Luton	Poplars Ward	8	0	0	3	5	9	06/04/2022	26/04/2022
CAMHS	Galaxy Ward	2	0	0	0	2	2	07/04/2022	18/04/2022
Bedfordshire	Willow Ward	2	0	0	0	2	2	07/04/2022	20/04/2022
City & Hackney	Joshua Ward	12	1	0	6	6	13	11/04/2022	04/05/2022
Forensics	Morrison Ward	2	0	0	1	1	2	11/04/2022	19/04/2022
Luton	Fountain's Court	6	1	1	1	4	7	19/04/2022	27/04/2022
Bedfordshire	Townsend Court	3	0	1	0	2	3	13/05/2022	25/05/2022
Forensics	Clerkenwell Ward	4	1	0	0	4	5	04/06/2022	16/06/2022
Luton	Coral Ward	5	1	0	0	5	6	08/06/2022	19/06/2022
Specialist Services (CAMHS)	Coborn (Acute)	3	1	0	0	3	4	10/06/2022	23/06/2022
Newham	Topaz Ward	4	2	0	0	4	6	17/06/2022	02/07/2022
Forensics	West Ferry Ward	6	2	0	0	6	8	22/06/2022	05/07/2022
Forensics	East India Ward	6	3	0	0	6	9	25/06/2022	08/07/2022
Bedfordshire	Townsend Court	7	9	0	0	7	16	27/06/2022	18/07/2022
Luton	Poplars Ward	2	0	0	0	2	2	24/06/2022	02/07/2022
City & Hackney	Brett Ward	3	2	0	0	3	5	29/06/2022	Closed
Tower Hamlets	Cazaubon Ward	12	2	0	0	12	15	30/06/2022	18/07/2022
City & Hackney	Joshua Ward	5	2	0	1	4	7	29/06/2022	12/07/2022
Newham	Topaz Ward	4	2	0	0	4	6	17/06/2022	19/07/2022
Forensics	West Ferry Ward	6	2	0	0	6	8	22/06/2022	23/07/2022
Forensics	East India Ward	6	3	0	0	6	9	25/06/2022	28/07/2022
Bedfordshire	Townsend Court (Jun)	7	9	1	0	6	16	27/06/2022	08/08/2022
Luton	Poplars Ward (Jun)	2	0	0	0	2	2	24/06/2022	22/07/2022
City & Hackney	Brett Ward (Jun)	3	2	0	0	3	5	29/06/2022	31/07/2022
Tower Hamlets	Cazaubon Ward (Jun)	12	3	0	0	12	15	30/06/2022	03/08/2022
City & Hackney	Joshua Ward (Jun)	5	2	0	1	4	7	29/06/2022	29/07/2022
CHN	Sally Sherman Ward	6	0	0	0	6	6	05/07/2022	19/08/2022
Tower Hamlets	Globe Ward	5	0	0	0	5	5	07/07/2022	09/08/2022
Newham	Crystal Ward	3	0	0	0	3	3	07/07/2022	11/08/2022
Forensics	Limehouse Ward	4	2	0	0	4	6	07/07/2022	09/08/2022
Forensics	Shoreditch Ward	3	1	0	0	3	4	09/07/2022	07/08/2022
Forensics	Ludgate Ward	3	2	0	0	3	5	08/07/2022	06/08/2022
Forensics	Aldgate Ward	2	2	0	0	2	4	12/07/2022	09/08/2022
City & Hackney	Bevan Ward	2	2	0	0	2	4	11/07/2022	08/08/2022
Newham	Sapphire Ward	5	2	1	1	3	7	08/07/2022	13/08/2022
Forensics	Broadgate Ward	4	1	0	0	4	5	12/07/2022	10/08/2022
Newham	Ivory Ward	5	2	1	1	2	6	16/07/2022	15/08/2022
Newham	Ruby Ward	4	0	1	1	2	4	17/07/2022	16/08/2022
Newham	Topaz Ward	3	1	0	1	2	4	20/07/2022	18/08/2022
Bedfordshire	Fountains Court	9	0	0	0	9	9	07/08/2022	16/09/2022
Tower Hamlets	Cazaubon Ward (Aug)	3	0	1	1	1	3	08/07/2022	04/09/2022
Tower Hamlets	Leadenhall Ward	10	1	0	1	9	11	10/08/2022	17/09/2022
Bedfordshire	Ash Ward	6	5	2	1	3	11	10/08/2022	13/09/2022
City & Hackney	Brett Ward (Aug)	2	1	0	1	1	3	11/08/2022	08/09/2022

CHN	Fothergill Ward	2	1	0	0	2	3	13/08/2022	10/09/2022
Forensics	Limehouse Ward	3	0	0	0	2	3	01/09/2022	29/09/2022
Forensics	Morrison Ward	6	1	0	0	6	7	12/09/2022	17/10/2022
Forensics	Victoria Ward	4	0	0	0	4	4	12/09/2022	10/10/2022
Forensics	Broadgate Ward	5	0	0	0	5	5	18/09/2022	16/10/2022
City & Hackney	Brett Ward	6	5	1	1	5	11	28/09/2022	Continued to Q3
City & Hackney	Bevan Ward	2	0	0	1	1	2	03/10/2022	Continued to Q3
City & Hackney	Brett Ward	7	6	1	1	5	13	28/09/2022	28/10/2012
City & Hackney	Bevan Ward	2	0	0	1	1	2	03/10/2022	28/10/2012
City & Hackney	Ruth Siefert Ward (Oct)	4	0	0	0	4	4	04/10/2022	01/11/2022
Forensics	Woodberry Ward	7	5	0	0	7	12	07/10/2022	10/11/2022
Forensics	Hoxton Ward	6	1	0	0	6	7	08/10/2022	10/11/2022
Tower Hamlets	Millhabour Ward	9	4	0	1	8	13	17/10/2022	20/11/2022
Specialist Services (CAMHS)	Galaxy Ward	4	1	0	1	3	5	17/10/2022	16/11/2022
CHN	Forthergill Ward	6	3	0	1	5	9	25/10/2022	26/11/2022
City & Hackney	Ruth Seifert Ward (Nov)	5	1	0	1	4	6	18/11/2022	20/12/2022
Tower Hamlets	Rosebank Ward	4	1	1	0	3	5	30/11/2022	31/12/2002
City & Hackney	Gardner Ward	3	1	0	0	3	4	01/12/2022	29/12/2022
Luton	Poplars Ward	11	5	0	1	10	16	06/12/2022	17/01/2023
Tower Hamlets	Lea Ward	6	1	1	0	5	7	07/12/2022	19/01/2023
City & Hackney	Conolly Ward	5	0	0	1	4	5	14/12/2022	14/01/2023
Bedfordshire	Fountains Court	9	2	1	0	8	11	16/12/2022	29/01/2023
Bedfordshire	Willow Ward	5	2	1	1	1	3	8	19/12/2022
Newham	Topaz Ward	5	0	0	0	0	5	5	23/12/2022
Newham	Emerald Ward	3	0	0	0	0	3	3	28/12/2022
Newham	Opal Ward	3	0	0	0	0	3	3	28/12/2022
Newham	Ruby Triage Ward	5	3	0	0	3	2	8	28/12/2022
Bedfordshire	Cedar House	2	1	0	0	0	2	3	30/12/2022
Bedfordshire	Fountains Court (Dec)	8	2	0	1	0	7	10	16/12/2022
Bedfordshire	Fountains Court (Jan	4	0	0	1	1	2	4	18/01/2023
Tower Hamlets	Globe Ward	14	4	1	1	2	11	19	10/02/2023
Bedfordshire	Fountains Court [Feb]	2	0	0	1	0	1	2	20/02/2023
CHN	Fothergill Ward	11	0	0	0	0	11	11	14/02/2023
Tower Hamlets	Brick Lane Ward	5	1	0	0	2	3	6	13/02/2023
CHN	Sally Sherman Ward	3	0	0	0	0	3	3	20/02/2023
Tower Hamlets	Rosebank Ward	7	3	1	1	1	5	11	17/02/2023
City & Hackney	Mother & Baby Unit	4	5	0	0	1	3	9	27/02/2023
Tower Hamlets	Leadenhall Ward	4	0	0	0	0	4	4	06/03/2023
Tower Hamlets	Millharbour Ward	4	1	0	0	0	4	5	02/03/2023
Forensics	West Ferry Ward	2	0	0	0	0	2	2	07/03/2023
CHN	Cazaubon Ward	2	0	0	0	0	2	2	09/03/2023
Specialist Services (CAMHS)	Coborn Acute	2	0	0	0	0	2	2	13/03/2023
Specialist Services (CAMHS)	Coborn Unit (PICU)	2	1	0	0	0	2	3	13/03/2023
Forensics	Broadgate Ward	2	2	0	0	0	2	2	17/03/2023
Bedfordshire	Cedar House	5	1	0	0	0	5	6	23/03/2023

Figure 60. *below illustrates a breakdown of service-users that tested positive during outbreaks across the Trust in 2022-2023 by directorate.*



Tower Hamlets had the highest number of confirmed COVID-19 patient cases with 95 patients involved in outbreaks, Forensics had 84 patients involved in outbreaks followed by City & Hackney with 76. This was reflective of the prevalence of COVID-19 in the community as reported by UKSHA. This is in comparison to last years' data, where Newham had the highest number of confirmed COVID-19 patients and highest number of outbreaks.

11.2 Root Cause Analysis 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 identified 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 increased 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.

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 meetings. The review process is carried out using a locally agreed RCA document/tool. This document was revised several times to help capture more relevant COVID-19 information related to contributing factors, in line with updates from UKSHA guidance.

RCA investigations were undertaken for index cases related to 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 individual teams. A breakdown of themes collated from RCA reviews are shown below.

Figure 61. *below shows a breakdown of themes identified Root Cause Analysis reviews in 2022-2023.*

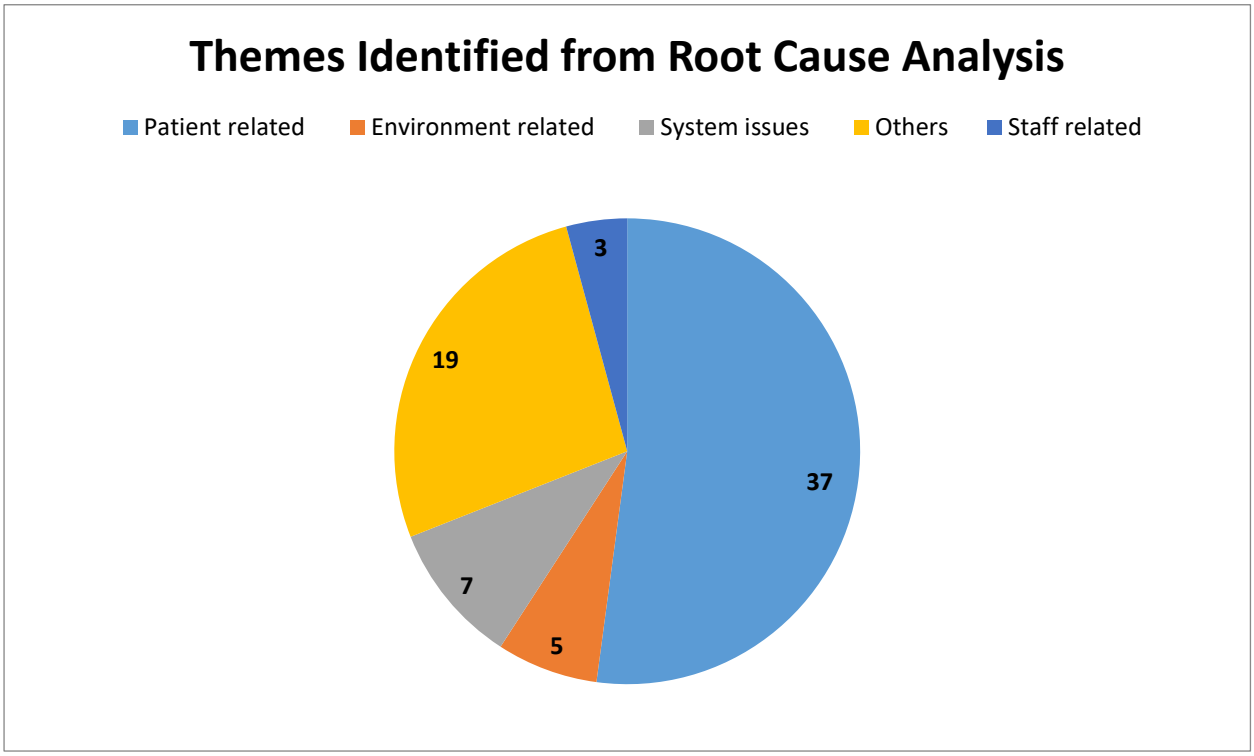


Figure 62. *below shows common factors of the environmental theme identified from RCA reviews.*

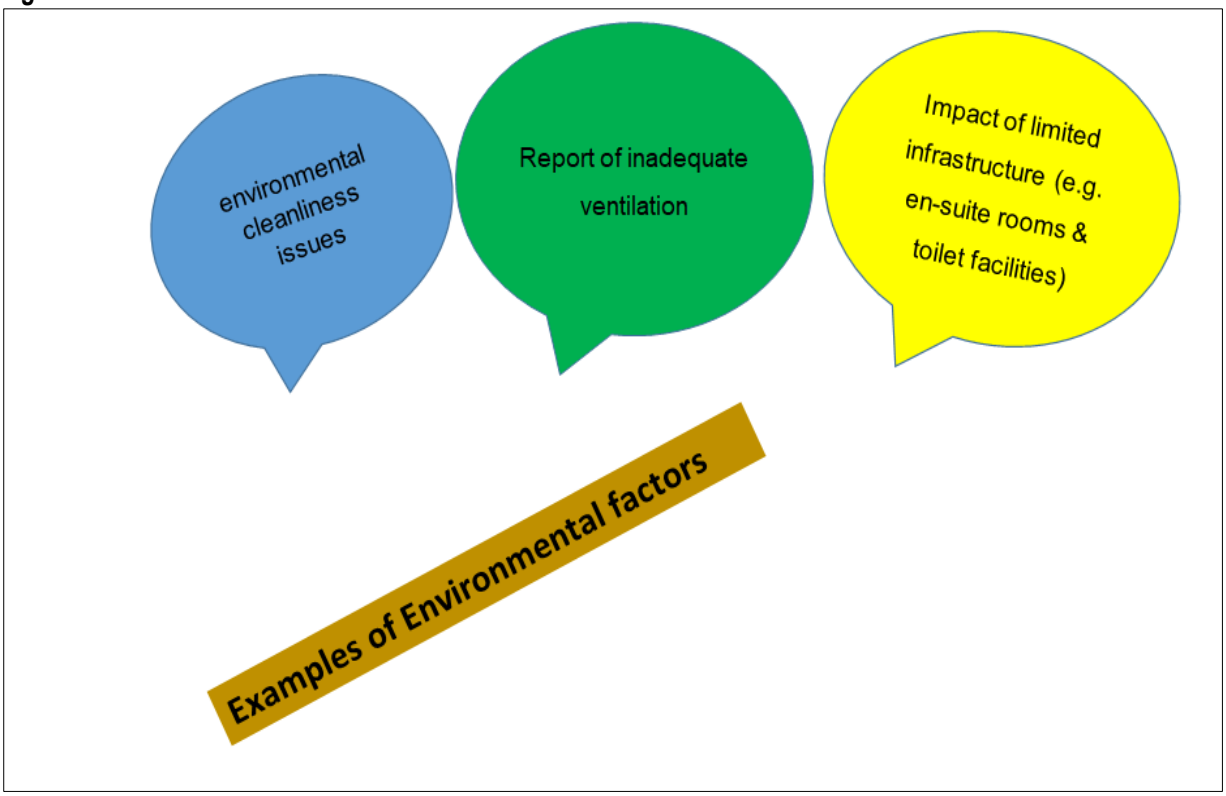


Figure 63. *below shows common factors of the patient-related theme identified from RCA reviews.*

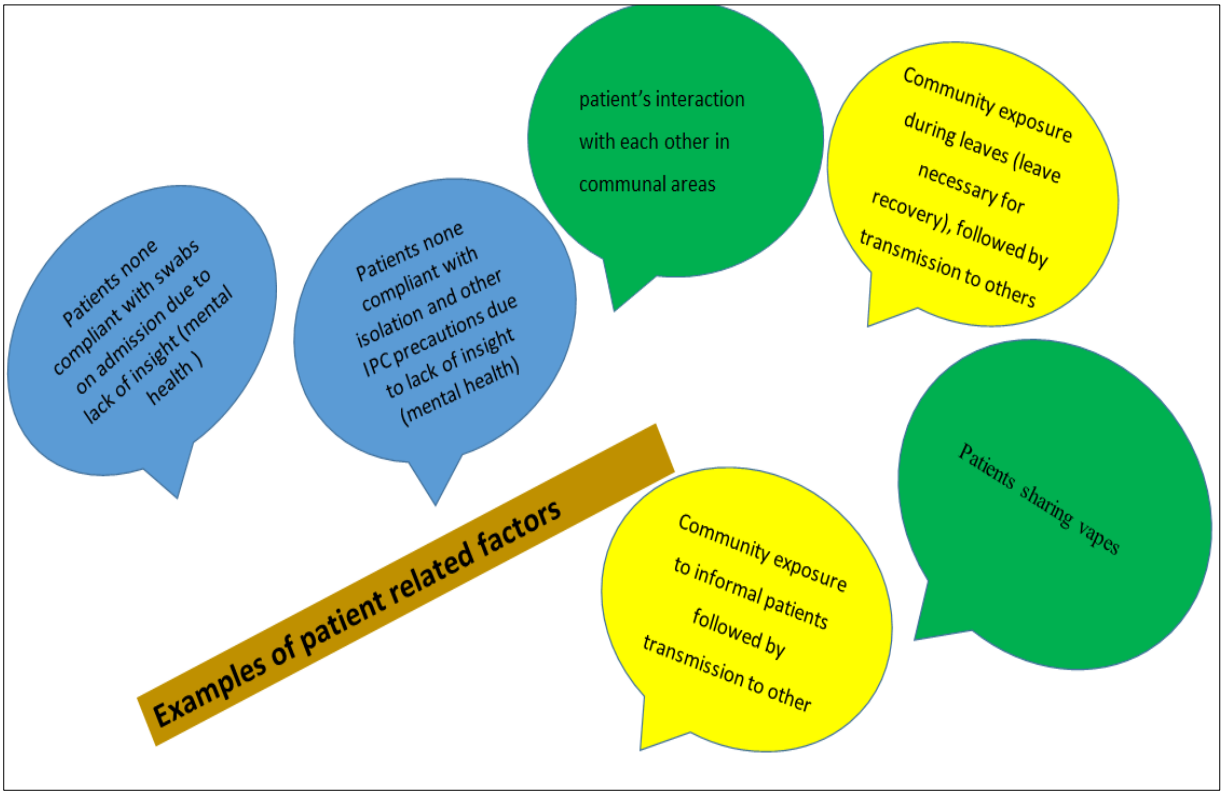


Figure 64. *below shows common factors of the staff-related theme identified from RCA reviews.*

Figure 65. *below shows common factors of the system-issue theme identified from RCA reviews.*

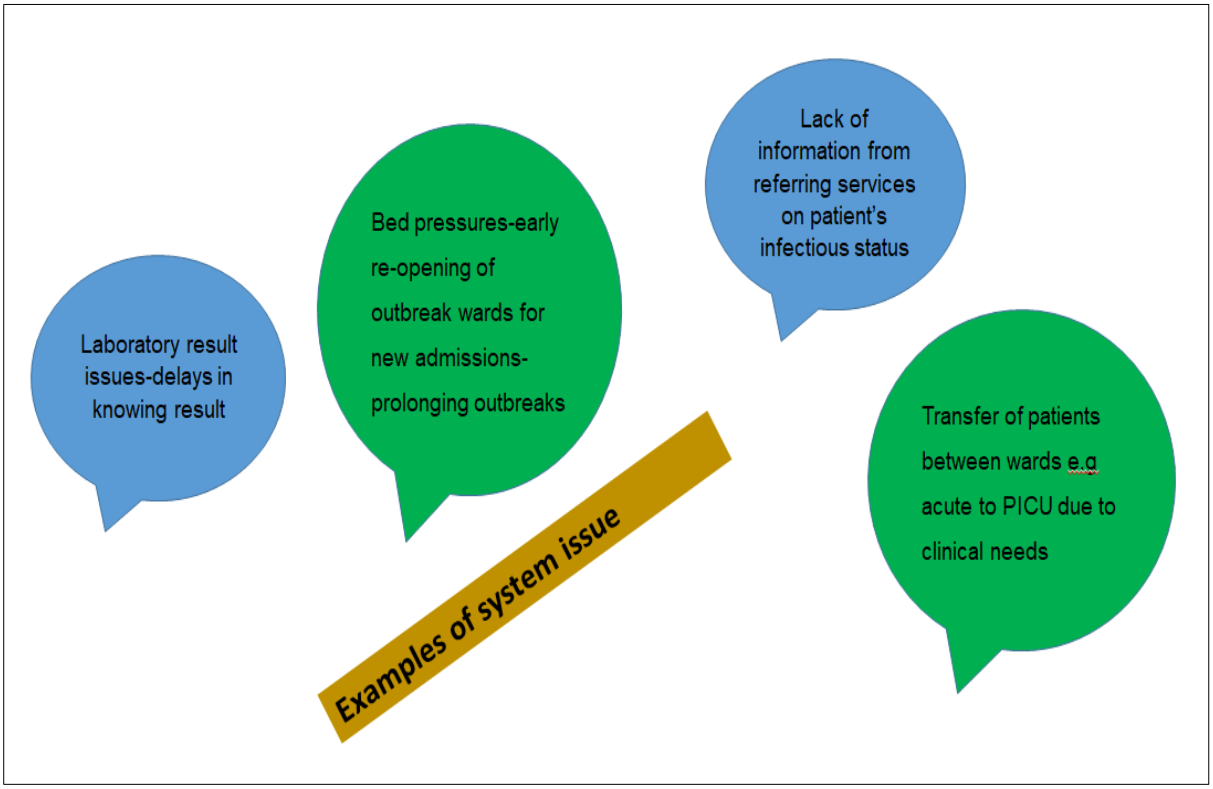
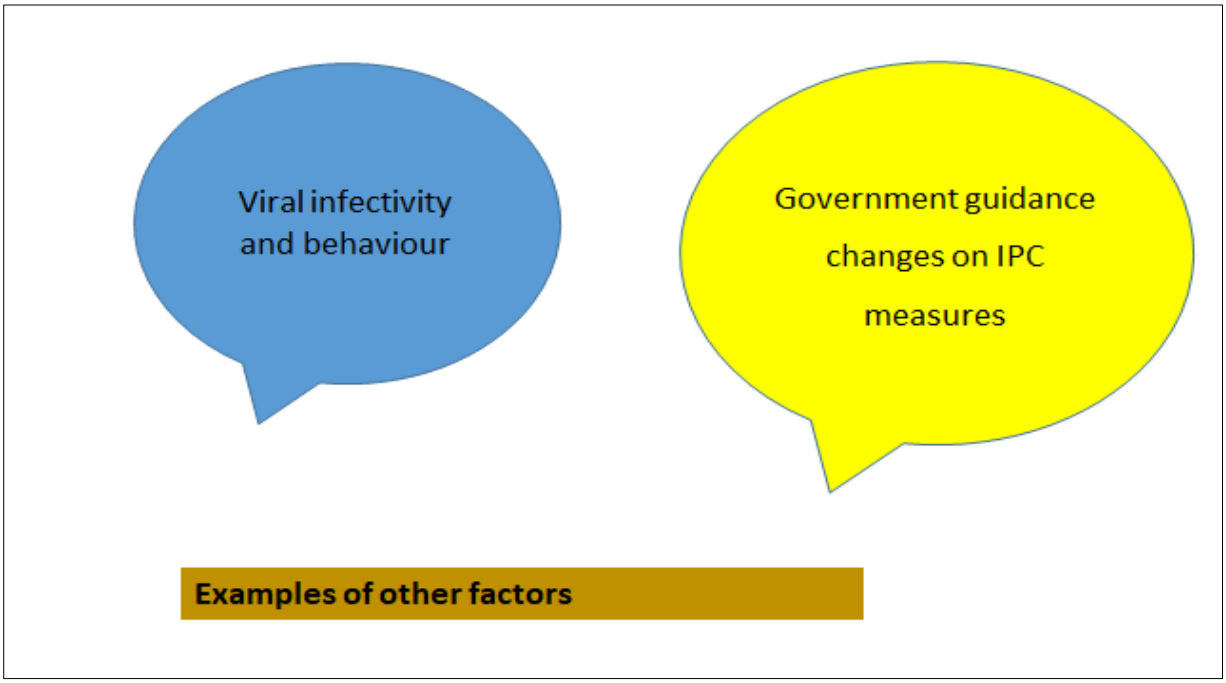


Figure 66. *below shows examples of other factors identified from RCA reviews.*



As Figure 61 demonstrates, patient related factors are the most dominant theme followed by environmental factors. In some outbreaks, there was a combination of 2 or more contributing factors e.g. staff and patient factors or patient and environmental factors.

Patient-related factors include patients who were exposed to the virus during leave to the community returning to wards before interacting with other patients on the ward enabling further transmission & contributing to increased numbers of definite HOCI cases.

Another patient factor was patients who refused admission swabs & also refused to isolate due to a lack of insight. It's possible these patients were incubating the virus on admission & challenges contributed to onward transmission. Once again, patient interaction with each other makes it possible for transmission to others on the ward contributing to increased numbers 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 have been service users who share vapes with each other, service users who refuse swabs & challenge isolation. IPC work jointly with the wider Physical Health and Smoking to team to ensure sufficient supplies of vapes are available for patients on wards.

Environmental factors included the impact of infrastructure/environment. Air conditioning is sub-optimal in many NHS sites. Recirculating air systems that are required to keep medication cool have had to be switched off while staff and patients are in the treatment room or when the treatment room is in use for medication rounds during outbreaks. In line with the hierarchy of controls and due to the infectious nature of the omicron variant, FFP3 masks were rolled out. The IPC team also worked collaboratively with the Trust Estates & Facilities team on using air purifiers and desk top fans during the excessive heat wave in summer 2022.

Staff related factors includes gaps in patient isolation, patient transfers and management of patient contacts. It also includes laboratory and specimen related issues. Instances where there is significant delay in knowing the result of the index case contributes to onward transmission.

11.3 Lessons Learnt & Changes Implemented from COVID-19 Outbreak Findings

New cleaning definitions/terminologies are in use for clarity when staff are requesting different levels of cleaning. Training on cleaning has been provided. Daily cleaning of patient bedrooms and maintaining three times daily cleaning of communal areas and nurses stations is now in place as routine to help reduce the viral load and reduce the risk of outbreaks as a preventative measure as advised by IPCT.

A Trust wide reflection event on outbreaks was held in June 2022 to capture learning in a dynamic way and look at applying the learning in practice on a local basis across the organisation. This was well attended by staff from all areas of the Trust. Staff were able to share best practice / innovations of practice around outbreak management.

During 2022-23 the formal PPE and hand hygiene audit was combined into one audit tool to improve user engagement and assurance on monitoring staff practices of IPC practices.

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 guidance protocols for services developed with IPC/COVID-19 precautions as per IPC quarterly committee reports. The IPCT Team have also attended away days and

emphasising swabbing patients on admission, raising datix for patients refusing swabs, to communicate with staff on risks and providing updates on ever changing guidance.

During 2022-23, a pathway was developed for service-users who test positive for COVID-19 infection to be referred for monoclonal antibody treatment if they met the criteria.

11.4 Influenza Outbreak

Influenza or 'flu' is a respiratory illness caused by infection by influenza virus. It affects mainly the nose, throat, bronchi and, occasionally, lungs. Infection usually lasts for about a week, and is characterized by sudden onset of high fever, aching muscles, headache and severe malaise, non-productive cough, sore throat and rhinitis.

Influenza occurs most often in winter and usually peaks between December and March in the northern hemisphere. Illnesses resembling influenza that occur in the summer are usually due to other viruses.

There are two main types that cause infection: Influenza A and Influenza B. Influenza A and Influenza B must not be nursed together in the same immediate environment.

Influenza A usually causes a more severe illness than Influenza B. The Influenza virus is unstable and new strains and variants are constantly emerging, which is one of the reasons why the flu vaccine should be given each year.

The typical incubation period for Influenza can be up to 7 days, with an average of 2-5 days. Individuals infected with Influenza are regarded as being infectious for one day before the onset of symptoms and up to 7 days after the onset of the symptoms. Severely immunocompromised persons can shed virus for weeks or even months.

During 2022-2023, there were 2 Influenza Outbreaks. This was in line with increased influenza cases reported nationally by UKSHA during winter 2022.

Figure 67. below shows a *breakdown of outbreaks of other infectious diseases across the Trust during 2022-23.*

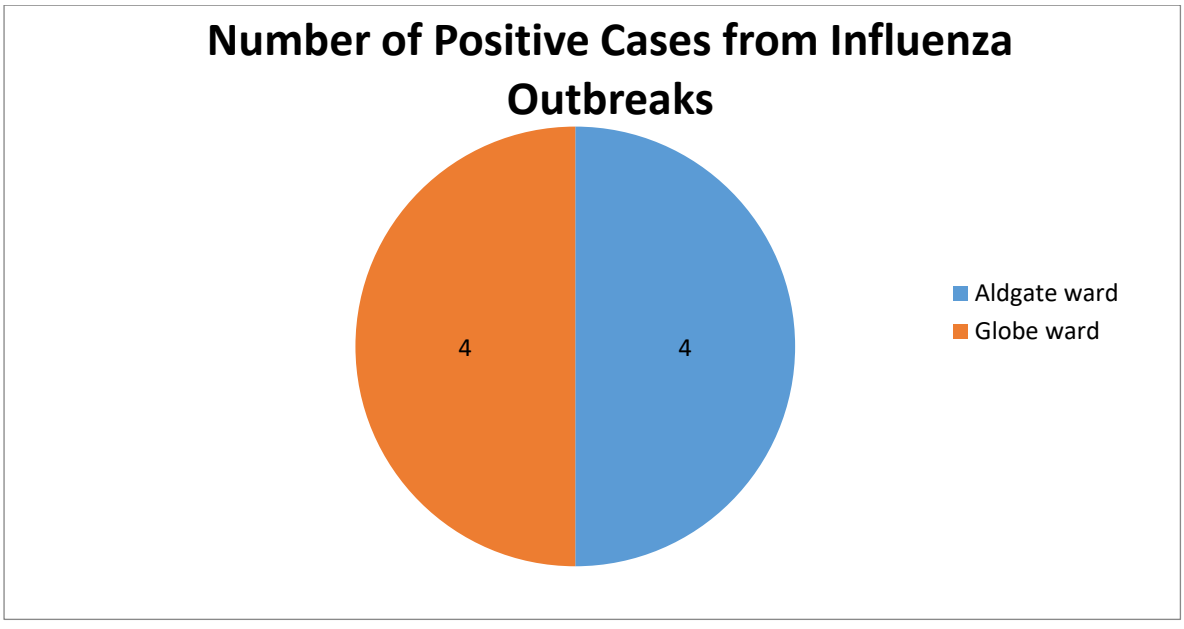


Figure 68. *provides an overview of Influenza outbreaks across the Trust during 2022-23.*

Directorate	Ward	Infection	No of confirmed patients	No of confirmed staff	Total Positive Cases	Date Outbreak Declared/Started (2 or more linked cases)	Date Outbreak is Officially Closed
Tower Hamlets	Globe Ward	Influenza A	4	0	4	15/12/2022	21/12/2022
Forensics	Aldgate Ward	Influenza A	4	0	4	16/12/2022	22/12/2022

Both Influenza outbreaks were well managed and the IPC measures in place for COVID-19 reduced the risk of transmission. Patients were treated with Tamiflu, however there were some delays in getting Tamiflu as it was not routinely stored on wards. A reflection event was held in January 2023 to share learning from managing Influenza outbreaks. This was well attended by teams involved with the Influenza outbreak. Learning from these outbreak reviews and lessons learnt include storing emergency supplies of Tamiflu and the creation of a SOP for admitting to wards with active Influenza outbreaks.

12.0 M-Pox (Previously called Monkeypox)

On the 7th of May 2022 there was an increase in M-pox cases across the United Kingdom. M-pox is a rare infectious disease that is not commonly seen in the UK. Spread of M-pox may occur when a person comes into close contact with an animal (rodents are believed to be the primary animal reservoir for transmission to humans), human, or materials contaminated with the virus. The virus enters the body through broken skin (even if not visible), the respiratory tract, or the mucous membranes (eyes, nose, or mouth). Person-to-person spread is very uncommon, but may occur through:

- contact with clothing or linens (such as bedding or towels) used by an infected person
- direct contact with M-Pox skin lesions or scabs
- coughing or sneezing by an individual with a M-Pox rash

In relation to the concerns for M-Pox virus and new UKSHA guidance, the IPCT developed an M-Pox SOP guiding staff on how to manage a suspected/confirmed case within ELFT services. An M-Pox information sheet was also developed, providing easy to read information & answering common questions about M-Pox. The Chief Nurse / Director of IPC / Deputy CEO wrote to all staff about the emerging threat of M-Pox and about concerns staff members may have. On-going communication regarding M-Pox have been disseminated to staff via the Trust communications bulletin on a weekly basis or when national guidance has been updated. A local system has been developed for reporting NHSE M-Pox sit-rep data should cases of M-Pox be identified in service users. ELFT staff (if they meet the requirements for vaccination based on risk assessment and exposure), can access Smallpox vaccines via the London M-Pox Vaccination Hub. Updated guidance was circulated in line with national guidance changes in August 2022. In Quarter 3, The IPCT supported with system wide implementation of the M-Pox vaccination and the use of inter-dermol vaccination. The IPCT saw a marked reduction of M-pox enquires during Q4.

Figure 69. *below displays Monkeypox cases across the Trust in Q1.*

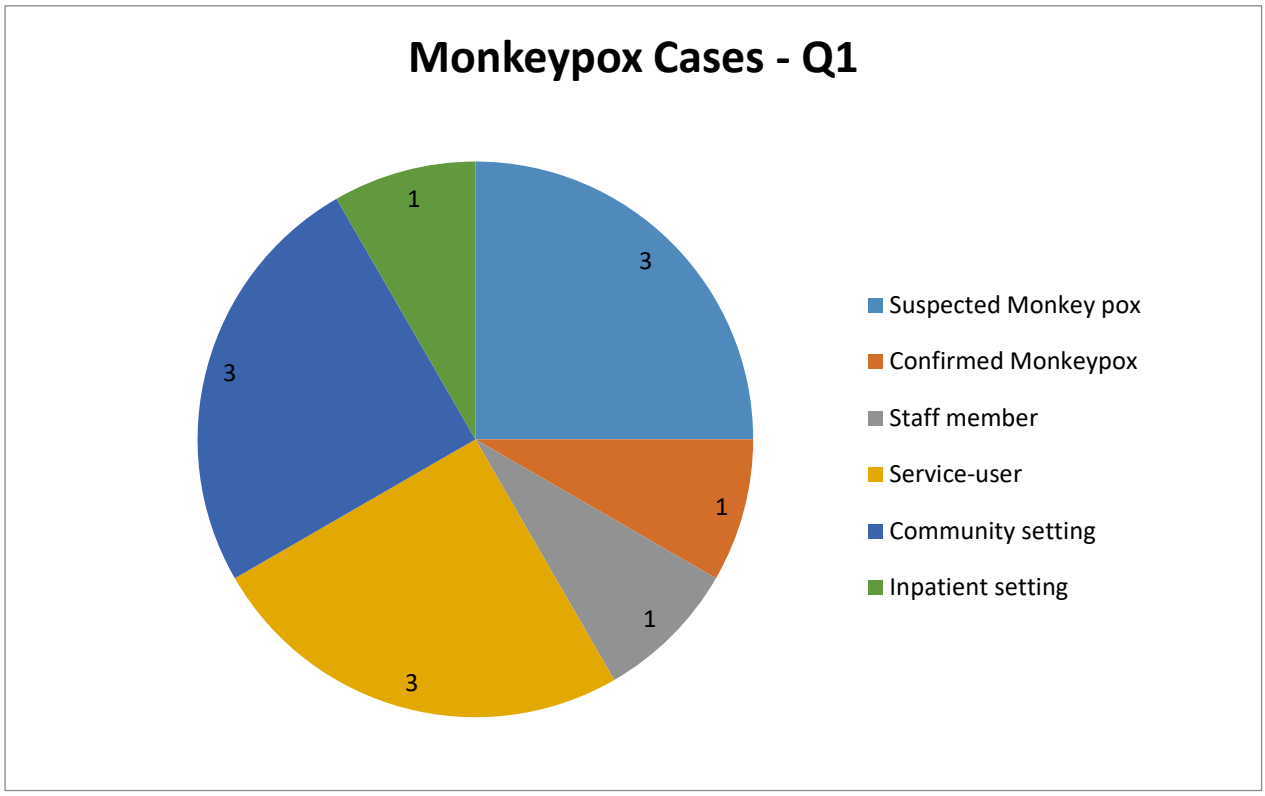


Figure 70. *below displays Monkeypox cases across the Trust in Q2.*

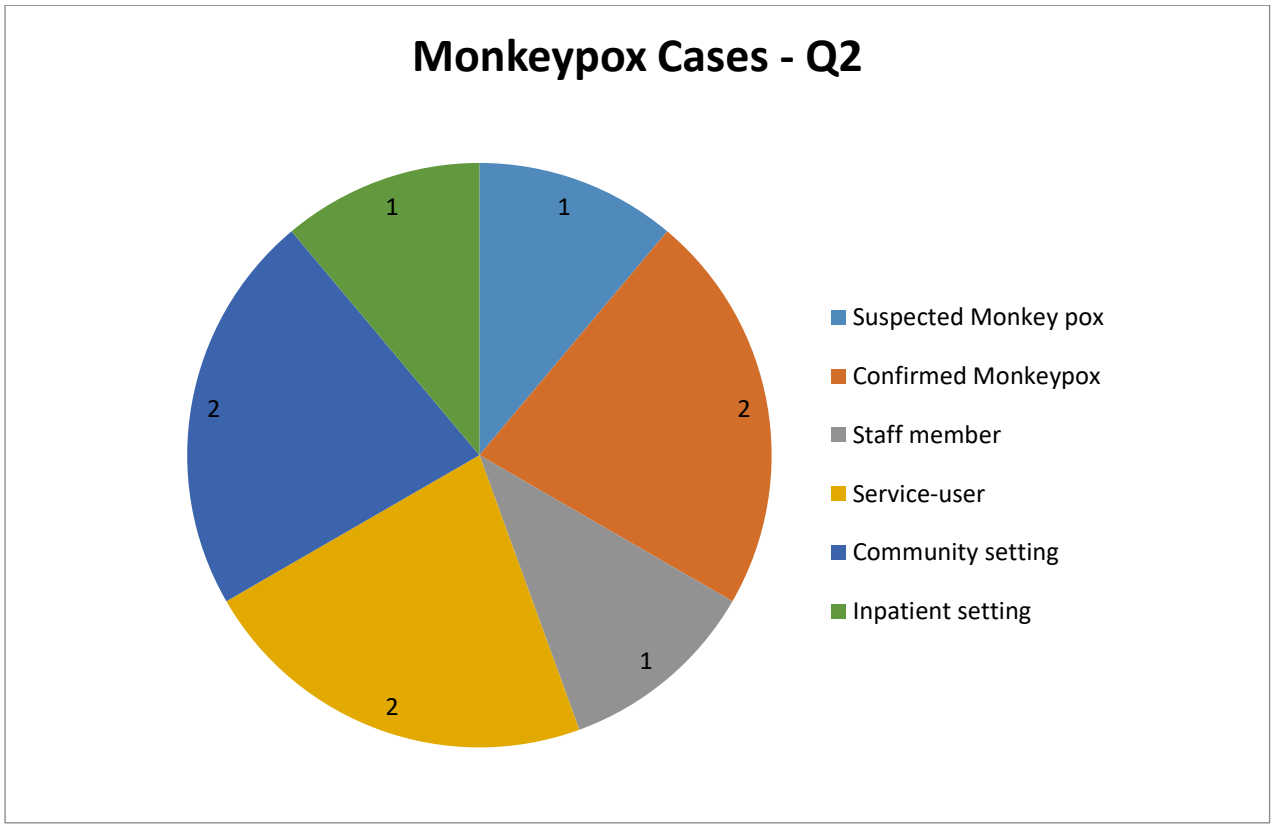


Figure 71. *below shows an in-depth breakdown of Monkeypox cases across the Trust in 2022-23.*

Quarter	Suspected / Confirmed Monkeypox cases	Service location	Staff member / Service user
1	Suspected	Coral ward – Luton	Service user
1	Confirmed	Telehealth Team	Service user
1	Confirmed	Westfield Vaccination Centre	Staff member
1	Suspected	Community Mental Health Team – Hackney	Service user
2	Suspected	Galaxy ward – CAMHs	Staff member
2	Confirmed	Hackney Early and Quick Intervention in Psychosis	Service user
2	Confirmed	Ruby Triage ward-Newham	Service user

13.0 Lassa Fever

During 2022-23 Q1, the IPCT provided support to staff in Calnwood Court, Bedfordshire on the safe management of a patient who was recently discharged from the National High Level Isolation Unit with Lassa Fever infection.

Lassa Fever is an acute viral haemorrhagic illness caused by Lassa virus. People usually become infected with Lassa virus through exposure to food or household items contaminated with urine or faeces of infected rats – present in a number of West African countries where the disease is endemic. The virus can also be spread through infected bodily fluids.
The Senior nurses and ICPT worked in-conjunction with external providers (The High Consequence Infectious Disease Network) to ensure the patient, staff and visitors were supported in an environment that was IPC safe, controlling and preventing further onward transmission of Lassa Fever. Face-to-face visits were conducted by IPC Nurses and Director of Nursing on alternative days to ensure that staff were supported and felt confident in caring for an individual with a category 4 pathogen. A reflective session was held with local staff to share the learning experience. A summary of the learning and reflection is provided below:

- Learning for all staff involved around Category A waste management & setting up process for Category A waste, as this is not routinely used within mental health/ community settings.
- Staff felt confident after face-to-face training on how to collect & package a Category 4 biohazard specimen. This is not routinely used within mental health/community settings.
- IPC Nurse visits to the ward alleviated anxiety of ward staff.
- Review of procedures and protocols ensured governance in line with quality care.

The IPCT received excellent feedback on how the IPC nurses supported them, in managing this rare infection within ELFT.

14.0 Clusters of Infection

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 chronologically by quarter below.

14.1 Cluster of Diarrhoea on Bevan Ward – City & Hackney (Q1)

This was a small scale cluster of diarrhoea amongst two patients on Bevan ward. The symptoms of the index case were recognised early and prompt action by the ward staff. Full infection prevention measures were instigated. No further cases of diarrhoea were reported. Microbiological confirmation of stool specimens were not obtained as diarrhoea had self-resolved. The nursing staff managed this cluster of D&V well.

14.2 Cluster of Diarrhoea and Vomiting on Morrison Ward – Forensics (Q1)

This was a small scale cluster of diarrhoea and vomiting (D&V) amongst two patients on Morrison Ward. The symptoms of the index case were recognised early and prompt action by the ward staff. Full infection prevention measures were instigated. No further cases of D&V were reported. Microbiological confirmation of stool specimens were not obtained as diarrhoea had self-resolved. However potential source of D&V was related to food. This incident was resolved within 48 hours. The nursing staff managed this cluster of D&V well.

14.3 Cluster of COVID-19 Infection on Shoreditch Ward – Forensics (Q2)

This was a small scale cluster of COVID-19 infection amongst two patients on Shoreditch Ward. The symptoms of the index case were recognised early and prompt action by the ward staff. Full infection prevention measures were instigated. The index case was in seclusion within the 48 hours prior to testing positive and had minimal contact with the subsequent case. The subsequent cases had escorted leave off the ward premises. It was concluded from an RCA investigation that there is a possibility that two cases have acquired COVID-19 separately off the ward.

14.4 Cluster of Suspected Scabies on Coborn Acute Ward – Specialist Services (Q2)

This was a small scale cluster of suspected scabies amongst 7 patients & 2 staff members at the Coborn Acute Ward. The symptoms of the index case were recognised early and prompt action taken by the ward staff. Full infection prevention measures and outbreak management protocols were instigated. Symptomatic services users where reviewed by dermatology, and suspected scabies was confirmed as papular urticaria likely secondary to insect bites. IPC measures including outbreak management were discontinued, as this was no longer considered as an infection control risk.

14.5 Cluster of Rotavirus on Mother & Baby Unit – City & Hackney (Q4)

Two babies had mild atypical symptoms of rotavirus. One of the babies was suspected of having a milk allergy therefore a sample taken to rule out other causes. One of the babies had recently had the rotavirus vaccine and the stool sample result was marked as low level positive and likely not indicative of current infection.

The other baby who tested positive was unvaccinated and thought to have caught this from siblings – however did not have typical symptoms of rotavirus. Both cases were treated as

treated as incidental findings as rotavirus is common in children. It was highly probably the two cases were not microbiologically linked. Full IPC measures were in place to manage the infections. At the time of writing, both babies have recovered. It must also be noted that babies are not classed as ELFT patients.

14.6 Cluster of Diarrhoea on Mother & Baby Unit – City & Hackney (Q4)

Two cases of Diarrhoea were reported on the Mother and Baby Unit. The index cases were probably related to food eaten from outside premises. The subsequent cases resolved before a stool sample was collected and sent to laboratory for microbiological testing. Full IPC measures were in place to manage the infections. At the time of writing, both patients have recovered.

15.0 Incidents of Infection

There were no IPC related incidents reported in Q1 or Q2.

During Q3, there were 4 incidents of infections reported. At the time of writing, one of these incidents continues to be monitored.

Figure 72. *below displays further information about incidents of infections.*

Directive	Service	Infection	Incident
Newham Community Services	Foot Health Services	iGAS	IPCT notified by UKSHA of positive iGAS case in patient seen at Foot Health Clinic. Patient was admitted to acute hospital with septicaemia. Post Infection Review (PIR) conducted. Lessons identified at PIR – patient was doing his own dressings at home as this could be potential source of infection. Action plan in place.
City & Hackney Mental Health Services	Home Treatment Team	Pulmonary TB	In April 2021, two ELFT staff members attended the home of an unwell patient. They spent around 3 hours with him, wearing PPE including surgical face masks. Patient was subsequently diagnosed with isoniazid resistant TB. The staff members were referred to TP Health. One of those staff members subsequently tested positive for TB in June 2022. This incident is currently under ongoing management by UKSHA and Occupation Health
Tower Hamlets Community Services	District Nursing Service	Pulmonary TB	Patient seen at TB clinic and diagnosed with pulmonary TB. District nursing team have been visiting patient for insulin

			therapy administration. Warn and inform letters circulated to staff identified as close contact. This incident is currently under ongoing management by UKSHA and Occupation Health. At the time of writing, this incident has been resolved.
Newham Mental Health Services	Plaistow Community Integrated Mental Health Service	iGAS	IPCT notified by UKSHA of positive iGAS case in patient seen at clinic. Patient was seen by locum Doctor who had symptoms of Strep A. At the time of writing report a post infection review of this incident is being conducted.

16.0 Notifiable Diseases

Figure 73. *below shows there were 396 notifiable diseases of infections reported to UKSHA during 2022-2023.*

Quarter	Notifiable Diseases	No. of patients	Health Care Acquired Infections
1	COVID-19	126	96
1	Suspected Monkeypox	1	0
2	COVID-19	158	121
2	Suspected Monkeypox	2	0
2	Malaria	1	0
2	Schistosomiasis	1	0
2	Scarlet Fever	1	0
2	Hepatitis C	1	0
3	COVID-19	105	105
4	COVID-19	94	77

17.0 IPC Service Enquires Surveillance

The IPC team also provide advice and guidance on infections other than COVID-19. An annual breakdown is shown on Figure 74. During 2022-23, there was a considerable decrease in other reported infectious diseases compared to previous years. This may have been due to several factors such as staff and patients were adhering to infection prevention and control measures and were less exposed to these due to lockdown measures of the pandemic.

***Figure 74**: below shows a breakdown of the subject areas IPC have provided support & advice on in 2022-23.*

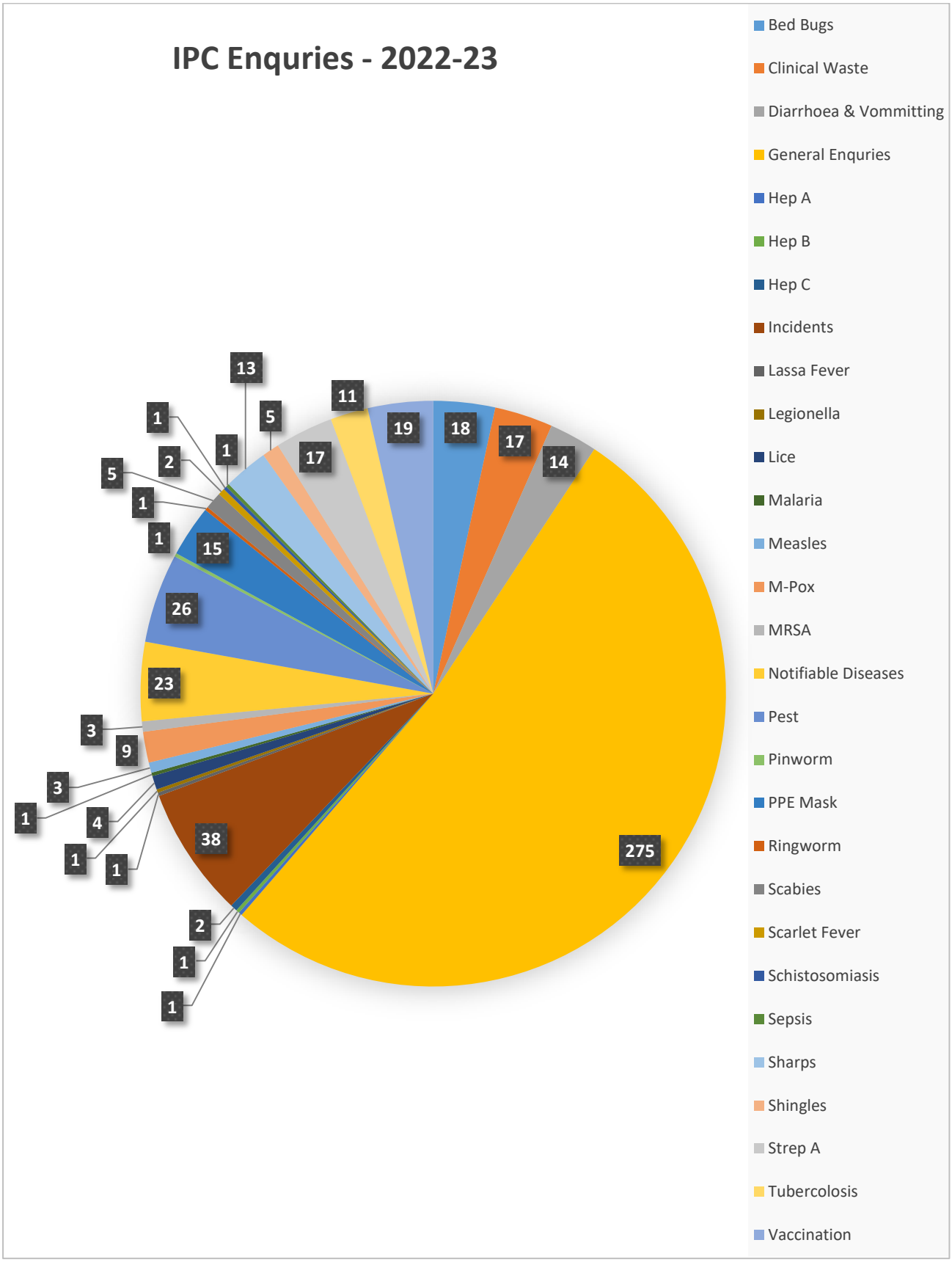


***Figure 75**: below shows a breakdown of the subject areas the IPCT have provided support & advice on in Q1.*

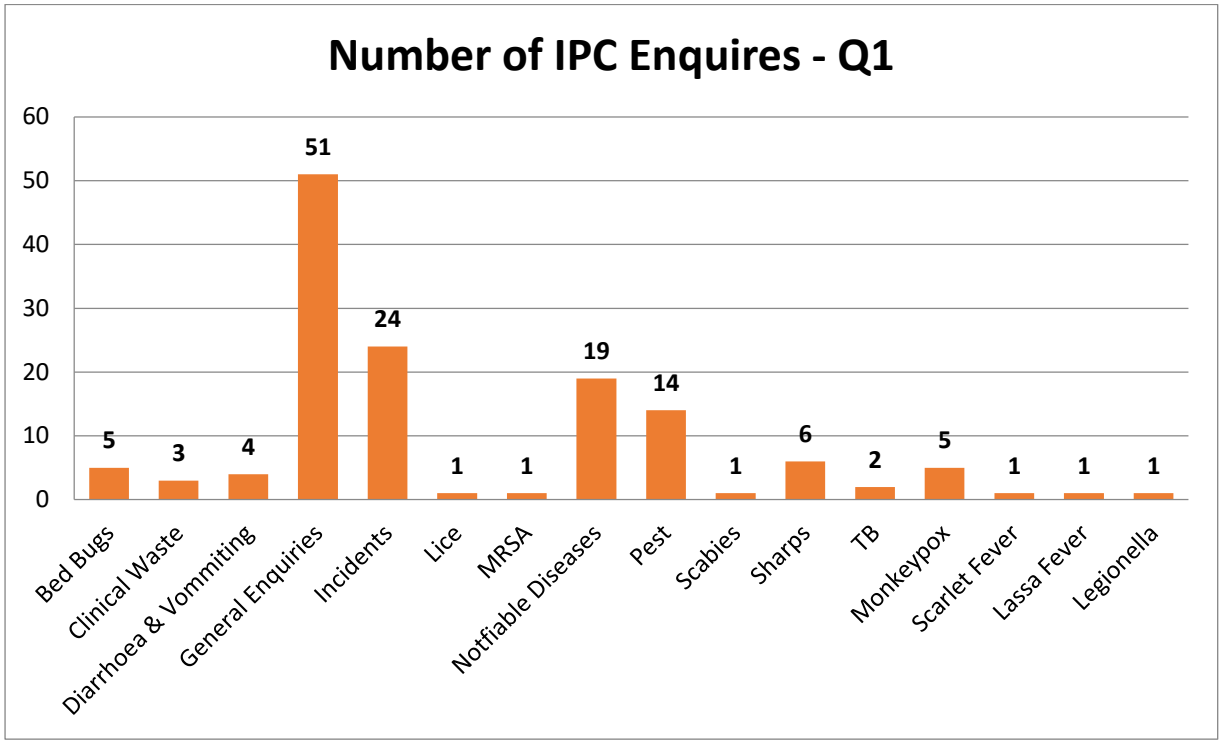


***Figure 76**: below shows a breakdown of the subject areas the IPCT have provided support & advice on in Q2.*

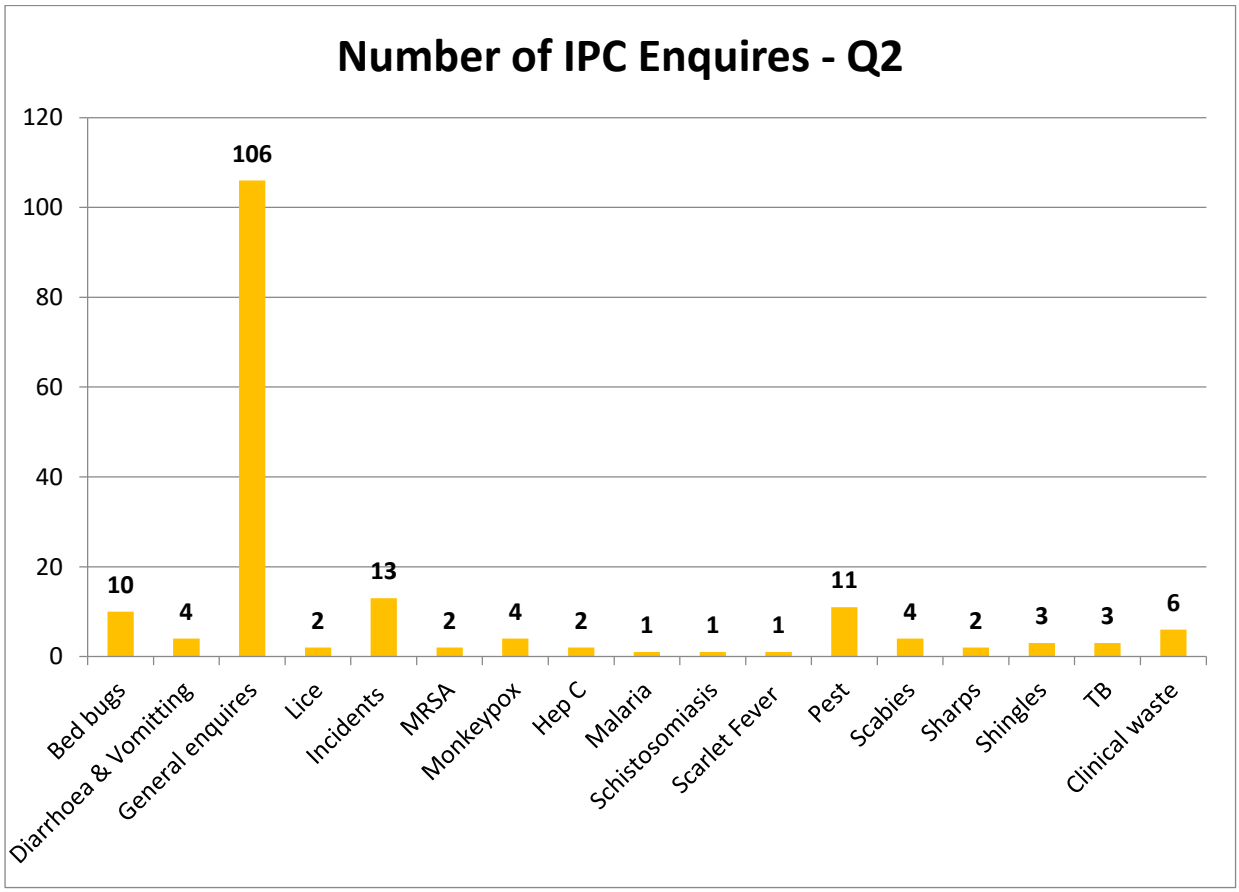


***Figure 77**: below shows a breakdown of the subject areas the IPCT have provided support & advice on in Q3.*

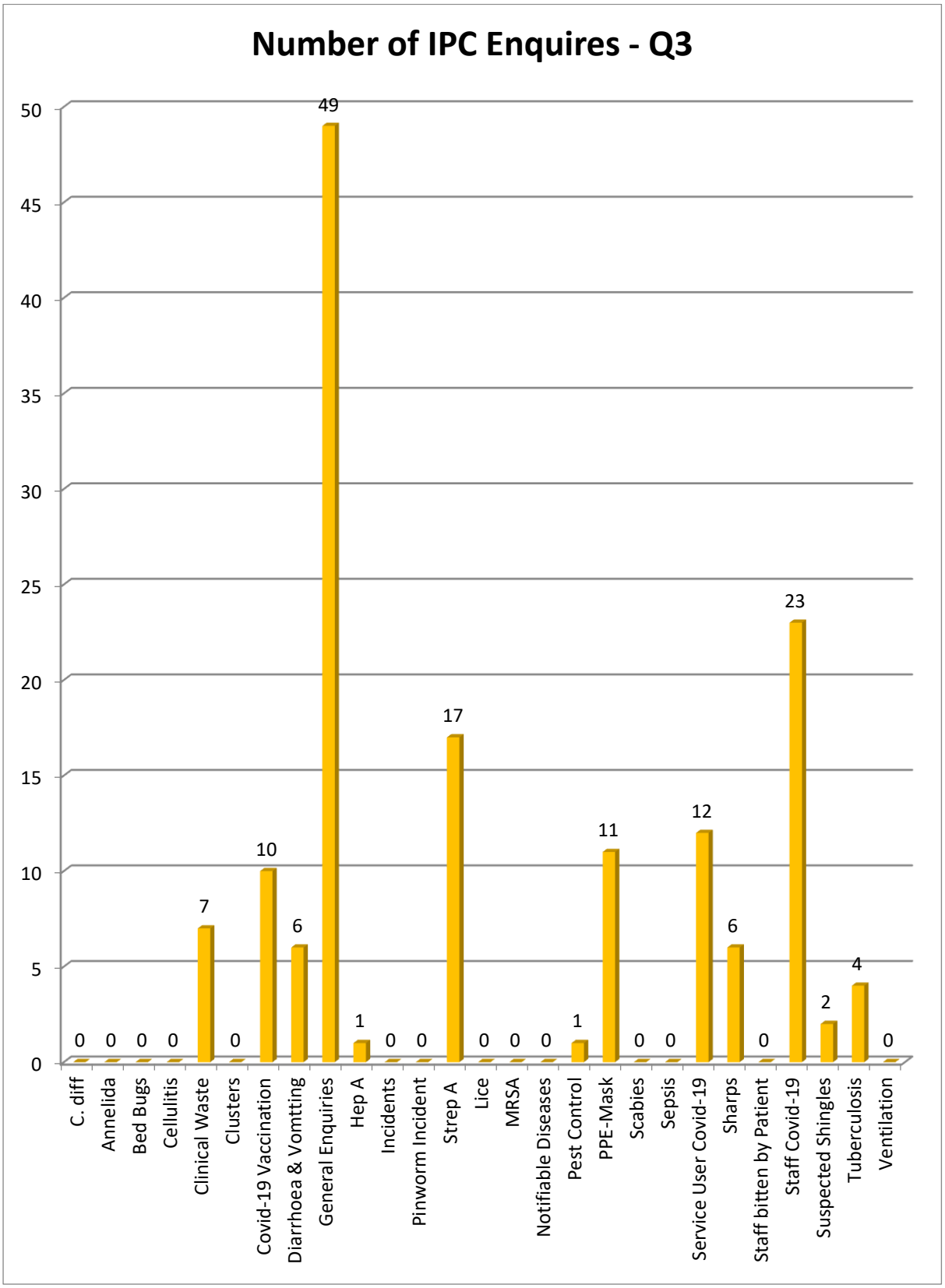


***Figure 78**: below shows a breakdown of the subject areas the IPCT have provided support & advice on in Q4.*

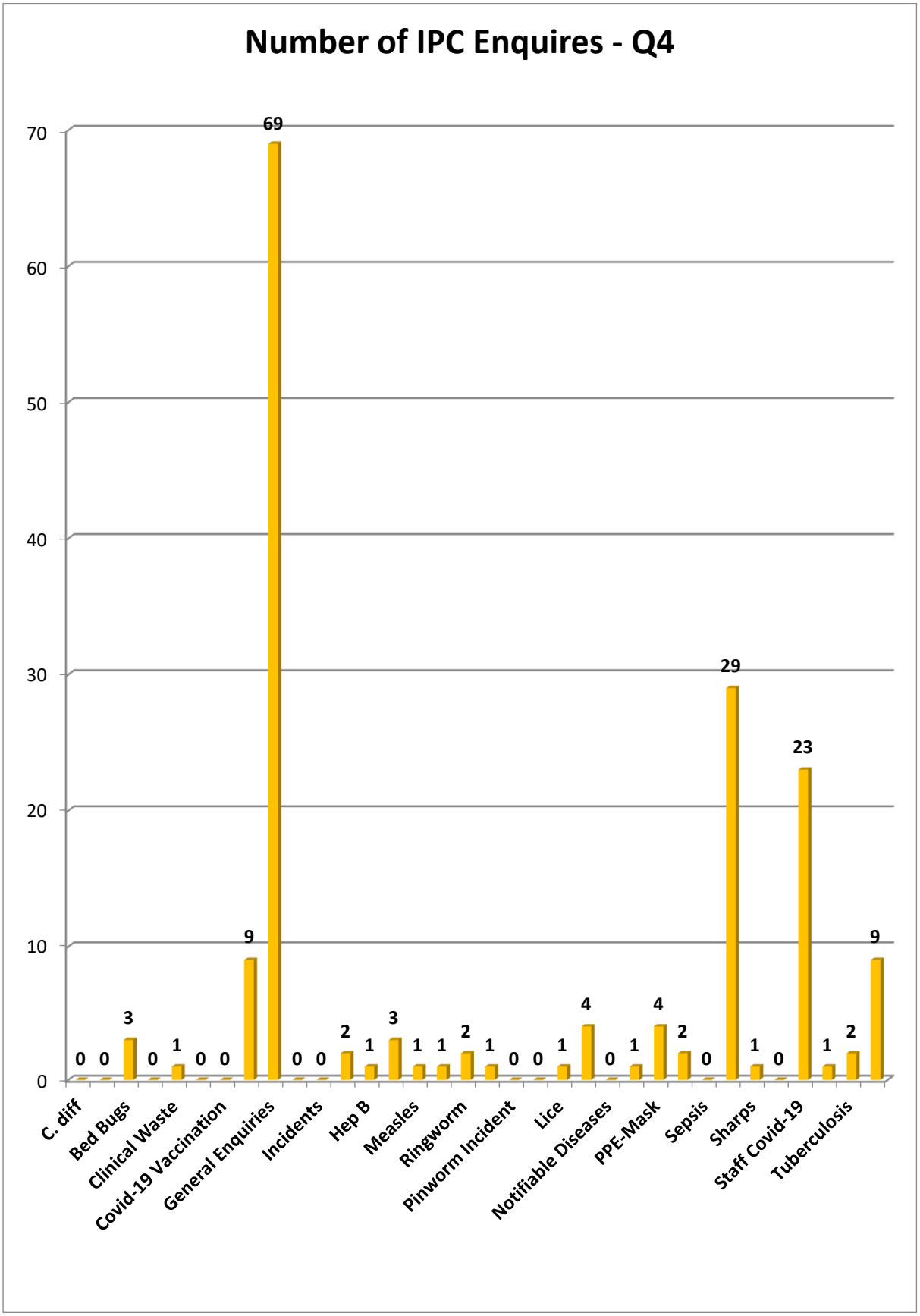


***Figure 79**: below displays the types of COVID-19 enquiries the IPCT have received & supported on during Q1.*

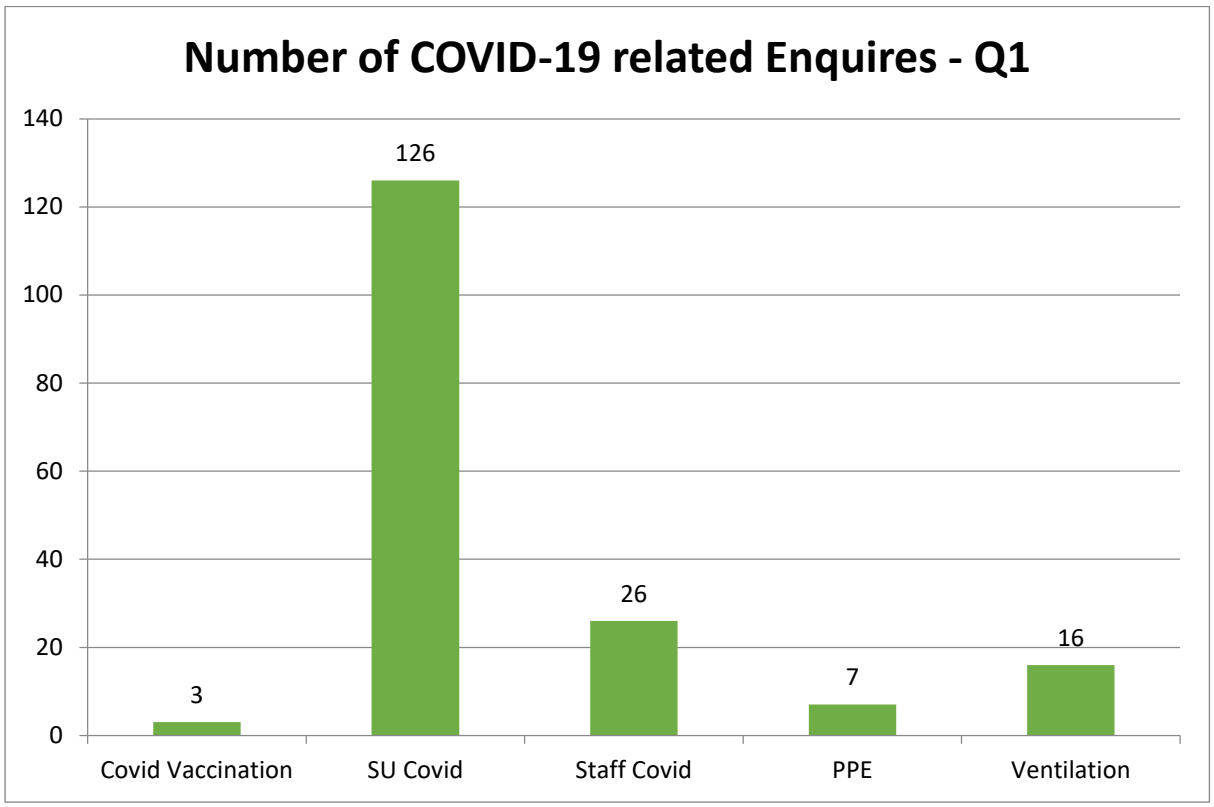


***Figure 80**: below displays the types of COVID-19 enquiries the IPCT have received & supported on during Q2.*

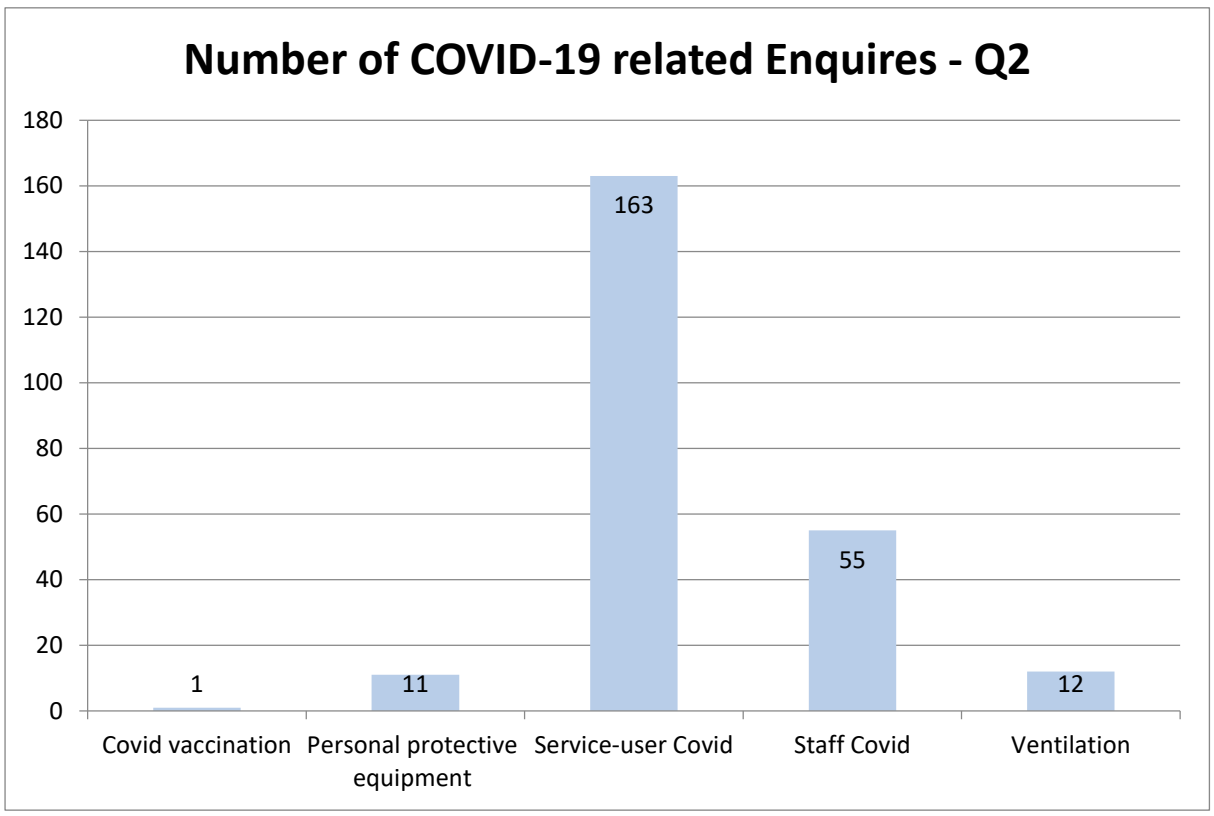


***Figure 81**: below displays the types of COVID-19 enquiries the IPCT have received & supported on during Q3.*

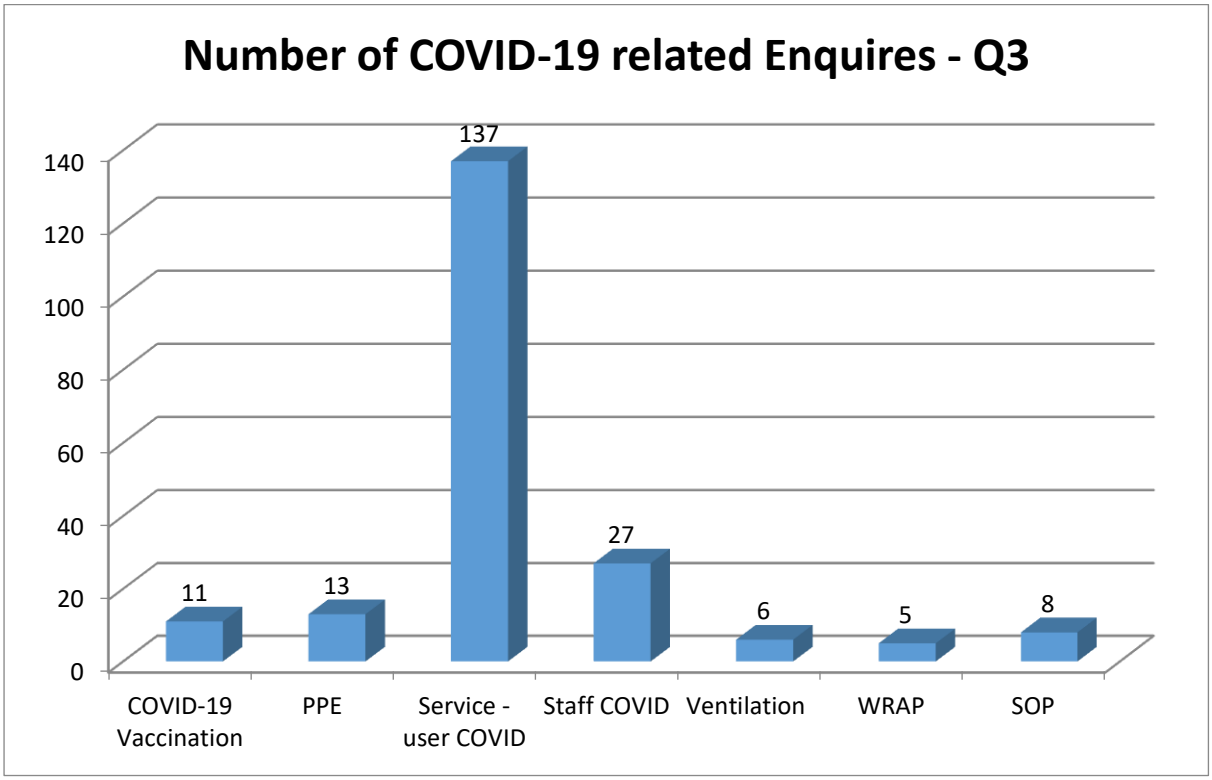
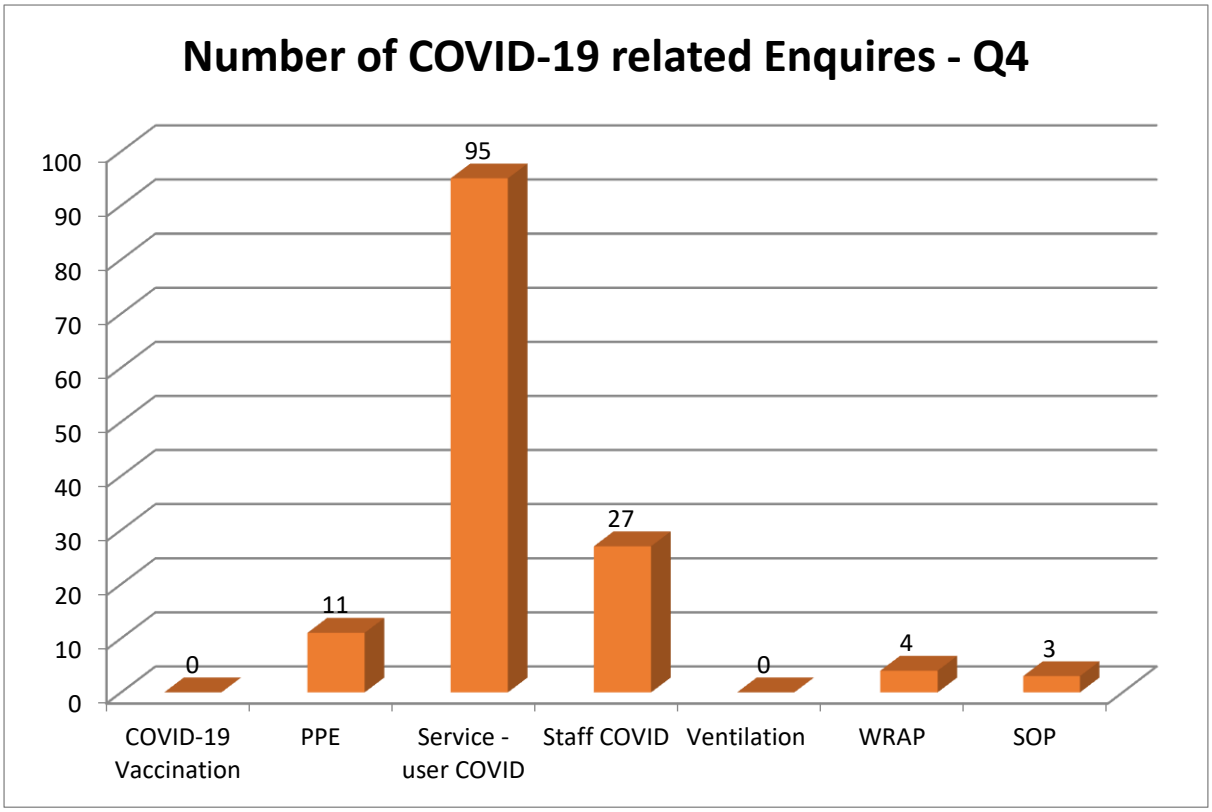


***Figure 82**: below displays the types of COVID-19 enquiries the IPCT have received & supported on during Q4.*



18.0 IPC Statutory & Mandatory Training 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. Figure 83 below shows compliance as of March 2023. Overall, IPC statutory and mandatory training compliance across the Trust is improving.

***Figure 83**: below shows the Level 1 and Level 2 Statutory & Mandatory Training compliance for 2022-23.*

Directorate	Infection Control - Level 1	Infection Control - Level 2
Bedford	89.58%	78.40%
Bedfordshire CHS	95.50%	84.96%
City & Hackney	79.59%	70.60%
CHS- Tower Hamlets	92.31%	79.21%
Corporate	75.17%	73.14%
Forensic Services	83.17%	81.49%
Luton	88.17%	81.58%
Newham CHS	93.86%	80.29%
Newham	84.67%	72.14%
Primary Care	92.50%	66.04%
Specialist CHS	87.37%	82.65%
Specialist Services	89.31%	75.22%
Tower Hamlets	89.88%	75.91%

(Data provided by Learning & Development team)

18.1 Board Training

In Q4, a bespoke training session was delivered to the Trust Board by the IPC Team in conjunction with the Director of Nursing for Community Health Services. This tailored face-to-face training session was to ensure statutory & mandatory training compliance for Board members. This event was well attended and evaluated.

18.2 Trust-wide Infection Prevention & Control Link Champion Programme

To proactively educate and upskill staff, there is a Trust-wide educational programme on various topics to improve staff understanding & awareness of IPC measures. There are scheduled sessions of webinars & in-person meetings covering topics including 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. Webinars also include question & answer sessions.

18.3 Other Education & IPC Training

The IPC Team have delivered additional bespoke training sessions across all services in response to the pandemic. There are an ongoing series of webinars planned to increase staff knowledge and skills in IPC across ELFT and to enable services to respond proactively in the event of future pandemic waves.

The IPC team have provided the following proactive services across the Trust during 2022-23*:*

- Ad-hoc face-to-face training session provided in City and Hackney
- Ad-hoc face-to-face training session provided on Forensics Wards during COVID-19 outbreaks
- Ad-hoc face-to-face training session provided on Bevan Ward
- Ad-hoc face-to-face training session provided on Brett Ward
- A training session facilitated on conducting RCAs across Bedford Wards
- Ad-hoc face-to-face training session provided on Townsend Court on Lassa Fever
- Ad-hoc face-to-face training session facilitated in Townsend Court
- Ad-hoc face-to-face training session facilitated in Coral Ward
- A Webinar was facilitated in-conjunction with the Advance Practice Lead Nurse & Trust-wide Lead IPC Nurse on restrictive practices and IPC challenges.
- A Trust-wide learning event was held in June for COVID-19 outbreaks that occurred in previous year (April 2021 – March 2022). This event reviewed commons themes and trends in outbreaks and RCA HOCI cases. This event was well attended with 60 attendees.
- Ad-hoc face-to-face training session provided on West Ferry Ward
- Ad-hoc face-to-face training session provided on Limehouse Ward
- Ad-hoc face to face training session provided on Shoreditch Ward
- Ad-hoc face-to-face training session provided at Jade Ward away day
- Ad-hoc face-to-face training session facilitated at Ash Ward away day
- Ad-hoc face-to-face training session facilitated at Cazaubon Ward away day
- Ad-hoc face-to-face training session facilitated in Tower Hamlets for new starter induction programme
- Q&A session held for Forensic leadership group on COVID-19 related questions
- Ad-hoc face-to-face training session facilitated in Newham for new starter induction programme
- Ad-hoc face-to-face training session facilitated in Tower Hamlets for new starter induction programme
- IPC Link Champion programme re-launched in Q3, October 2022. On-going programme led by Band 7 IPCNs.
- Ad-hoc face-to-face training session provided on Joshua Ward.
- Ad-hoc face-to-face training session provided on Brett Ward.
- Ad-hoc face-to-face training session provided on Mother & Baby Unit.
- Ad-hoc face-to-face training session provided on Shoreditch Ward.
- Ad-hoc face-to-face training session provided on Bow Ward.
- Ad-hoc face-to-face training session at Crystal Ward away day
- Ad-hoc face-to-face training session at Fothergill Ward staff meeting

19.0 IPC Campaigns

- In Q1, a Trust-wide Hand-hygiene roadshow campaign was held across the Trust on during the first week of May, promote World Hand Hygiene day (5th May).
- The aim this year Hand-hygiene roadshow campaign was focused on recognising that we can all add to a climate or culture of safety and quality through cleaning our hands but also that a strong quality and safety culture will encourage people to clean hands at the right times and with the right products.
- Road shows were held across the trust, including the visit to wards and engaging service-users with the hand hygiene activities such as testing their hand washing technique using the glow germ gel and UV light. They were also encouraged to take part in quizzes and word searches involving infection control to make it more fun and test their knowledge. Many service users reported how much they enjoyed participating in the hand hygiene road show. A hand hygiene webinar was also held. See Appendix 4 for pictures from the hand-hygiene roadshows.
- In Q3, the IPC team delivered the IPC Roadshow for National IPC Week. The campaign was facilitated over a two week period in October 2022. Roadshows were held across the Trust including corporate services and teams, service users, visitors, and contractors on the importance of Infection Control. Many of the Roadshows held in October, were facilitated with the wider physical health team and smoking cessation team. This was an excellent opportunity to discuss the implications from an infection control perspective with service users sharing vapes. Throughout the campaign, Twitter was accessed and the days promoted, and posts shared including Senoir leaders across the Trust. Overall, the campaign was successful and had a positive impact, with the teams and service users engaging well. See Appendix 5 for pictures from National IPC week roadshows.

20.0 Projects

During 2022-23, the IPCT supported with the following projects:

- Project on improving Trust-wide RIO documentation compliance. This project was discontinued in Q2, in line with national guidance changes and the pause on asymptomatic routine testing.
- On-going project on improving Fit-testing compliance across Tower Hamlets Mental Health Services.
- On-going project on improving Fit-testing compliance across Newham Mental Health Services.
- Project updating service user leaflets.
- Project on sharps in conjunction with the Diabetes Nurse.
- Quality Improvement project reducing Gram-negative Rod Blood Stream Infections – Catheter associated Urinary Tract Infections on Fothergill Ward.
- Quality Improvement project on Sustainability & Gloves at Fountains Court & Crystal Ward.
- Ventilation – Air disinfection/cleaning study at Fountains Court.

21.0 Policies / Guidance Documents

During 2022-23, the IPCT provided support and specialist input on the following policies/ guidance documents:

- Infection Prevention & Control Policy Manual has been updated
- Fact sheet on Track and Trace updated following guidance changes
- SOP for music therapies and recovery college reviewed
- SOP for Admitting to wards with COVID-19 outbreaks updated
- SOP for inpatient LFD testing updated

- Patients COVID-19 testing and management flow chart continually updated to reflect changes in national guidance
- Staff testing and management guidance with flow charts updated
- SOP for COVID-19 infection control guidance for Group Based Treatments held in the Large Meeting Room at Tower Hamlets reviewed
- COVID-19 Outbreak Management guidance updated
- Standard Operating Procedure for Transformation People Participation Older Adults Working Together Group reviewed
- Blood glucose monitoring flowchart reviewed & updated in-conjunction with Diabetes Nurse
- FPP3 posters on mask availability reviewed with fit testing team
- FFP3 mask audit tool developed in-conjunction with fit testing team
- New water management flowchart reviewed
- IPC have developed a community IPC audit tool including Asepsis non-touch technique
- Guidance developed on managing & creating an alert system for clinically vulnerable patients
- Guidance developed for identification and management of clinically vulnerable patients
- WRAP tool updated to reflect national guidance changes
- COVID-19 RCA report tool updated to reflect levels of harm
- FFP3 mask information sheet updated
- Monkeypox SOP developed
- Monkeypox Information Sheet developed
- Team Huddle SOP developed
- PPE options paper developed to support Executive decision-making on fluid resistant surgical mask use in non-patient facing environments
- COVID-19 IPC workplace guidance developed
- Action plan developed for improving compliance of FFP3 masks across Tower Hamlets
- Reviewed North East London wide Catheter Passport
- Fan guidance / alert communication developed for heat wave
- Review of PPE & Hand hygiene audit tools. These have now been combined into one audit tool
- CAS alert written for Contamination of hygiene products with Pseudomonas aeruginosa
- CAS alert written Vaccine Derived Polio Virus type 2 (VDPV2) in London sewage samples
- CAS alert written for M-pox
- Reviewed SOP for Long COVID service
- Reviewed SOP for Coborn Day service
- Reviewed & updated ECT SOP
- Reviewed & updated Barbeque SOP
- Guidance updated on managing & creating an alert system for clinically vulnerable patients
- Guidance updated for identification and management of clinically vulnerable patients
- FFP3 mask information sheet updated
- Statutory and mandatory training slides updated
- Review of new changes to the waste management guidance
- COVID-19 IPC workplace guidance updated
- Review of Conservative Sharp Debridement Guidelines

- Supported Ruby Ward Management team with response to complaint raised by CQC that was reported by a service-user.
- Options Appraisal report – Portable Air Conditioning Units in exceptional heat written jointly with Estates & Facilities department
- Business development bids pertaining to IPC written for new services acquisitions for the Trusts business development team.
- Business cases – Enhanced Cleaning across ELFT services written jointly with Estates & Facilities department
- Review of national cleaning standards functional risk ratings / stars on the door jointly with Estates & Facilities department
- Review & updated Antimicrobial policy jointly with Pharmacy department for treatment in positive cultures from catheter urines in asymptomatic patient with low inflammatory markers.
- CAS alert written for recent increase in cases of Diphtheria in the UK and WHO European Region amongst asylum seekers and refuges
- New Respiratory Infection policy developed
- CAS alert written Ebola virus outbreak in Uganda (Sudan Ebola virus)
- Reviewed SOP for Tower Hamlets OT department
- Business development bids pertaining to IPC written for new services acquisitions for the Trusts business development team.
- CAS alert written for recent increase in cases of Diphtheria in the UK and WHO European Region amongst asylum seekers and refuges
- Respiratory Infection policy updated
- CAS alert written Ebola virus outbreak in Uganda (Sudan Ebola virus)
- COVID-19 and respiratory illness quick reference guide developed
- SOP for admitted to wards with active Influenza outbreaks
- Weekly communications written regarding IPC measures / COVID-19 updates
- Factsheet produced on Group A Strep infections
- CAS alert written for Group A Strep infections
- Fountain Court – Ventilation Study paper
- Review of Work Place risk assessment tool
- Reviewed SOP for Newham learning Disabilities team
- Weekly communications written regarding IPC measures / COVID-19 updates.
- SOP for spirometry clinics.

22.0 Complaints

During 2022-23 Q1, the IPCT received a formal complaint from a service user on Jade ward, Luton. This complaint was related to the management of the service user during a COVID-19 outbreak. The service user was a contact of a positive COVID-19 case and was denied leave to attend hospital appointment. The ELFT legal team supported the IPC Team in responding to the complaint and apologised to the patient for any undue harm caused. There were several learning points identified for the IPC Team these are:

- IPCT members are to keep abreast of latest guidance on management of COVID-19.
- IPCT member's knowledge & awareness on handling complaints process and following Trust polices when handling complaints.

To address learning for this compliant:

- IPC team members have completed the Trust compliant training
- Policy and guidance changes related to COVID-19 are communicated to all team members on daily huddles meetings by Lead IPC Nurses.

23.0 Information Governance – GDPR Breach

During 2022-2023 Q4, patient-related information was shared on a section of the Respiratory Policy related to RiO documentation process. At the time of writing, Duty of Candour is in process to notify the patient of the GDPR breach. Learning from this GDPR breach has been followed-up with all IPC Team members at Team Meetings & at individual supervision meetings. All IPC Team members have also had refresher training on Information Governance.

24.0 Environmental Cleaning

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.

Figure 84*: displays cleaning and facilities services that are out-sourced by the Trust.*

Sites	***Provider***
Newham Centre for Mental Health	Grosvenor Facilities Management (GFM)
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 – 1st of April provided by Outsource Client Solutions (OCS)
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 1st of April provided by Outsource Client Solutions (OCS)
Bedfordshire community Health services	NHS Property Services & Mitie

24.1 Cleaning Audit Scores for 2022-23

***Figure 85**: below displays cleaning Audits scores for 2022-23.*

Cleaning audit results *Target is 95%	Q1	Q2	Q3	Q4
OCS (Forensic John Howard Centre - London)	96.5%	97%	97%	96.8%
OCS (Forensic Wolfson House - London)	96.9%	97%	96.3%	96.0%
OCS (Trust-wide)	95.9%	97%	97.6%	96.1%
ISS (City & Hackney Centre for Mental Health)	-	96.3%	-	-
NHS Properties Service (Bedford)	98%	96%	-	-
Serco (Mile End Hospital)	97.99%	97%	97%	97.7%
GFM (Newham Centre for Mental Health)	87%	89%	-	-

(Data provided by Estates and Facilities department and cleaning contractors)
(Please note: where blank, cleaning scores were not submitted)

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 frequently join walkarounds with Facilities on sites 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.
The cleaning scores in Figure 85 above suggest that cleanliness standards across the Trust are on par with the national average of 95%. Mile End Hospital, Forensic Services and NHSPS managed buildings in Bedford have scored above 95%. There have been on-going cleaning issues in Newham Centre for Mental Health and Coborn Unit. Joint walkabouts with Estates and Facilities department and the IPCT continued to monitor the situation. As part of a rolling programme Environmental Audits are carried out by IPCT and facilities alongside Ward Managers. A new cleaning contract with OCS commenced on the 1st of April 2022.

In Q2, there were a number of concerns at The Green House GP practice / St Mungo's. Joint work between IPCT and Estates and Facilities continued. Cleaning on-site was acceptable but works are in progress on improvements to the building fabric. IPCT worked closely with Estates team on this as they are aware of current condition of the site.

Due to the continued COVID-19 situation, all cleaning processes were maintained until August 2022 when national COVID-19 guidance recommended cleaning should return to pre-pandemic levels. As a result of this guidance, a joint business case by IPC and Estates was produced for enhance cleaning during outbreaks. Enhanced cleaning of patient's bedrooms, communal areas & high-touch point cleaning 3 times daily using a chlorine-based product is in place and being maintained across the service to help reduce the microbial burden in the environment during outbreaks. During Q2, the IPC team have supported with reviewing the new NHS cleaning standards, risk categories, standards for functional areas & 'stars on the door' ratings. The FR rating tables for individual wards were agreed, with the exception of Newham where further discussions continue with IPC and the Service to ensure risks are managed appropriately. In November of Q3, the new FR cleaning ratings commenced.

25.0 Patient Led Assessment of Care Environment (PLACE) Inspections

Patient Led Assessment of Care Environment (PLACE) PLACE is an annual programme. All NHS funded healthcare providers in the UK are required to undertake an in-depth assessment of qualifying inpatient settings as part of a national programme, overseen by the Health & Social Care Information Centre (HSCIC) on behalf of NHS England. The purpose of PLACE is to assess how the healthcare environment supports patient care and looks at areas such as cleanliness, food, maintenance, condition/appearance, privacy and dignity, disability compliance and dementia compliance. PLACE is undertaken from the patient's perspective, is based on practice, not policy, and is intended as a visual audit with no scientific or technical processes. PLACE assessment teams are made up of a combination of staff and patient assessors, with the patient representation having to equate to at least half the scoring team. PLACE patient assessors are local people, who are provided through ELFT Patient Participation Service. The ELFT PLACE assessment programme took place in October & November 2022.

All PLACE audit data was submitted to the National Portal in March 2023. There have been action plans drawn up for each ward, they have been issued to Managers on sites and they have signed to agree management of the action plan so works are completed and any additional requirements to meet the closure of outstanding/recognised concerns from Service user Group attendance will be priced as project works and discussed at a higher level to seek approval. The action plans will be maintained and monitored, they will be discussed every quarterly at the DMT to give updates on progress.

26.0 ELFT Fit-Testing Service

In line with UKSHA and the 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

***Figure 86**: below shows fit-testing compliance during 2022-23.*

Testing Criteria	Q1	Q2	Q3	Q4
Total No. of staff passed an FFP3 fit-test	56%	56%	38%	48%
Staff non-complaint (not been tested at all)	44%	44%	62%	52%
Staff requiring re-testing	68%	68%	32%	32%

(Data provided by Fit-testing department)

During Q2 & Q3, the IPCT have been working with the closely with the fit testing department in Tower Hamlets and Newham to increase fit-testing compliance and staff awareness of FFP3 masks. This is a response to staff-side union visits conducted in Q4 of 2021-2022 where concerns were raised about FFP3 mask usage.

The compliance figures have decreased from the previous quarter due to a higher number of staff required to be re-tested as the 2-year cycle has lapsed & also due to new staff joining the Trust that require fit testing. A joint meeting with IPCT and staff-side union representatives was held in 2022-2023 Q4, with positive outcomes including a collaborative approach to updating the respiratory policy.

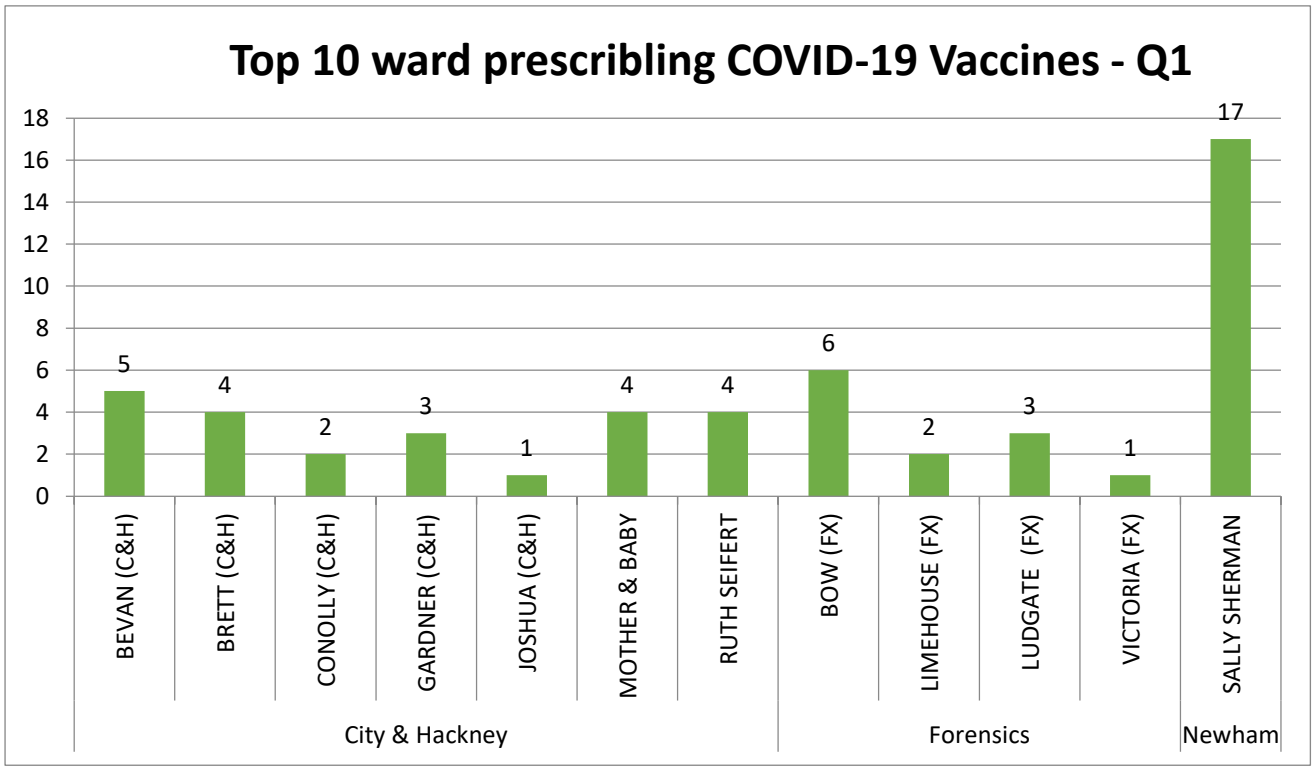
27.0 COVID-19 Vaccination

Westfield Vaccination Centre in Stratford has been delivering COVID-19 vaccination for staff and the public since the start of national roll out. Additionally, in-patient Vaccination Hubs have been trained to deliver COVID-19 immunisation The immunisers have also been trained on the National Vaccination Immunisation System (NVIS) to enable timely recording of patient vaccinations on their NHS record. This should avoid duplication and enable service user access via the NHS App as required and appropriate.

During Q2, the Westfield Vaccination Centre in Stratford relocated to Beaumont House and was re-named as the East London Vaccination Centre. The IPCT have supported thorough-out the relocation process including scoping of Beaumont House. A smooth transition was noted. The East London Vaccination service local SOP was updated to reflect IPC national guidance. The IPCT supported the Trust weekly Vaccination Huddle and the East London Vaccination Centre Operational Meeting. The Vaccination Centre at Mile End Hospital was closed on the 31st of March 2023.

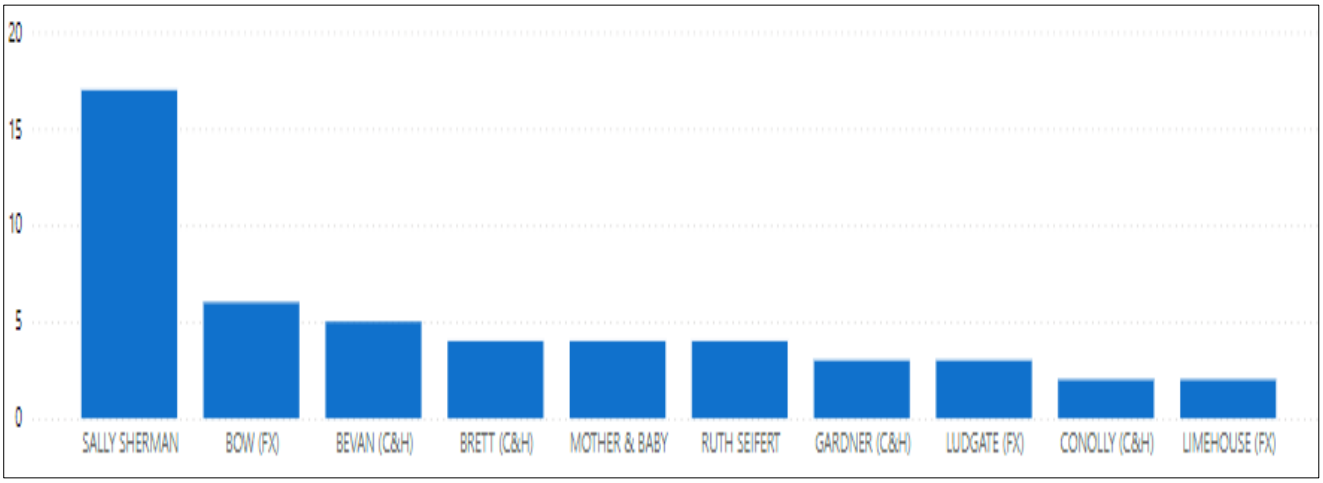
27.1 Top Ten Wards Prescribing COVID-19 Vaccines during 2022-23

***Figure 87**. below Illustrates the top 10 wards prescribing COVID-19 vaccines in Q1.*



(Data sourced from JAC system)

***Figure 88**. below Illustrates the top 10 wards prescribing COVID-19 vaccines in Q2.*



(Data sourced from JAC system)

***Figure 89**. below Illustrates the top 10 wards prescribing Influenza vaccines in Q3.*

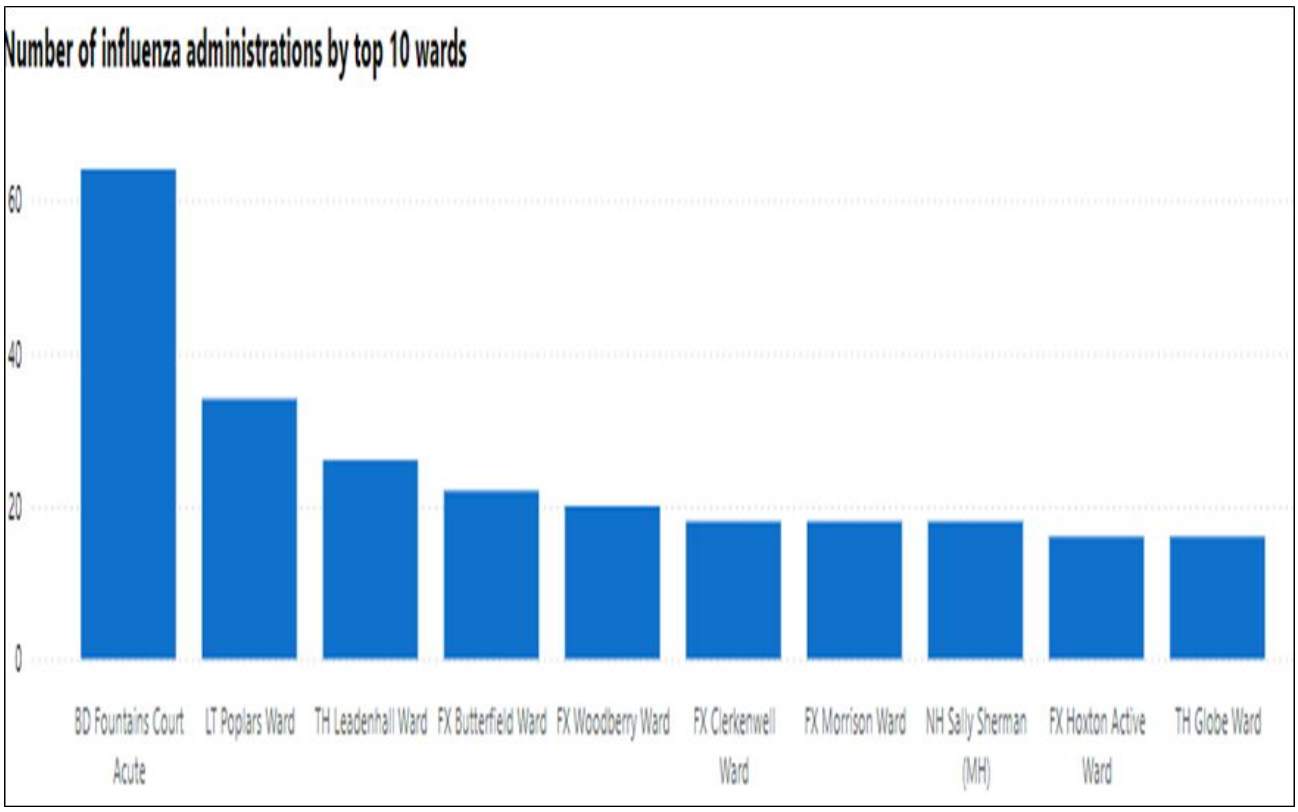
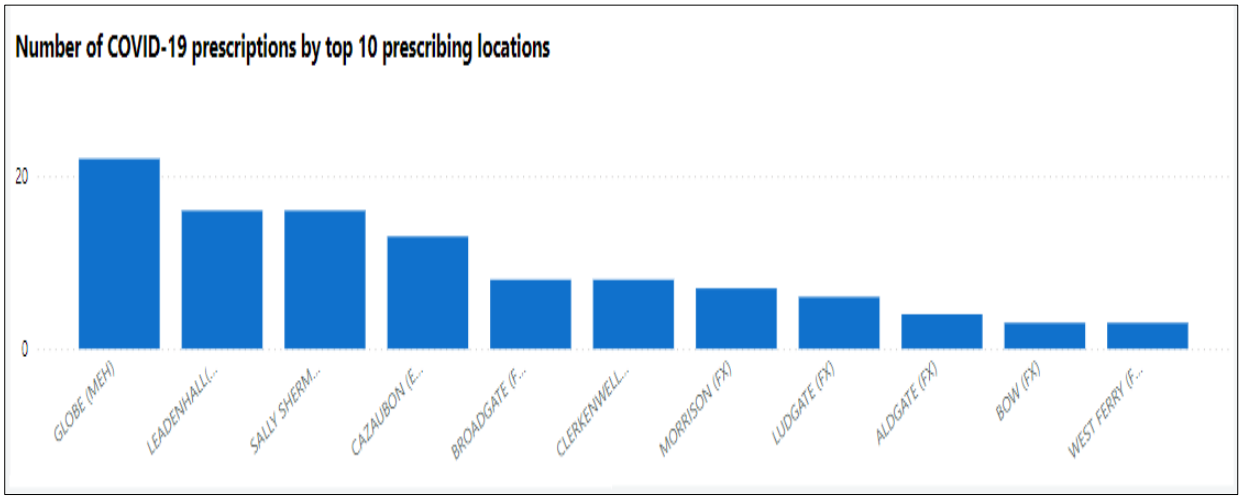


***Figure 90**. below Illustrates the top 10 wards prescribing COVID-19 vaccines in Q4.*



(Data sourced from JAC system)

28.0 Sharps Injuries

During 2022-23, there were 30 Sharps injuries reported to TP Health, ELFT Occupational Health provider. This is a decrease from previous year, whereby 48 Sharps injuries were reported to TP Health. The IPC Team follow-up and provide education and training in order to minimise risks associated with needlestick injuries (NSI's). All sharps incidents that are reported are followed-up on ELFT systems and by the Trust's Occupational Health Provider (TP Health) and also in relation to learning from Incidents.

28.1 Safer Sharps Devices

The IPC team have been raising the profile on the safe disposal of used sharps, the management of NSI's, and the use of safer sharps devices (retractable needles) during IPC training sessions. There has been extensive work carried out in Tower Hamlets following an incident there in Quarter 2. In line with lessons learnt an 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 August 2022.

***Figure 91**. shows a breakdown of Classifications of types of NSIs.*

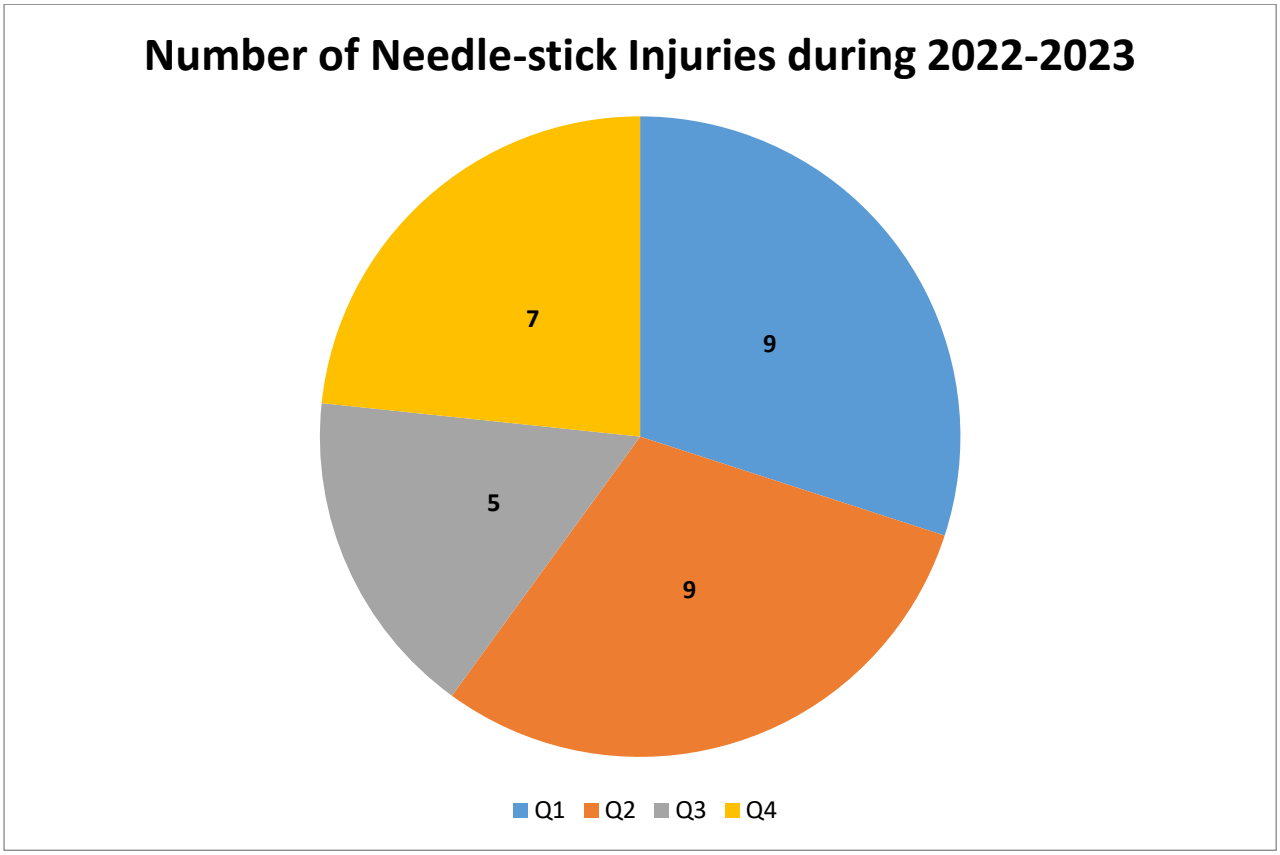
Classification of Injury	Splash of blood/bodily fluid on intact skin
Mucocutaneous Exposure	where there is direct contact of blood/bodily fluid with eyes, nose or mouth or on broken skin e.g. uncovered cuts or eczema not covered with waterproof dressing.
Percutaneous Injury	is an exposure incident in 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.

28.2 Safer Sharps Audits

Safer sharp audits are undertaken as part of Environmental Audits 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. IPC promote safer sharps practice during teaching sessions/audits.
Safer sharps devices are available for insulin pens for Nurses to use as appropriate in community services.

The IPC Team follow up needle-stick injuries (NSI's) reported via Datix. The IPC team provide support and education to minimise risks associated with NSI's.

***Figure 92**. below shows the total number of NSIs in 2022-23 by quarter.*



(Data sourced from Datix system)

***Figure 93**. below shows NSIs per month in Q1.*

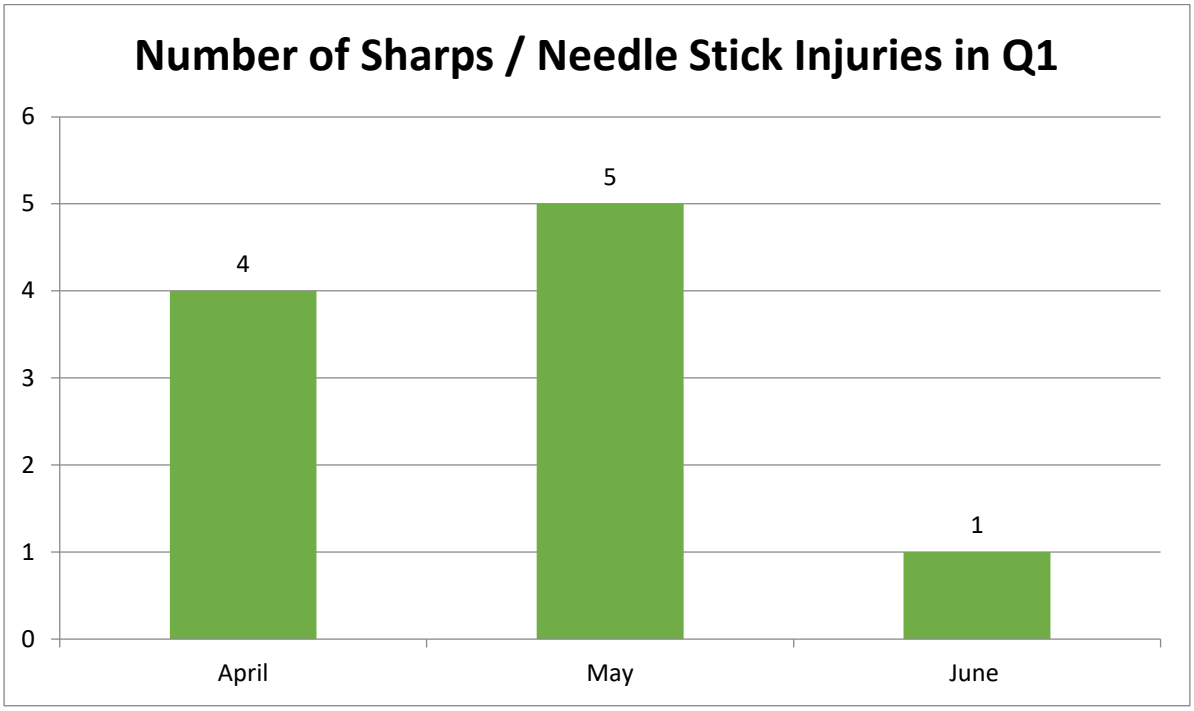


***Figure 94**. below shows NSIs per month in Q2.*

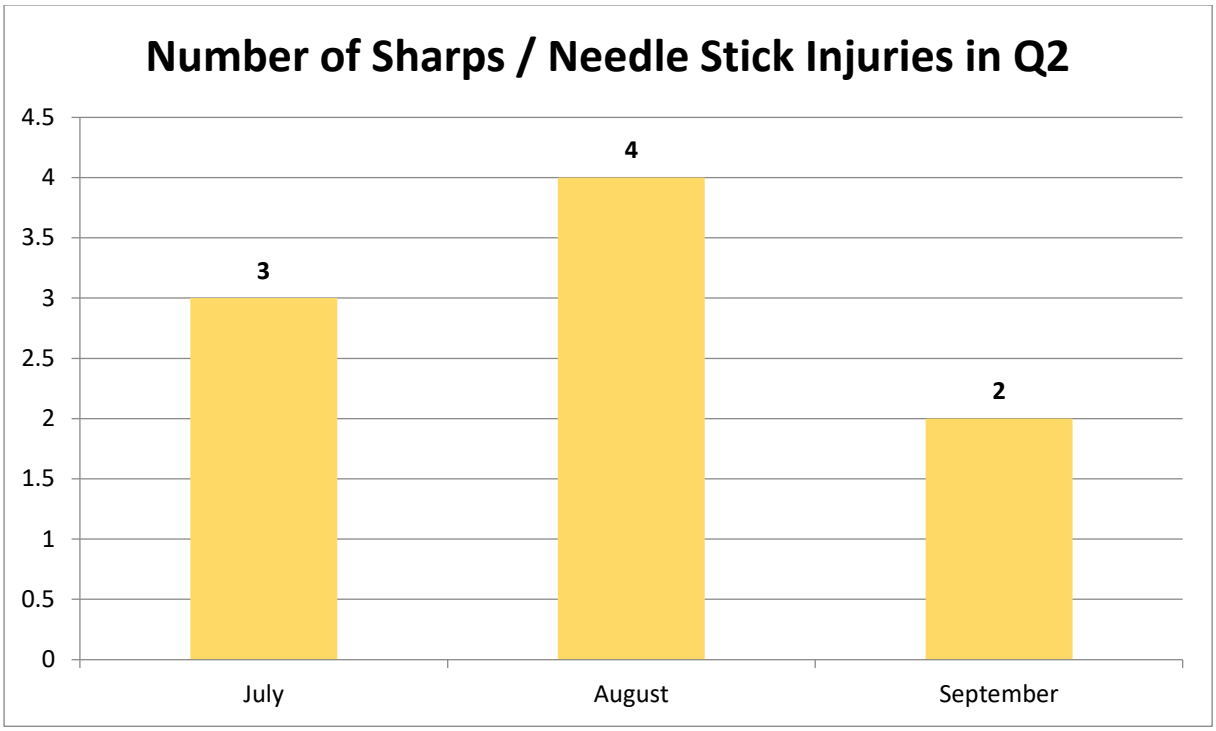


***Figure 95**. below shows NSIs per month in Q3.*

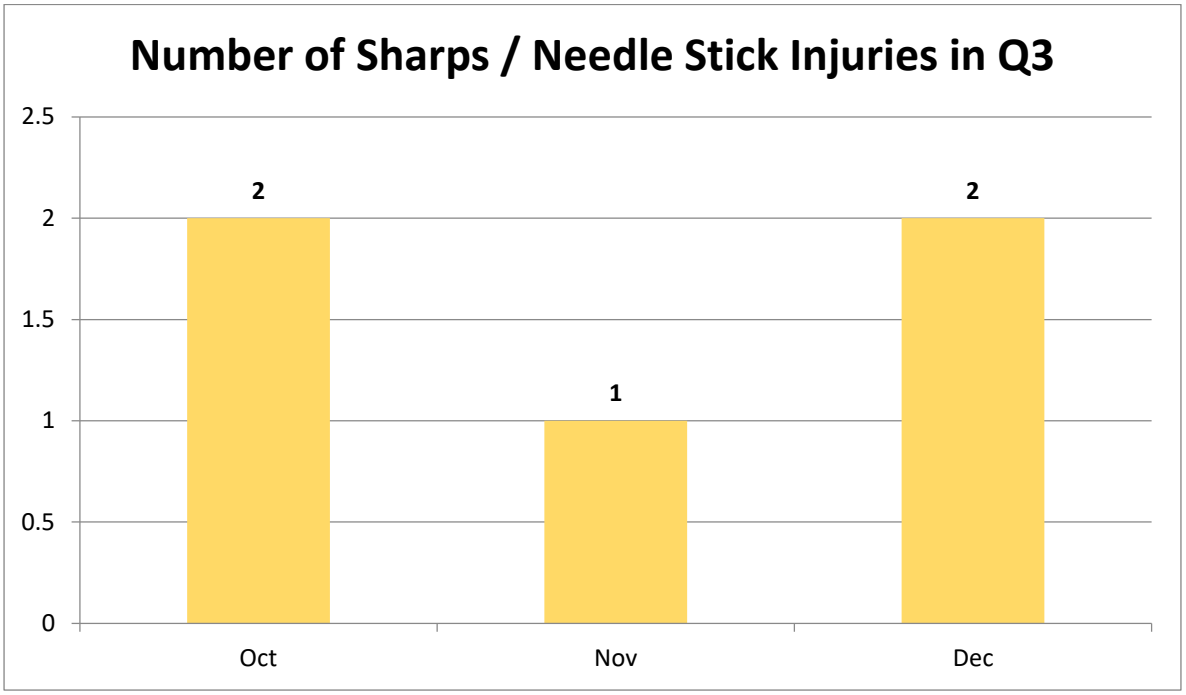


***Figure 96**. below shows NSIs per month in Q4.*

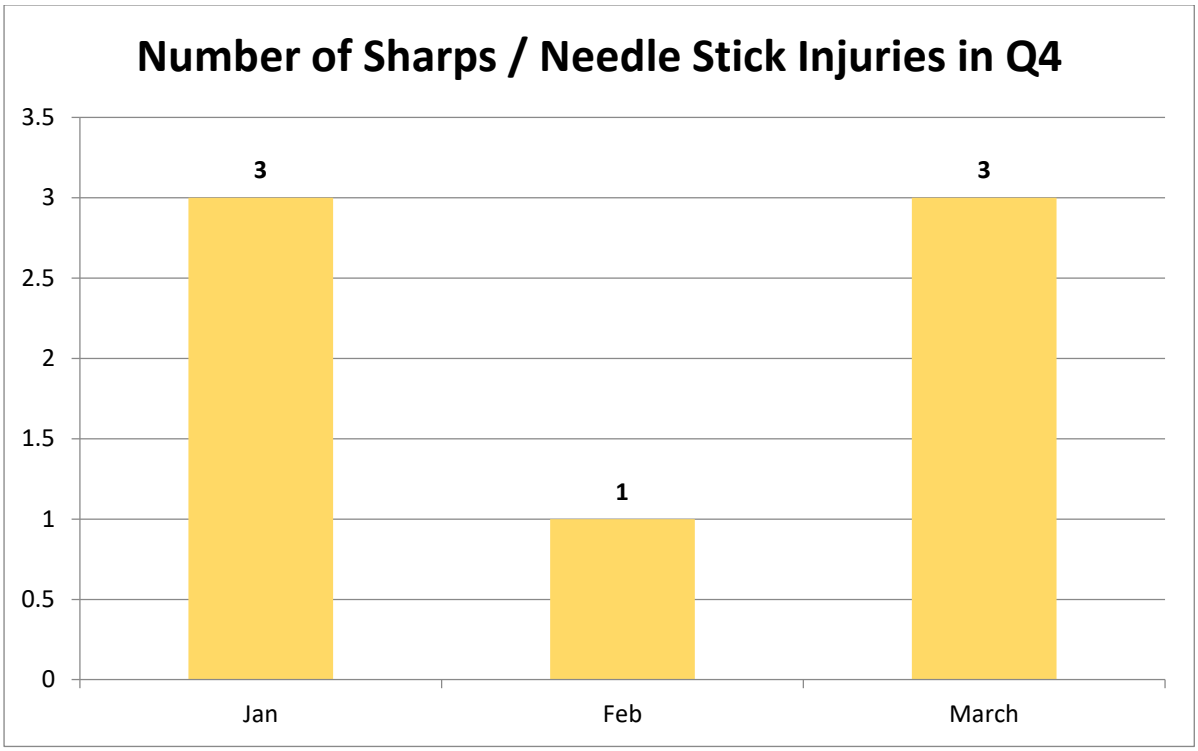


***Figure 97**. below shows a breakdown of type of Sharps injury (clean/dirty/non-clinical) for Q1.*

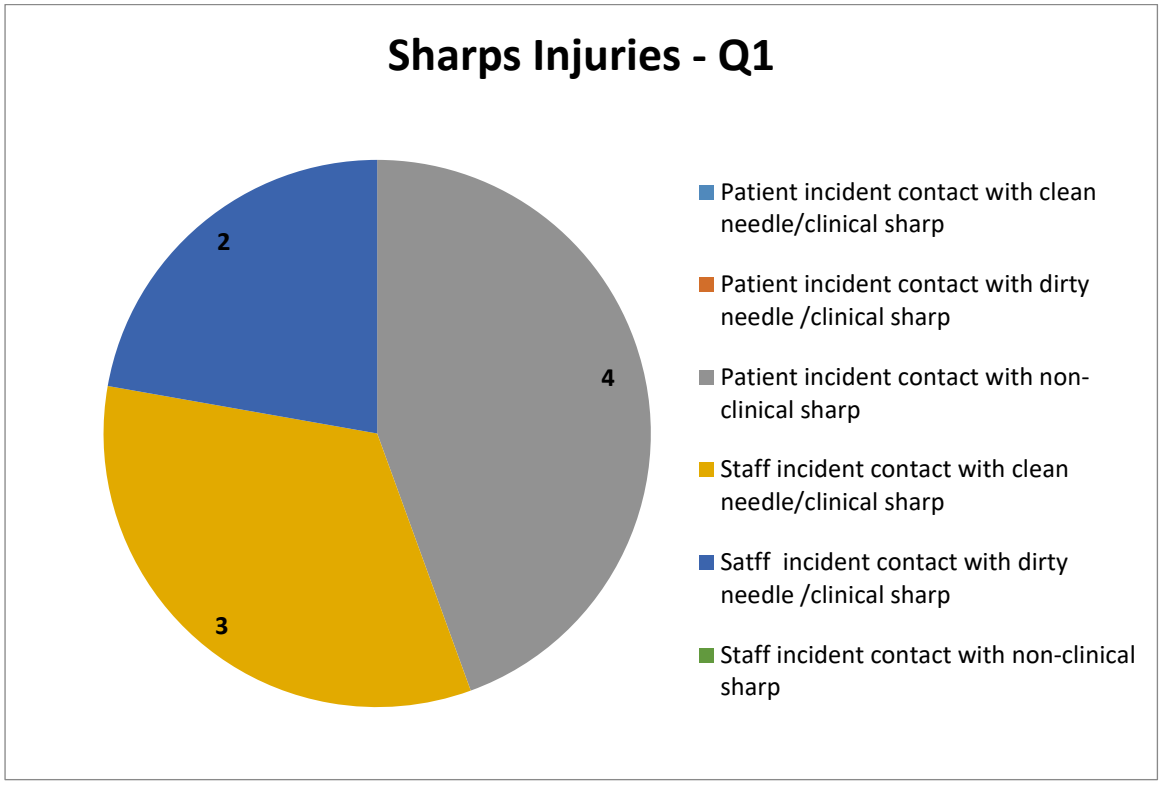


***Figure 98**. below shows a breakdown of type of Sharps injury (clean/dirty/non-clinical) for Q2.*

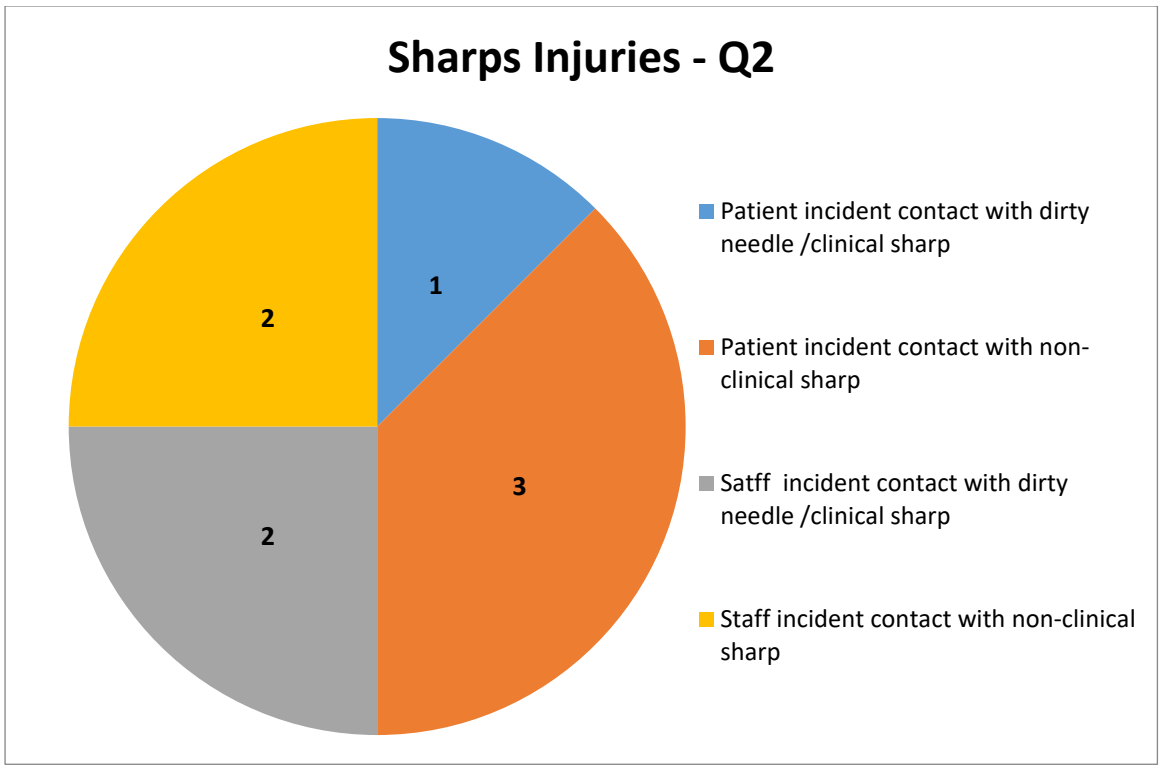


***Figure 99**. below shows a breakdown of type of Sharps injury (clean/dirty/non-clinical) for Q3.*

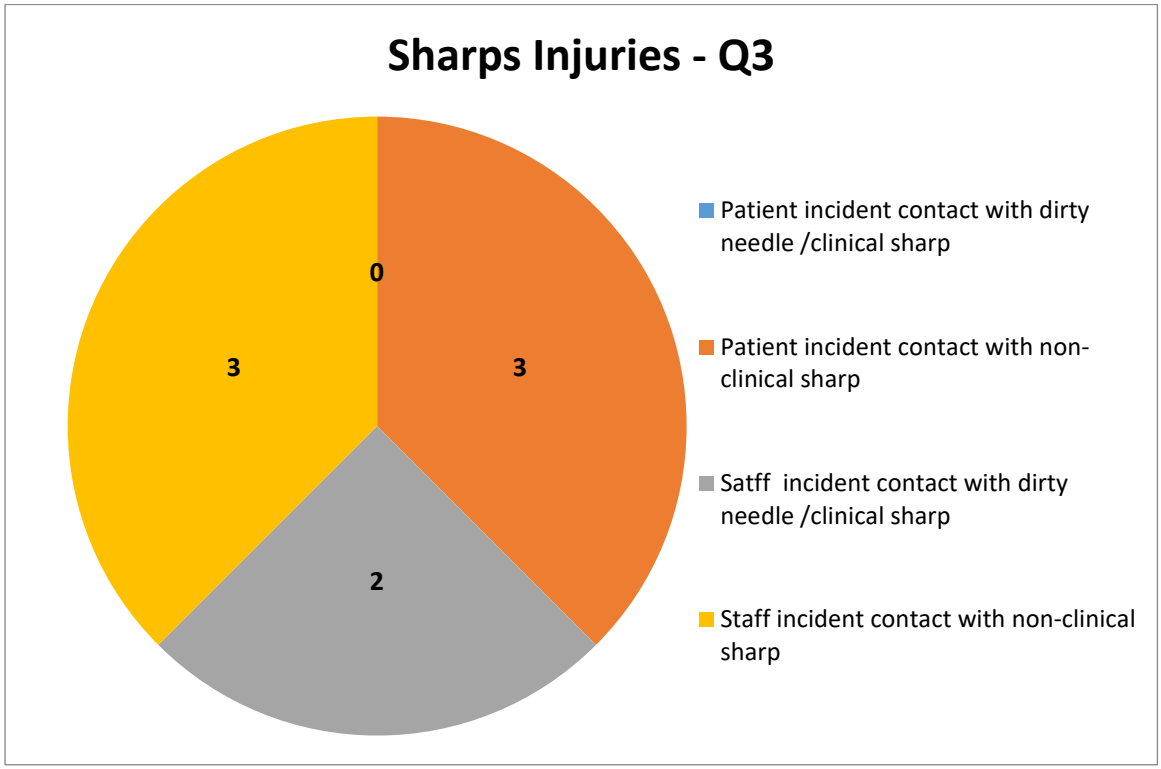


***Figure 100**. below shows a breakdown of type of Sharps injury (clean/dirty/non-clinical) for Q4.*

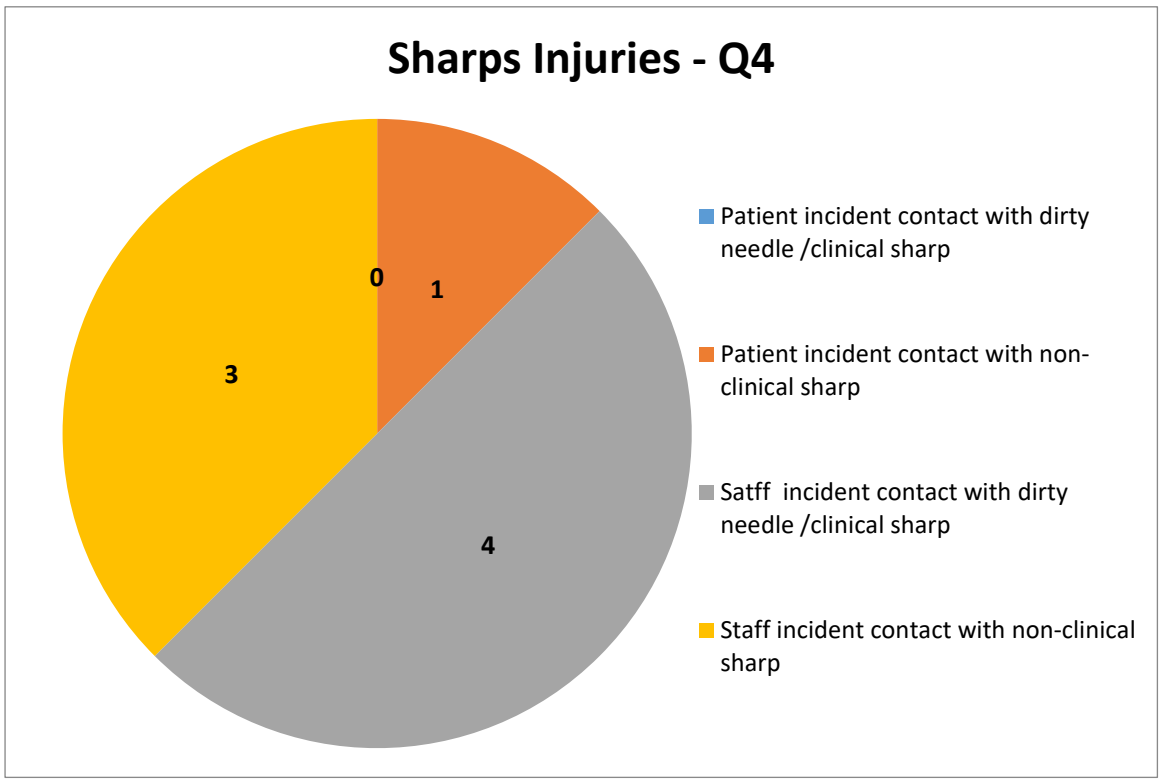
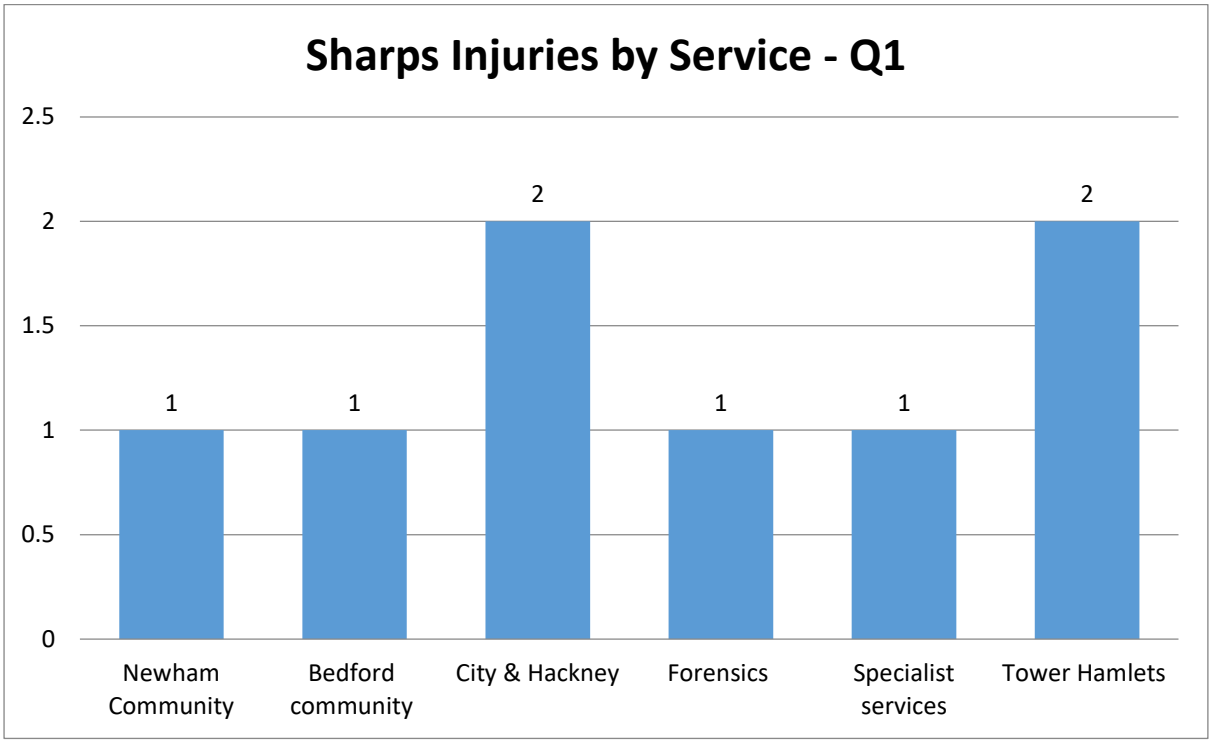
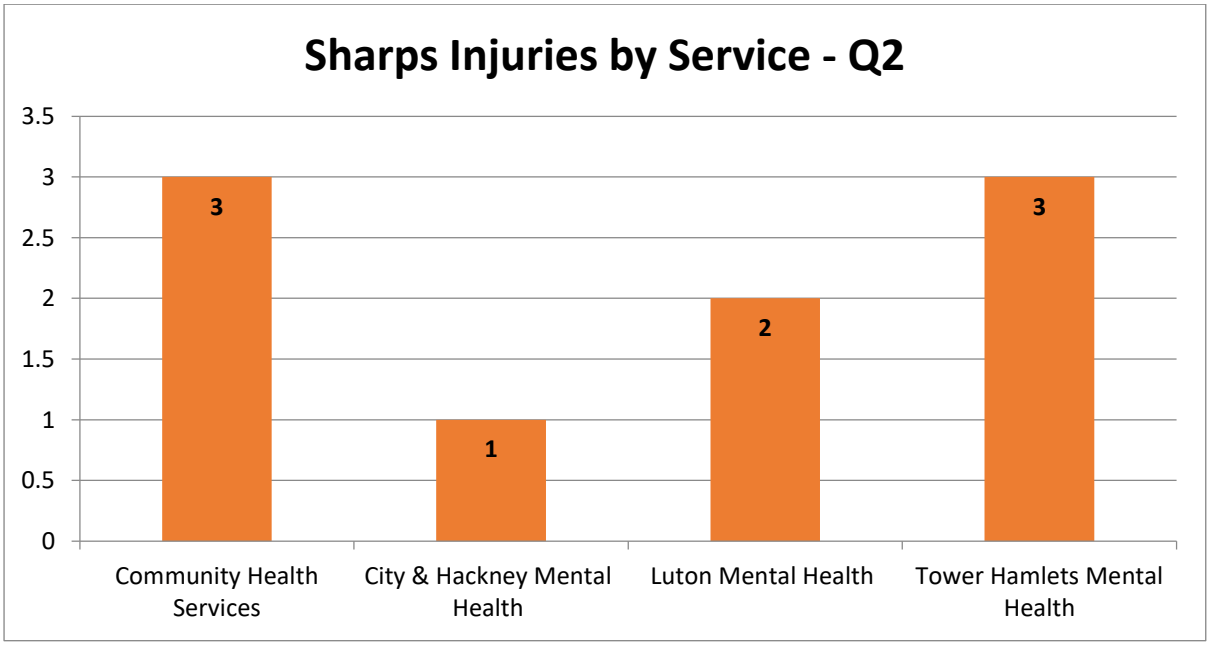


Figure 101. *below shows a breakdown of Sharps injury by Service in Q1.*



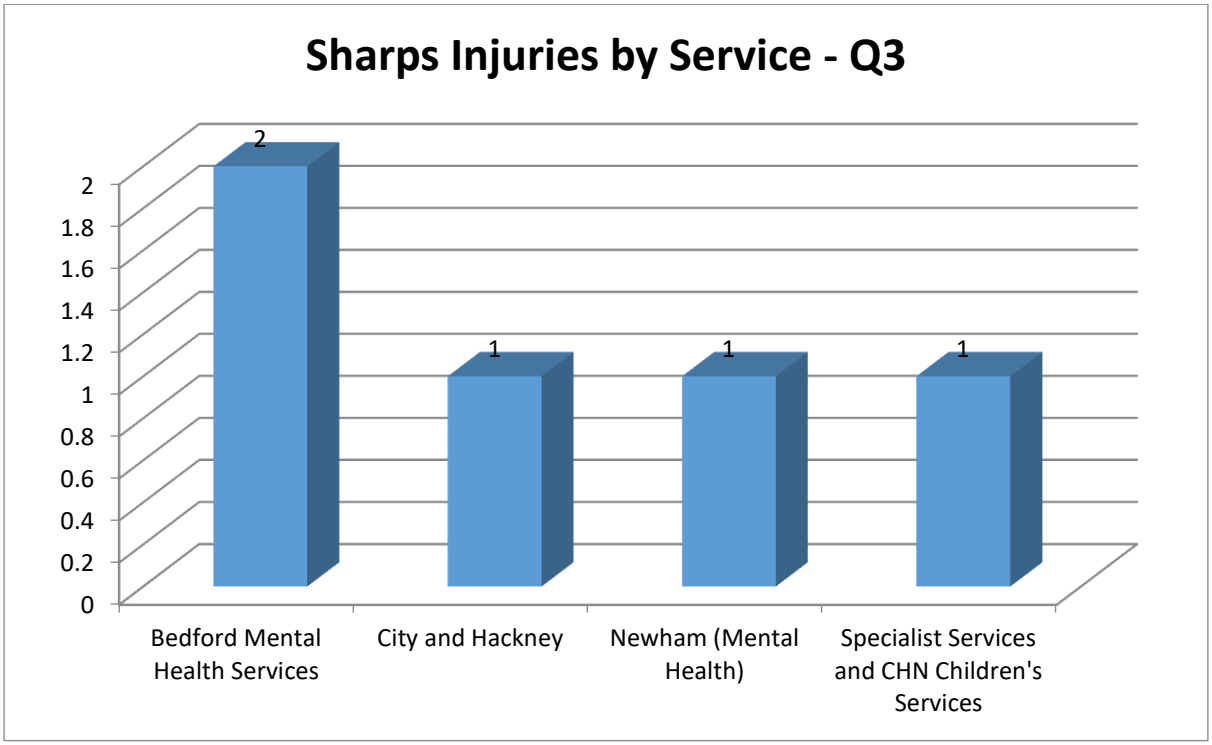
In Q1, Tower Hamlets and City and Hackney had the highest number of sharps injuries. There was a sharps incident relating to insulin devices in Tower Hamlets. As a result, joint working between IPCT and the Diabetic Nurse took place. Any unsafe diabetic devices found were removed. The joint visit with the Diabetic Nurse identified gaps in communication around management of Care Sense Lancet. A pathway was developed on the management of non-safety diabetic devices brought in by patients to the ward.

Figure 102. *below shows a breakdown of Sharps injury by Service in Q2.*



In Q2, Tower Hamlets and Community Health Services had the highest number of sharps injuries. Sharps injuries were related to insulin pens or used needles accidentally causing sharps injury to user during point of disposal. Ad-hoc training was provided to local teams on safe disposal of sharps.

***Figure 103**. below shows a breakdown of Sharps injury by Service in Q3.*



29.0 Annual Work Plan 2022-2023

The annual work plan was based on the requirements of the code of practice for infection control, stakeholder feedback and IPC nurse visits. Key themes were used to formulate the action plan. See last year's summary diagram on Appendix 3. The requirements of the annual work plan for the last financial year were met. This year's plan has been submitted to the IPC Q4 Committee 2022-2023 for approval.

30.0 IPC Audit Programme

Regular self-monitored IPC audits focusing on hand hygiene facilities and products, decontamination material, 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. Figures 106-114 show the results of validation audits.

30.1 Environmental Audits

There is an on-going annual rolling programme of clinical environmental audits undertaken across the Trust by IPCNs. It is the intention of the IPC team to encourage staff to undertake their own audits in low risk areas with support from IPCNs. Recommendations and action plans are formulated where required with timeframes for actions to be undertaken and sent back to Infection Prevention and Control Nurses.

These are carried out by the IPC Team alongside ward managers and Matrons on a rolling programme. Areas with scores under 85% will be re-audited with in-patient areas prioritized. This is a vital part of IPC through preventing and controlling infection by maintaining standards. Audits 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 the year to achieve good standards of infection prevention and control, through shared working with the wider team (Estates, clinical teams and contractors).

***Figure 104**. below shows environmental audits conducted during 2022-2023.*

Area (Patient-facing services)	Q1- Audit score	Q2- Audit score	Q3- Audit score	Q4- Audit score	Comments
Gardner Ward	94%				
Conolly Ward	90%				
Fothergill Ward	91%				
Roman Ward	85%				
Mother & Baby Unit	96%				
Victoria Ward	84%				Majority of actions identified are easily rectifiable, however some major actions noted of the hard facilities of the environment. Re-audit due in 2023-24 Q1.
Brett Ward	81%			90%	
Sally Sherman Ward	89%				
Bow Ward	90%				
Bevan Ward	98%				
Ruth Siefert Ward	91%				
Clerkenwell Ward	94%				
Joshua Ward	88%				
Ivory Ward	87%				
East India Ward	97%				
Millhabour Ward	85%				
Sapphire Ward	88%				
Coral Ward	83%			93%	
Jade PICU Ward	91%				
Onyx Ward	82%			94%	
Poplars Ward		98%			
Fountains Court		96%			
The Lawns, Biggleswade		87%			
Beech Close, Dunstable		94%			
Flitwick Health Centre		93%			
Limehouse Ward		90%			
West Ferry Ward		94%			

Emerald Ward		81%	90%		
Opal Ward		84%	85%		
Brick Lane Ward		87%			
The Green House GP Practice		92%			
CMHT Passmore Edwards Building		90%			
Ash Ward		97%			
Cedar House		86%			
Willow Ward		96%			
Broadgate Ward			86%		
Butterfield Ward			99%		
Clissold Ward			92%		
Crystal Ward - Newham			83%	85%	
Ruby Triage Ward			91%		
Sapphire Ward			88%		
Topaz Ward			89%		
Galaxy Ward			86%		
Leadenhall Ward			86%		
Clozapine Clinic - Primrose Square				95%	
Balaam Street Clinic				95%	
Appleby Centre				92%	
Centre Manor Park				92%	
Globe Ward				84%	Actions identified are easily rectifiable. Re-audit due in 2023-24 Q1.
Lea Ward				88%	
Cazaubon Ward				93%	
Coborn PICU				89%	
Coborn Acute Ward				82%	Actions identified are easily rectifiable. Re-audit due in 2023-24 Q1.
Galaxy Ward				86%	
Hoxton Ward				96%	
Moorgate Ward				93%	
Aldgate Ward				87%	
Morrison Ward				86%	
Gardner Ward				89%	
Evergreen Unit				97%	
Crystal Adult Ward				92%	
Townsend Court Adult				76%	Majority of actions identified are easily rectifiable. Re-audit due in 2023-24 Q1.

30.2 Hand Hygiene Validation Audits and PPE Doffing and Donning Audits

The IPC nurse and matron in high-risk areas such as the older adult wards where patients are more vulnerable and are exposed to more invasive direct clinical care implement electronic hand hygiene validation audits on a quarterly basis. The hand hygiene audit captures five opportunities to decontaminate hands based upon the World Health Organisation (WHO) 5 moments of hand hygiene these are show below on Figure 105.

There is an Audit plan for next year which includes Hand hygiene and PPE audits on Trust System.

Figure 105*. below displays WHO's 5 moments of hand-hygiene.*

***Figure 106**. below illustrates self-reported Infection Control Audits for Q1.*

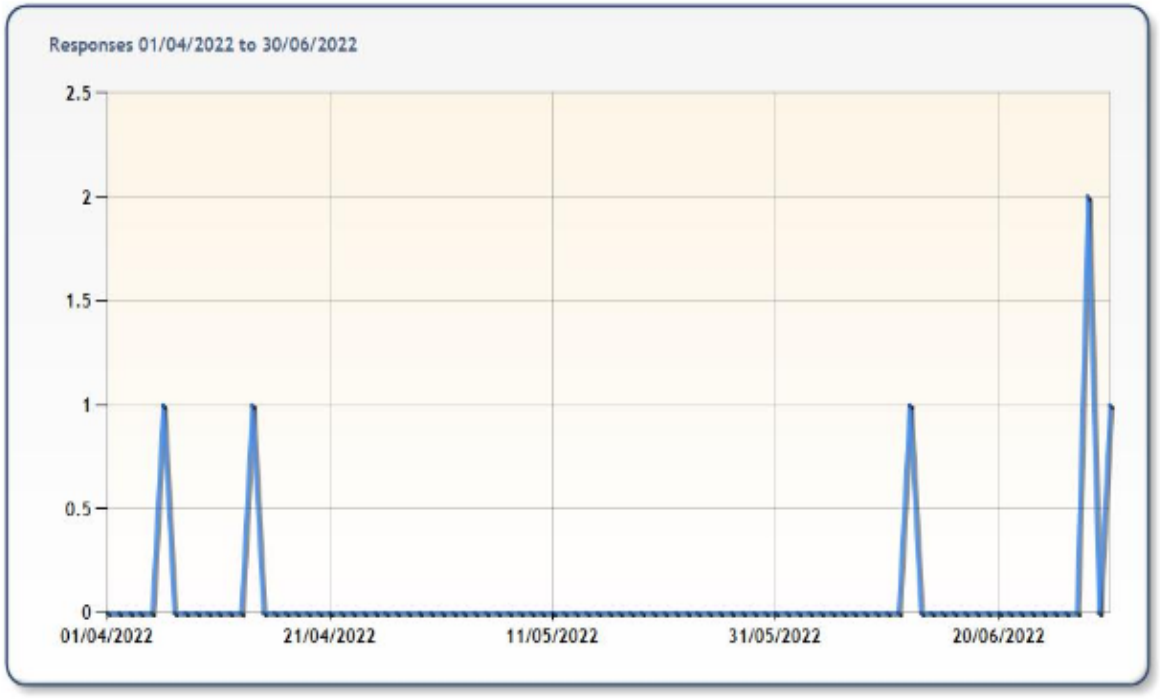


***Figure 107**. below illustrates self-reported Infection Control Audits for Q2.*

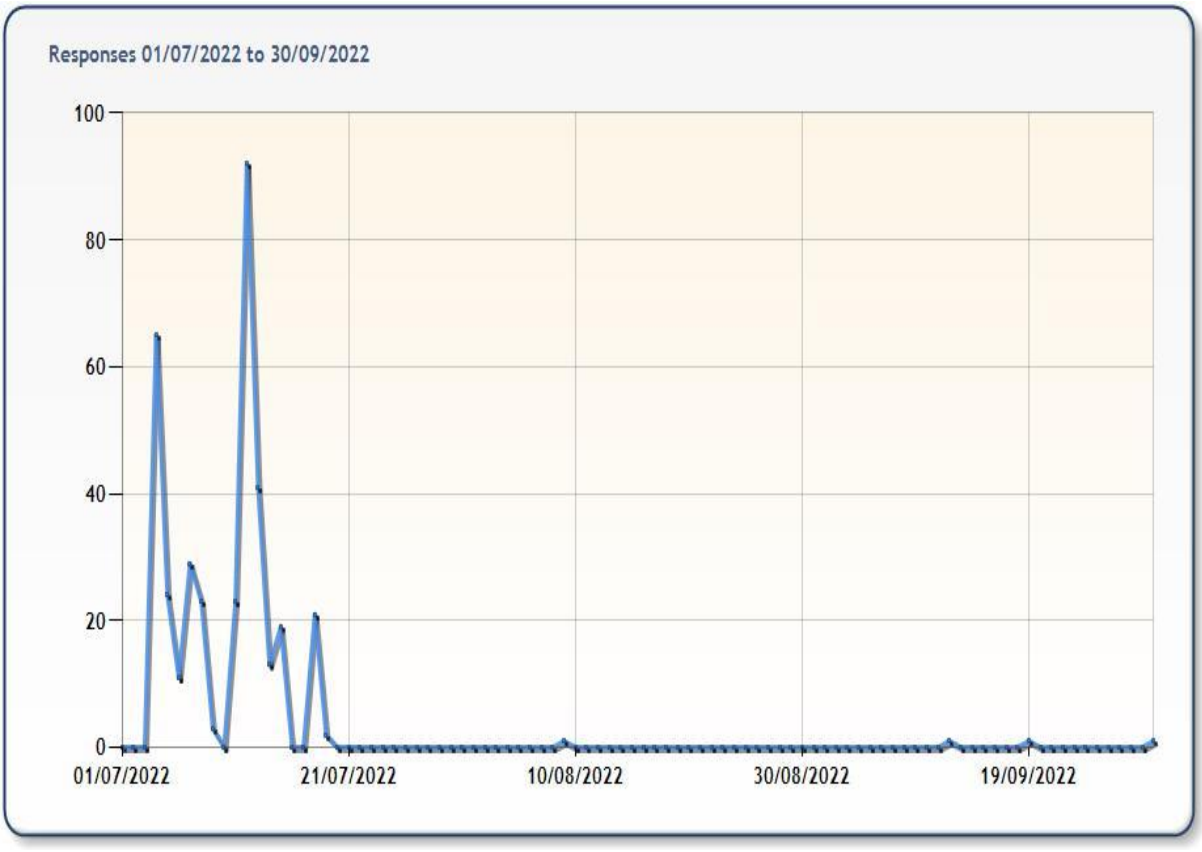


***Figure 108**. below illustrates Combined PPE & Hand Hygiene Audits for Q2.*

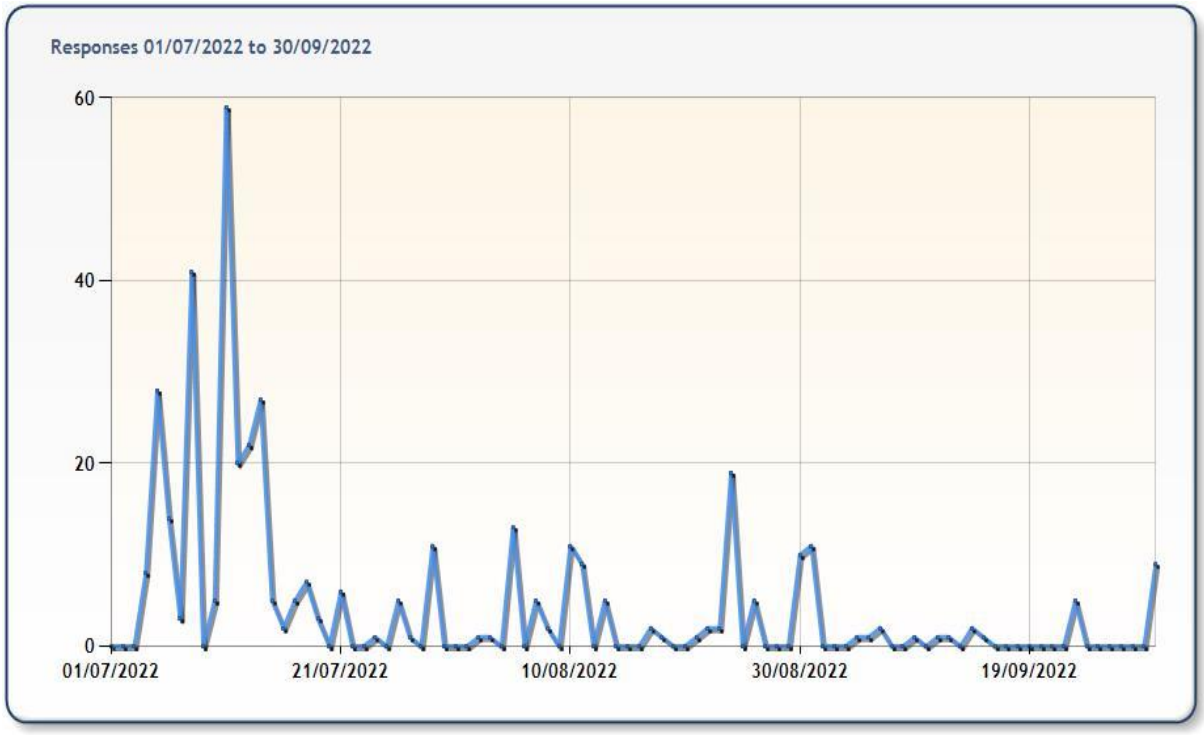


***Figure 109**. below illustrates Combined PPE & Hand Hygiene Audits for Q3.*

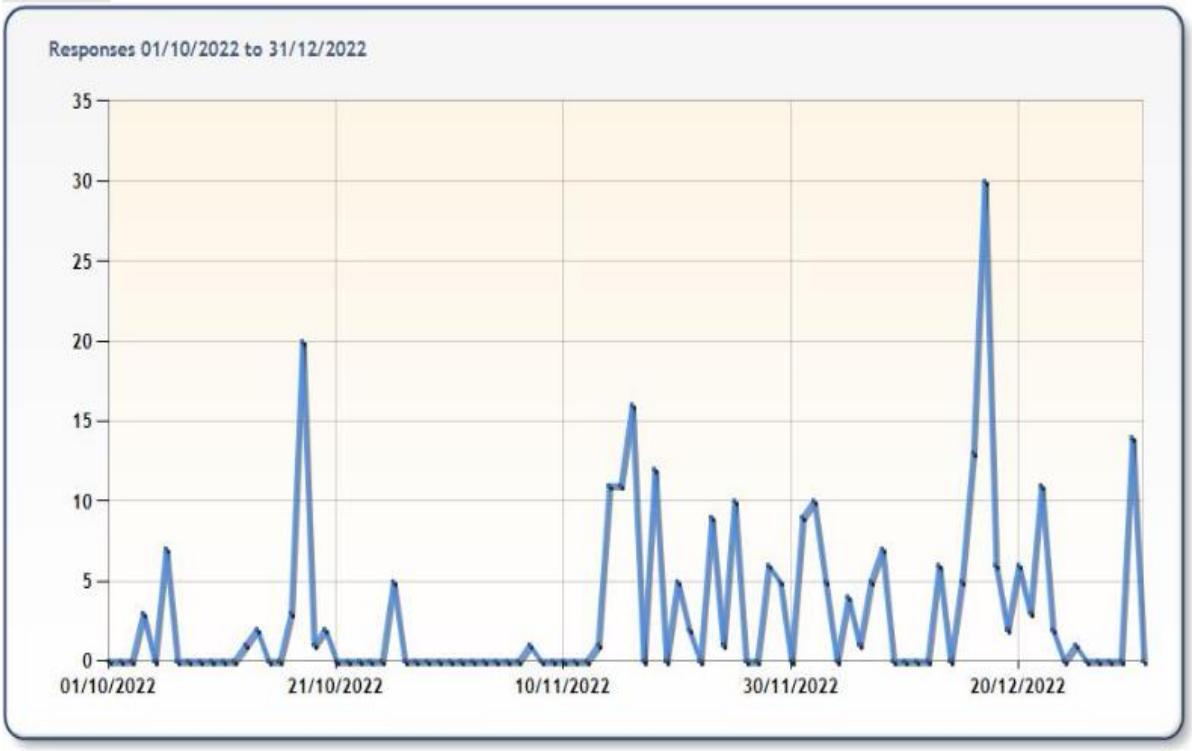


***Figure 110**. below illustrates Combined PPE & Hand Hygiene Audits for Q4.*

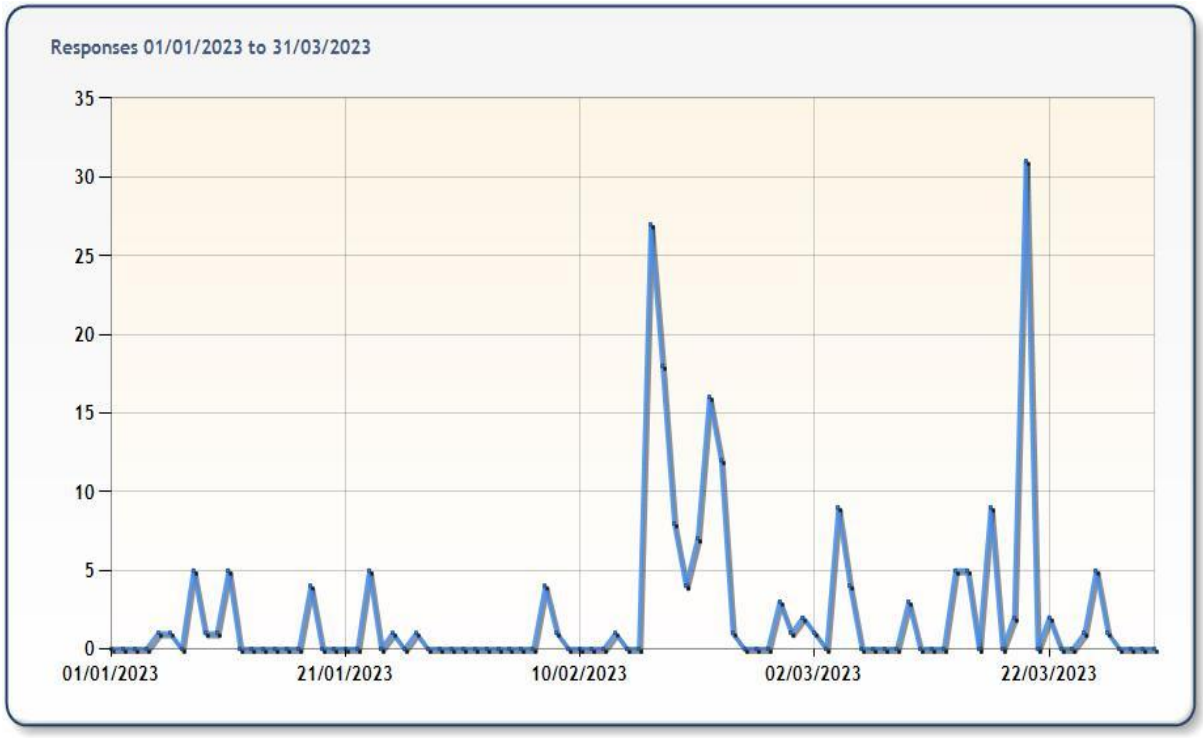


***Figure 111**. below illustrates Hand Hygiene Audits for Q1.*

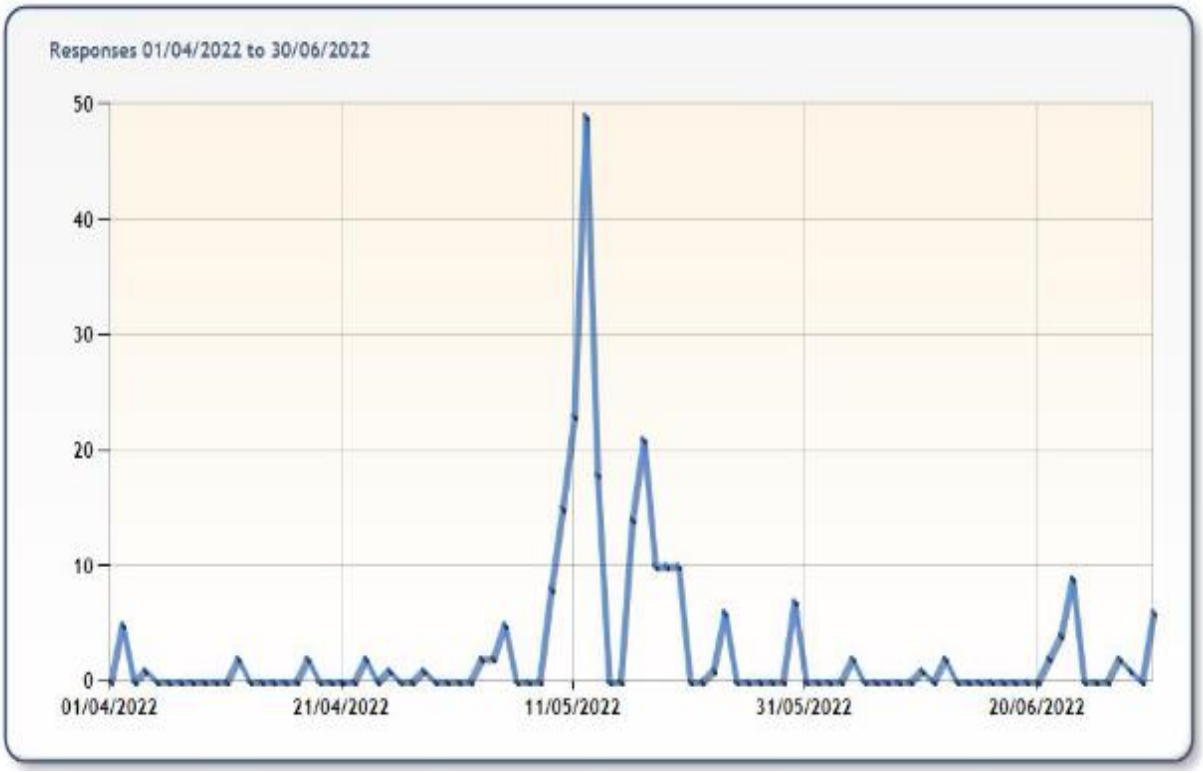


***Figure 112**. below illustrates Hand Hygiene Audits for Q2.*

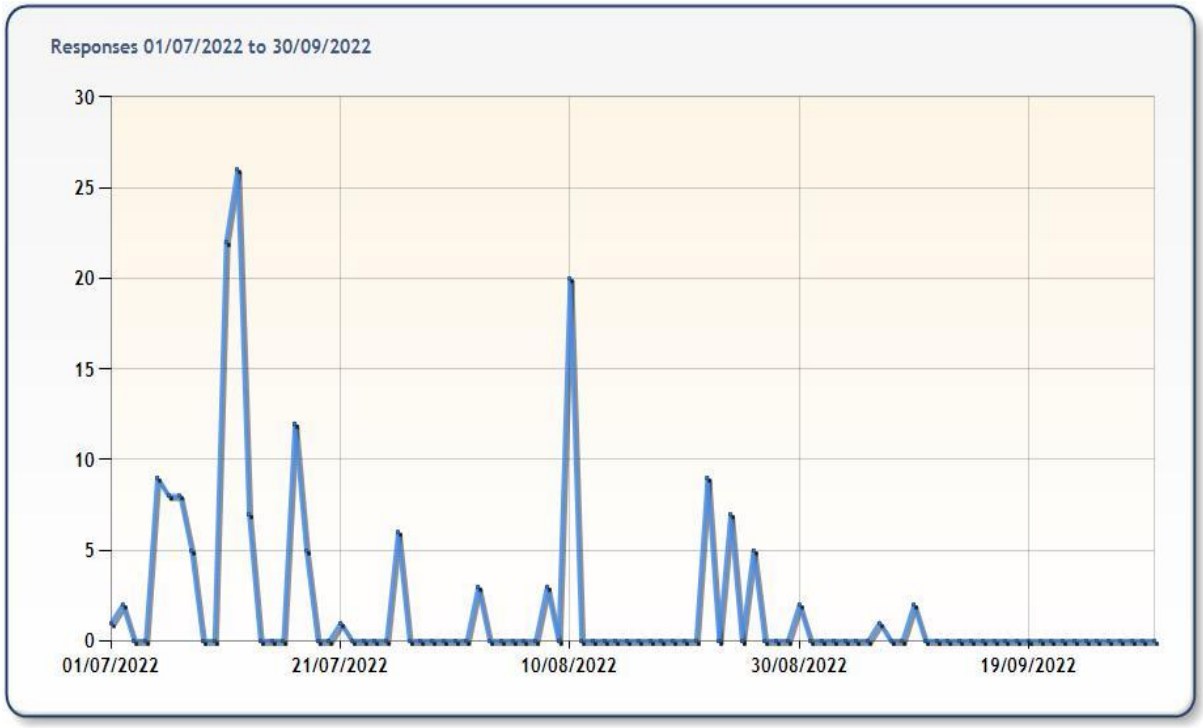


***Figure 113**. below illustrates PPE Audits for Q1.*

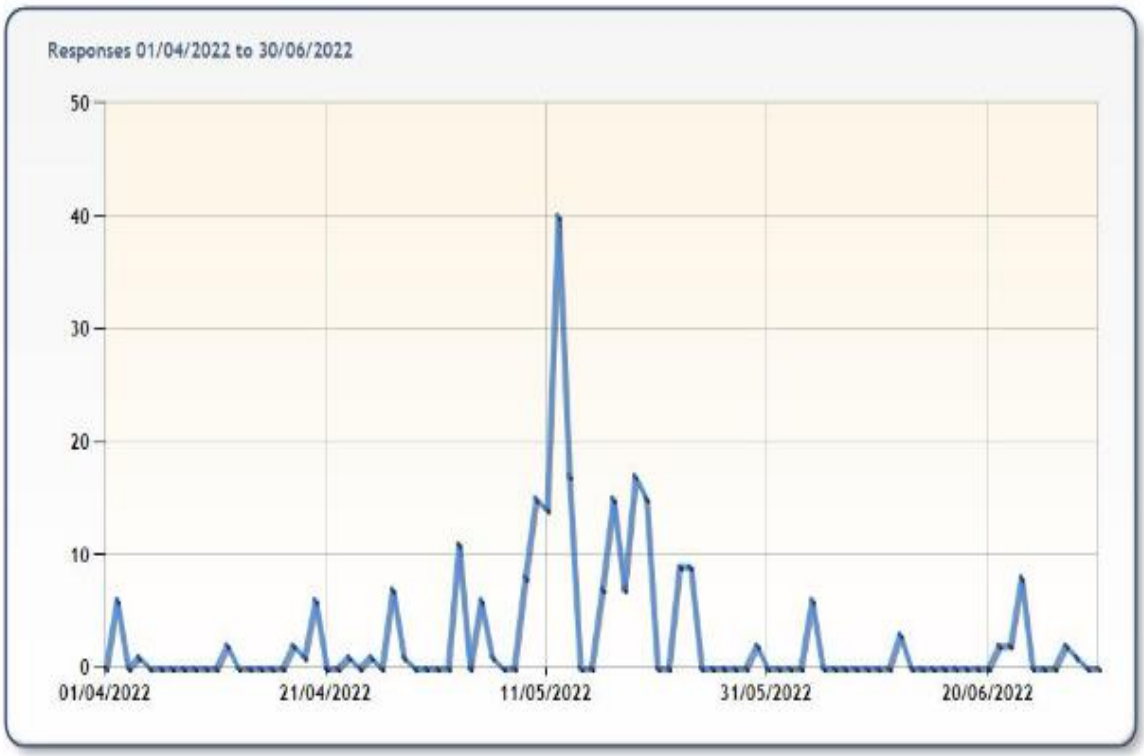
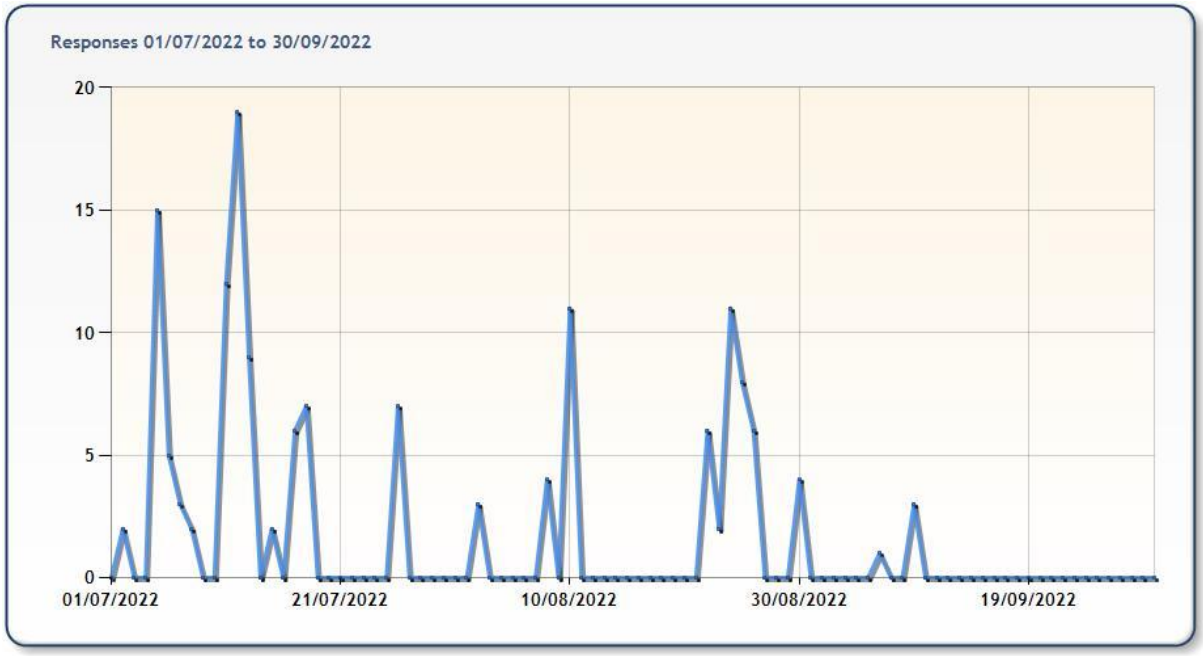


***Figure 114**. below illustrates PPE Audits for Q2.*



31.0 COVID-19 Documentation Compliance

National reporting was required for COVD-19 lateral flow test. The IPC team developed a RIO documentation template to record data. This project on improving documentation compliance was discontinued in August 2022, in line with national guidance changes to pause routine asymptomatic testing.

32.0 Antimicrobial Resistance (AMR) Quarterly Meetings

Antimicrobial Resistance (AMR) Meetings are held quarterly. During 2022-23 the terms of reference for group have been updated. The AMR policy has been updated to reflect North East London Catheter Passport steering group advice on treatment for positive cultures in asymptomatic patients with low inflammatory markers. The live dashboard has been providing useful data as it links to the patient electronic record for greater analysis. During 2022-23 this was further refined / updated with input from pharmacy and ELFT IPC Doctor. Reports are reviewed from key findings of the antimicrobial prescribing audit. This is used to monitor antimicrobial prescribing trends and quality indicators as part of the Trust-wide Antimicrobial Stewardship initiatives.

32.1 Antimicrobial Prescribing Audits

The ELFT pharmacy team collect data across all sites every quarter during a two-week 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:

32.2 AMR Method and Standards

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.

Figure 115*. below displays RAG rating parameters.*

RAG Rating	Required parameter
Red – Poor Compliance	Below 50% total compliance
Amber – Good Compliance, improvement needed	Total compliance between 50%- 89%
Green – Excellent Compliance	Above 90% total compliance (100% for allergy status documentation)
No colour	Insufficient forms to RAG rate

A total of 542 prescriptions were audited across all sites in February 2023, of which 24 were prescribed antibiotics.

Site	n	Completion of Allergy Status	Appropriate Treatment Choice	Documentation in RIO progress notes and medication chart			
				Indication	Dose	Course Length	Stop/Review Date
Bedfordshire & Luton	8	100%	100%	100%	100%	100%	75%
Tower Hamlets	6	100%	100%	100%	100%	83%	83%
Newham	5	100%	100%	100%	100%	100%	80%
City & Hackney	1	100%	100%	100%	100%	100%	0%
CAMHS	1	100%	100%	100%	100%	100%	100%
Forensics	2	100%	100%	100%	100%	100%	100%
CHN Adults	1	100%	100%	100%	100%	100%	0%
TOTAL	24	100% (24/24)	100% (24/24)	100% (24/24)	100% (24/24)	96% (23/24)	75% (18/24)

Figure 116*. above shows data on antimicrobial prescribing for 2022-23.*

CAMHS and Forensics: Overall results showed excellent compliance (100%) with audit standards.

Bedfordshire & Luton, Tower Hamlets, Newham and CHN Adults: This service has demonstrated good compliance with most audit standards. Compliance with the course length recorded on the medication chart in Q4 was 83% for Tower Hamlets.

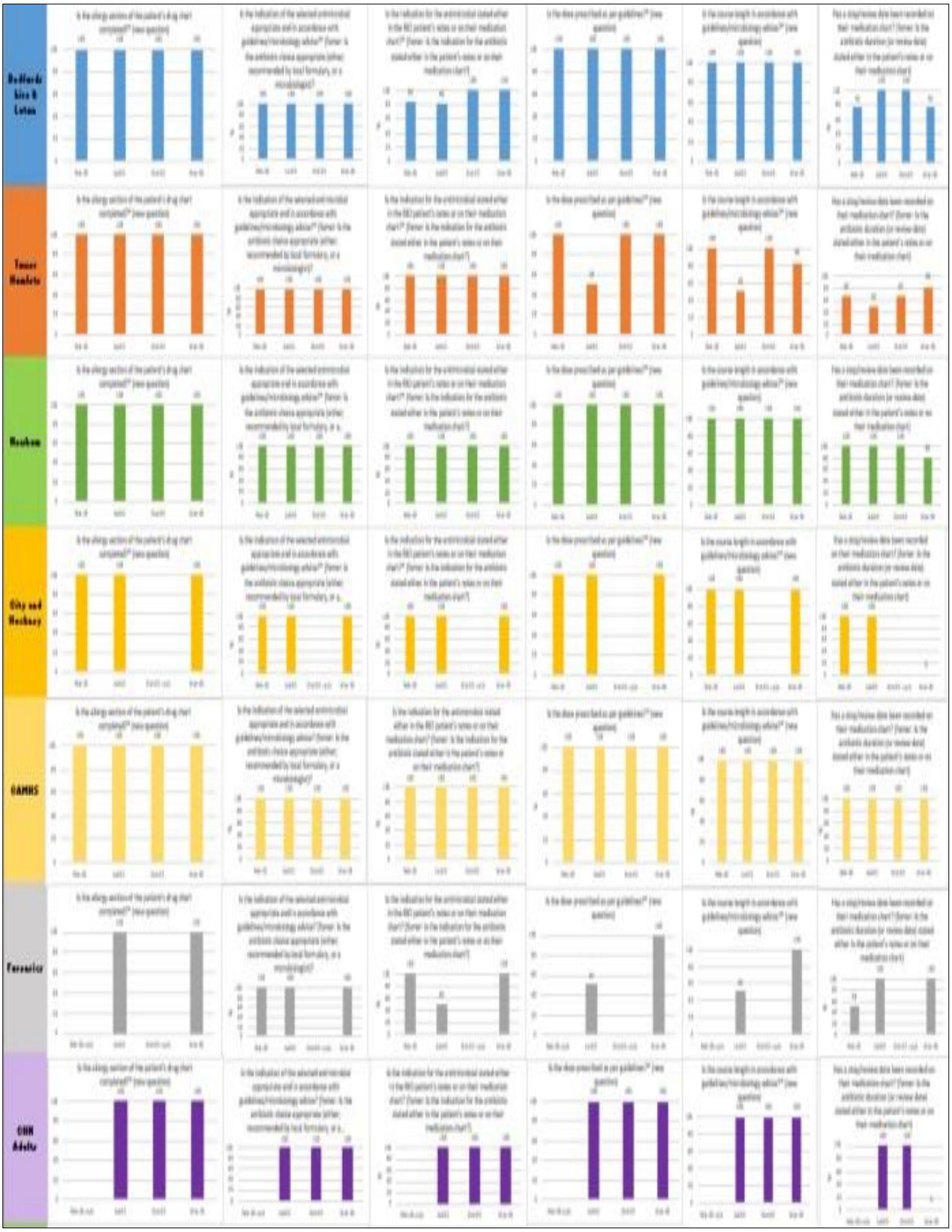
Compliance with the stop/review date recorded on the medication chart in Q4 was:

- 75% for Bedforshire and Luton; this was due to two prescriptions, which were non-compliant.
- 83% for Tower Hamlets; this was due to one prescription, which was non-compliant.
- 80% for Newham; this was due to one prescription, which was non-compliant.
- 0% for City & Hachney and CHN Adult; this was due to one prescription in both sites, which was non-compliant.

Comparison Data

A comparison chart was developed for 2022-23.

***Figure 117**. below shows a summary of compliance scores for prescribing across the Trust during 2022-23.*

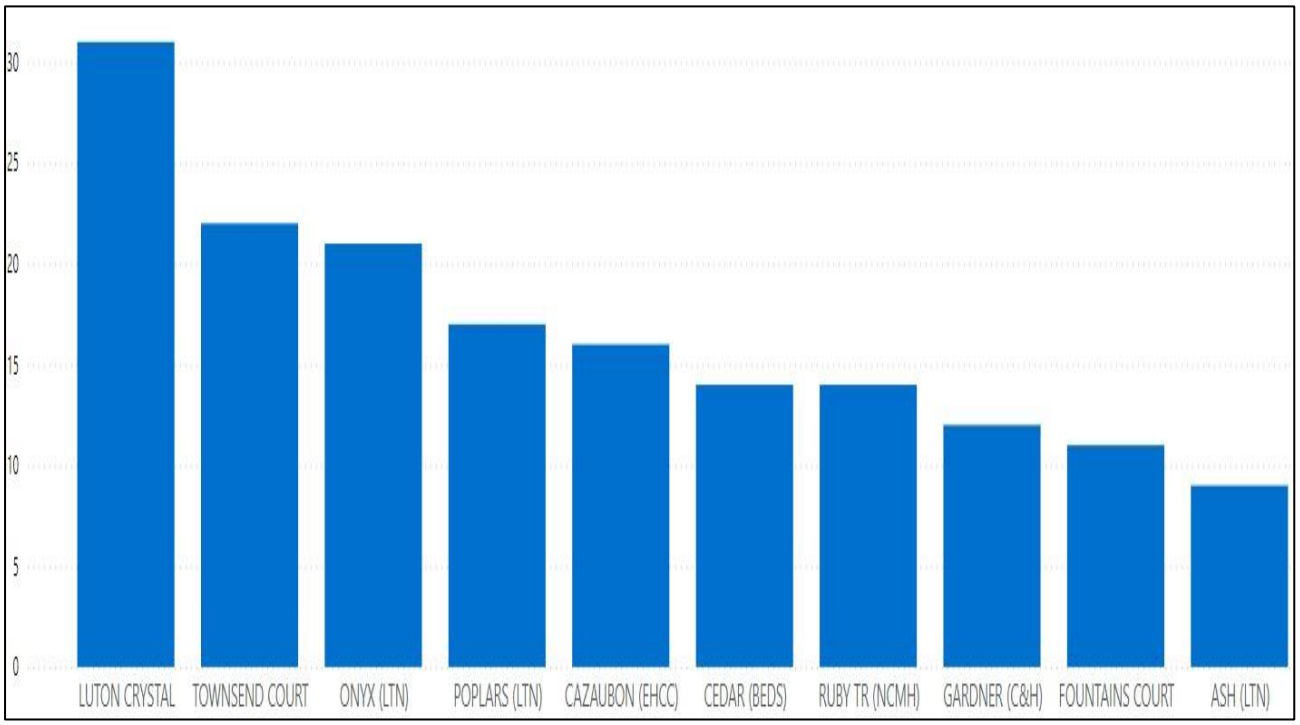


Top TEN Wards Prescribing Antimicrobials

***Figure 118**. below displays the top 10 wards prescribing Antimicrobials for 2022-23.*

Prescribing Location	No of Prescriptions (Antimicrobials)
Luton Crystal	31
Townsend Court	22
Onyx (LTN)	21
Poplars (LTN)	17
Cazaubon (EHCC)	16
Cedar (BEDS)	14
Ruby Tr (NCMH)	14
Gardner (C&H)	12
Fountain Court	11
Ash (LTN)	9

***Figure 119**. below illustrates the top 10 wards prescribing Antimicrobials for 2022-23.*



Top TEN Antimicrobials Prescribed

***Figure 120**. below displays the top 10 Antimicrobials prescribed for 2022-23.*

Drug	No of Prescriptions (Antimicrobials)
Co-Amoxiclav	60
Nitrofurantoin	48
Flucloxacillin	47
Amoxicillin	28
Terbinafine	19
Clarithromycin	15
Doxycicline	13
Trimethoprim	12
Metronidazole	10
Ciprofloxacin	9

***Figure 121**. below illustrates the top 10 Antimicrobials prescribed for 2022-23.*

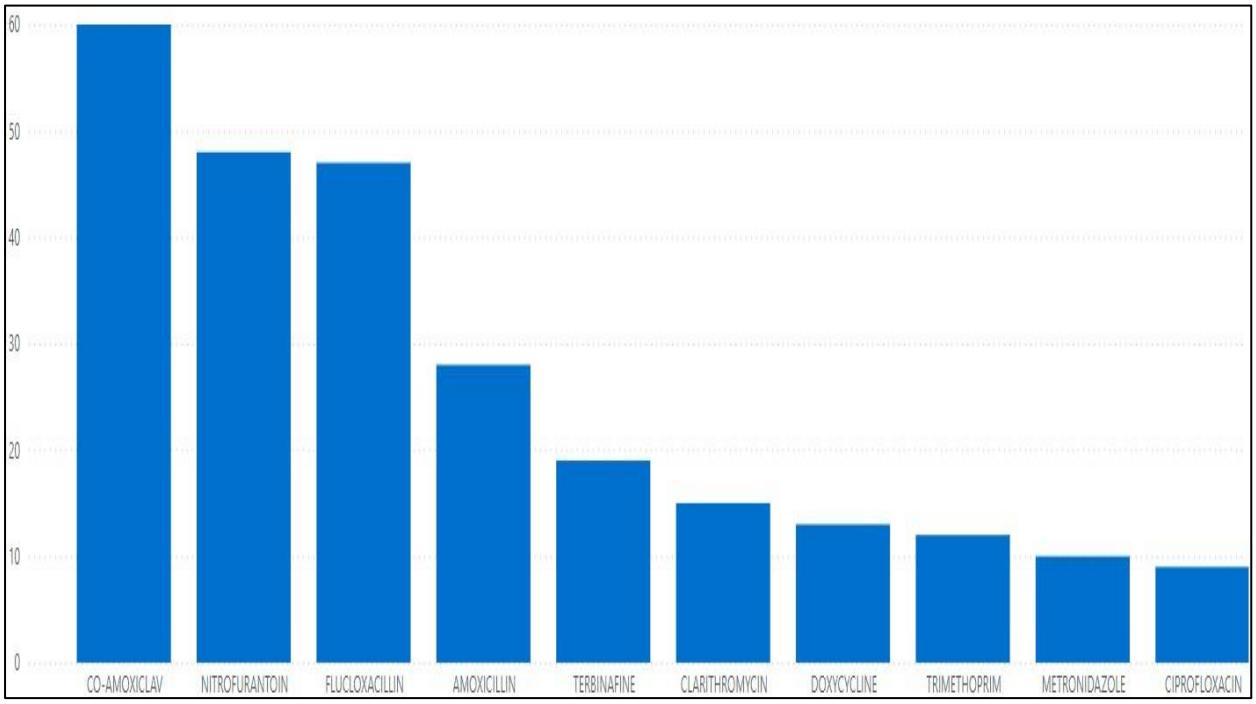


***Figure 122**. below displays the number of Antimicrobials prescribed from February 2022 to February 2023.*

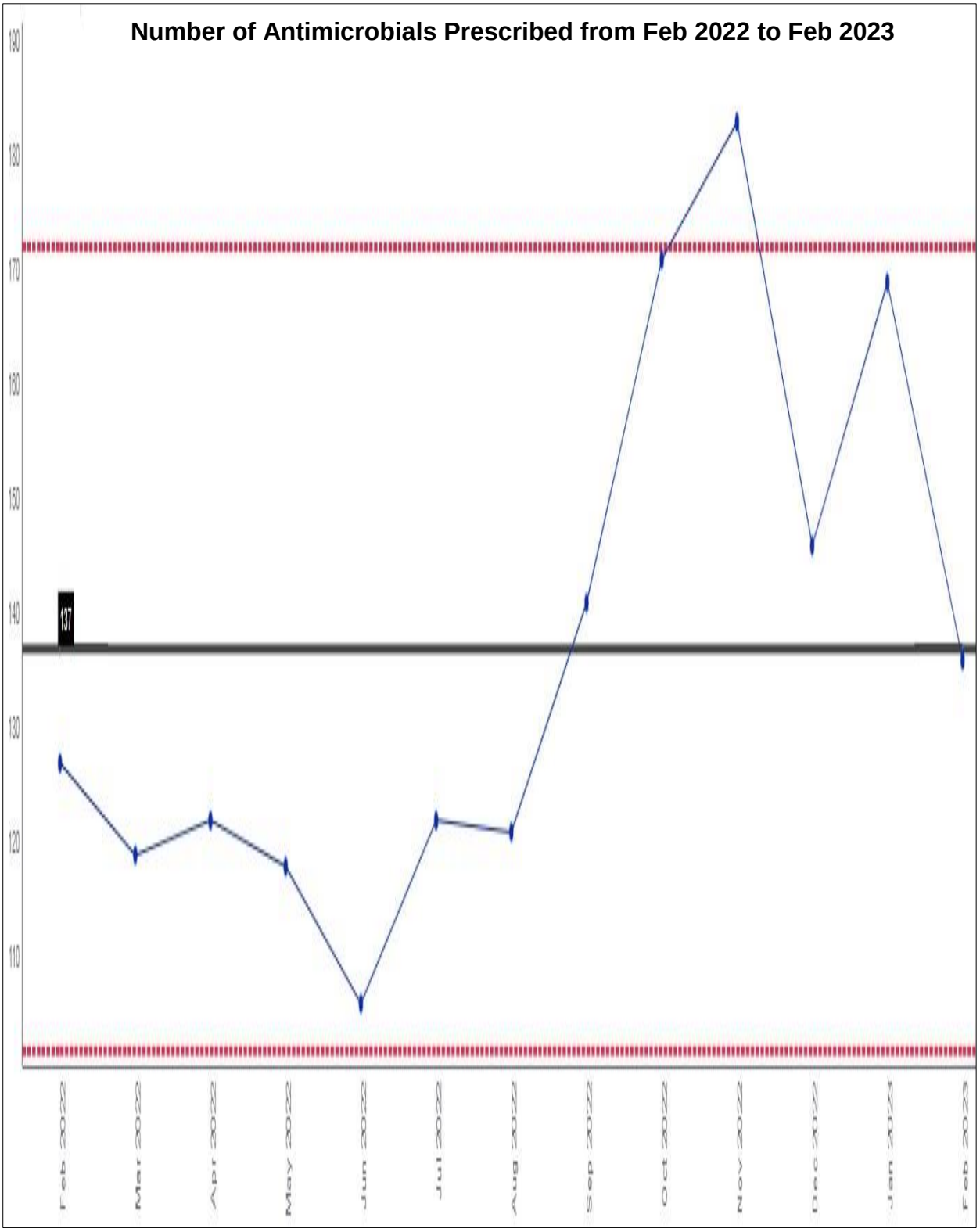
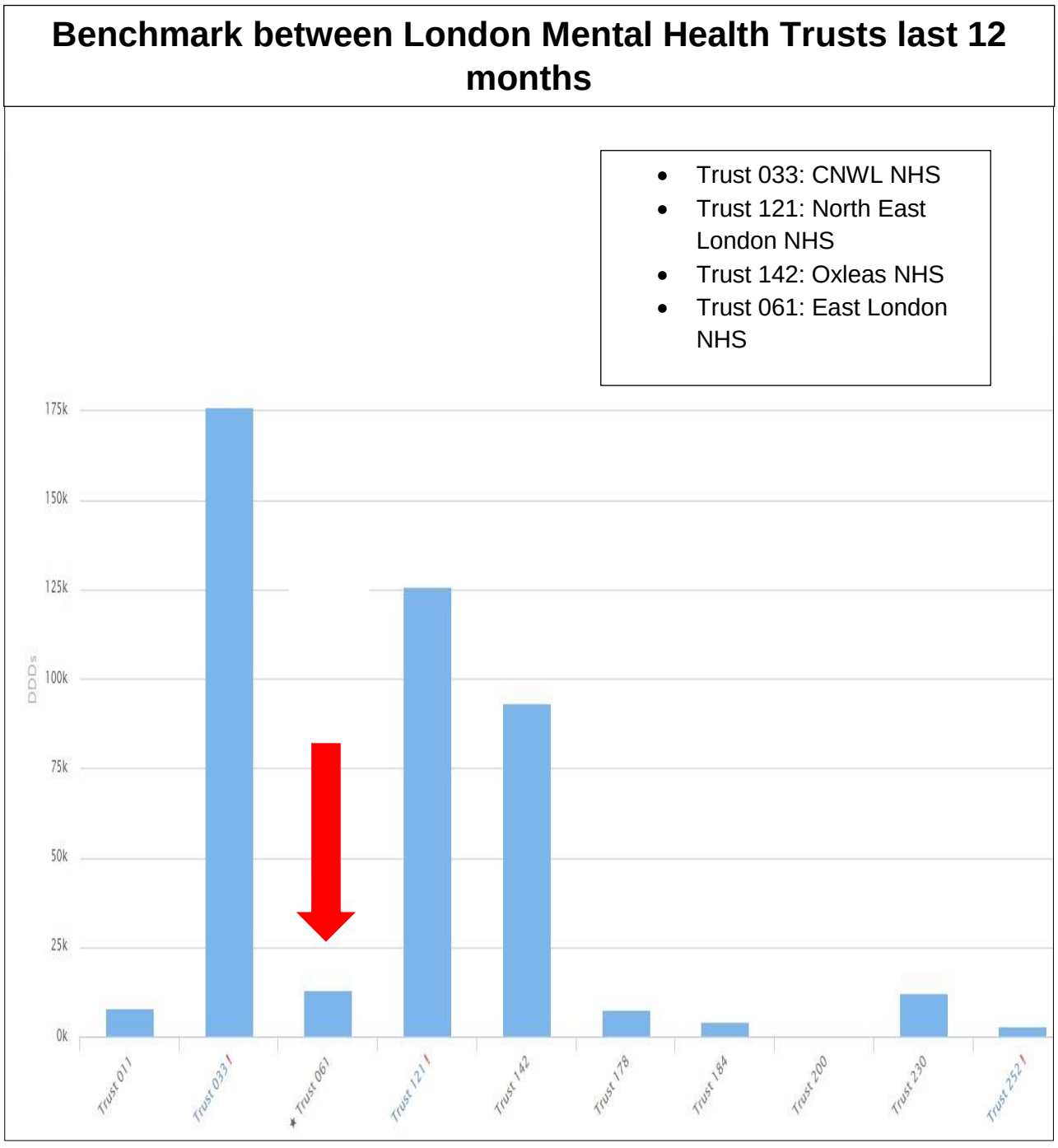


***Figure 123**. below shows antimicrobial prescribing within ELFT compared to other London-based Mental Health Trusts during 2022-23.*



During 2022-23, ELFT antimicrobial prescribling usage was benched marked with other Mental Health Trust similar to ELFT. Figure 123 shows antimicrobial prescribling in comprasion to other London based Mental Health Trust ELFT had a very low usage of antimicrobials and this is possible down to the success of the Pharmacy and IPCT joint working in reducing inapproroate antimicrobial usage.

33.0 Seasonal Influenza Vaccination Programme Healthcare Workers and Patients

In line with the National strategy, ELFT has been promoting and delivering Immunisation to protect staff & service users from Influenza and COVID-19.

Figure 124 shows a summary of data from the final flu report of the 2022-23 Flu season. During 2022-23 Frontline staff reported to NHS England is currently at 62.3%.

Figure 124. *below shows data for the Seasonal Influenza Vaccination Programme for Healthcare workers.*

Influenza Vaccination data						
Directive	***Yes***	***No***	***Total (Yes & No)***	***Total Staff***	***% Vaccinated***	***% including declines***
Bank	111	156	267	1932	5.75%	13.82%
Bedford	295	290	585	754	39.12%	77.59%
Bedfordshire CHS	276	171	447	459	60.13%	97.39%
City & Hackney	159	398	557	600	26.50%	92.83%
Tower Hamlets Community Services	106	80	186	213	49.77%	87.32%
Corporate	177	245	422	721	24.55%	58.53%
Forensic Services	141	282	423	536	26.31%	78.92%
Honorary Contracts	95	142	237	1865	5.09%	12.71%
Luton	110	214	324	379	29.02%	85.49%
Newham CHS	143	209	352	421	33.97%	83.61%
Newham	195	274	469	490	39.80%	95.71%
Primary Care	66	50	116	116	56.90%	100.00%
Specialist CHS	89	70	159	159	55.97%	100.00%
Specialist Services	305	515	820	1159	26.32%	70.75%
Tower Hamlets	193	311	504	637	30.30%	79.12%
Vaccination clinic	23	19	42	50	46.00%	84.00%
Grand Total	2484	3426	5910	6694	37.11%	88.29%

34.0 Decontamination of Medical Devices

Inadequate decontamination can result in the transmission of a range of micro-organisms from blood-borne viruses such as HIV or Hepatitis B, to fungal and common bacterial infections. Safe and effective decontamination of all re-usable equipment in-between use is imperative to ensure equipment is clean.

A single-use device (SUD) 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 mainly uses single-use non-invasive reusable medical devices. However in Podiatry services, some clinics use reusable devices which are decontaminated at sterile service facilities.

All equipment in the Trust, including items such as beds, sphygmomanometers and commodes, are cleaned in-between use as per the Trust's Decontamination Policy and monitored as part of the annual environmental audit programme.

During 2022-23, Tower Hamlets Community Health Services set up a contract with Enabled Living to support with decontamination of portable suction machines.

During 2022-23, teams have been self-reporting 99% compliance with decontamination.

35.0 Water Testing / Water Safety

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).

35.1 Management of Water Systems

Water Safety Group (WSG) oversees governance related to water safety issues across the Trust. Meetings are held on a quarterly basis. A water report is produced by the ELFT Estates and Facilities Team to the quarterly WSG and IPC Committee meetings.

There is a newly appointed Authorised Engineer who will be providing services to ensure ELFT remain compliant with water safety legalisation and they will be working collaboratively with the IPC Team and contractors reporting to the Trust's WSG.

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.

35.2 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

Water monitoring services at ELFT are out-sourced to several providers. Figure 125 shows a breakdown by site.

Figure 125. *below shows water monitoring services out-sourced to providers by site.*

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 Centre for Mental Health	Homerton	1
Newham Centre for Mental Health	GFM – sub contractor WCS	1

	Group	
Luton & Bedfordshire Sites	Rydon – sub contractor is Evolution	33
	EPUT	1
	Bedford Hospital	1
Bedford Community	NHSPS	17
	Bedford Hospital	1
	CHP	1
	Central Beds	1

Figure 126. *below shows water issues reported during* 2022-23.

Water Issues	Q1	Q2	Q3	Q4
Total buildings currently being monitored	1	3	8	10
Building currently identified with water quality issues (Legionella)	1	2	5	6
Water Risk assessments completed	8	5	6	4

35.3 Legionella Testing

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).

Every case of Legionella is a risk to any organisation. However, there are robust proactive and reactive measures in place to manage Legionella. Monthly Water Safety Sub-group Meetings with Estates & Facilities, IPC and the authorising engineer are held to monitor water issues.

Contractors have responsibility to maintain hot and cold water systems, completing monthly water temperature checks, and to have implemented a programme of water sampling. They also complete water tank disinfection and showerhead cleaning. All site visits and certification is available to view via contractor portals. London site visits and certification is available to view on the Clearwater portal, Luton & beds sites are the responsibility of Rydon/Evolution.

Figure 127. *below shows sites that reported positive legionella samples during 2022-23.*

Quarter	Site	Resampling results
Q1	East Ham Care Centre in Newham	There was an incident regarding the management of legionella. The External contractors did not notify the ELFT Estates & Facilities team nor IPCT of positive legionella results in timely manner. The IPCT facilitated a lessons learnt reflection meeting to look at current systems and processes for reviewing Water Testing. As a result, monthly water safety sub-group meetings have been arranged to

		review water testing results. A flowchart has been developed to ensure all Water Safety Group members and Contractors are aware of process for reporting results.
Q2	Roman Ward -Mile End Hospital	Disinfection & further re-samples were taken. Following, resampling site were negative for legionella.
Q2	Brick Lane Wards -Mile End Hospital	Disinfection & further re-samples were taken. Following, resampling site were negative for legionella.
Q3	Appleby Health Centre	Presumptive samples were detected. Cleaned and disinfected. Retested- results clear
Q3	121 Balaam Street Clinic	Disinfection & further re-samples were taken. Following, resampling both sites were negative for legionella.
Q3	Centre Manor Park	A notification of adverse water analysis results. Sampling was advised & resamples retuned all clear. Going forward, sampling will continue quarterly.
Q3	Vicarage Lane Health Centre	A notification of adverse water analysis results. Sampling was advised & resamples retuned all clear. Going forward, sampling will continue quarterly.
Q3	East Ham Care Centre	There are ongoing localised issues with local disinfections and servicing of the Thermostatic Mixer Values. There were some issues with isolation valves not working and flexible hoses. The plan is to replace the hoses with hard copper hoses and to replace the isolation valves. Improvements were implemented in May 2023.
Q4	• Beaumount House • 10 Vicarage Lane Health Centre • East Ham Care Centre • The Lodge • Alie Street • John Warburton Building	Positive samples of Legionella were detected. Remedial actions are in place and at the time of writing report. Re-sampling results are pending.

35.4 Water Tank Disinfections

The compliance of cleaning and chlorination of water tanks is in compliance to the regulations and managed by an external provider. During 2022-2023 Q2 all showerheads and hoses were dismantled, cleaned and chemically descaled, flushed with fresh water and returned to normal service. During Q3 November 2022 all water tanks had their annual disinfection programme.

35.5 Water Safety Training

During 2022-2034, the IPC team also procured Water training for IPC team and Estates team members via the Trust Authorised Engineer on:

- Water Management – hygiene & awareness
- Water Management & Responsible persons training

36.0 Ventilation Safety

In line with the HTM guidance ELFT have set up a Trust Ventilation Safety Group (VSG). The Group is chaired by the Director of Estates and there is representation from ELFT Microbiologist, Health and Safety, IPC and staff-side representatives. Work Place Risk Assessments (WPRA) are completed and escalated as required and appropriate to the group. An approved advisor has been appointed to the group to advise on the ongoing work plan across Trust sites. An alert has been communicated to turn-off air-conditioning units that circulate the same air and do not bring in fresh-air for adequate air exchange on wards. These are mainly in medication/treatment rooms. Ventilation is discussed at all outbreak meetings and risks identified and management plans in place in line with the hierarchy of controls. FFP3 mask wearing is promoted where there is inadequate ventilation to reduce risks from COVID-19. A Ventilation policy is in place. The IPCT continue to provide support at the VSG meetings.

During 2022-2023 Q1, IPCT supported with writing an options paper in-conjunction with Estates & Facilities, Health and Safety departments on the use of re-circulating portable fans/air conditioning units, during extreme heat waves.

36.1 Air Cleaning Study

During 2022-23 the IPCT, Estates and the Luton and Bedfordshire Mental Health Clinical teams are participating in a study led by Cambridge University Hospitals Trust (CUH) called the Addenbrookes Air Disinfection Study – Implementation of air disinfection to prevent hospital acquired infections on inpatient wards for older people: A pragmatic controlled before and after study. Work has shown that air cleaning units remove almost all airborne COVID-19 virus traces and other viruses, bacteria and fungi. Fountains Court is hosting the study. The IPCT have provided support on the design of the air cleaning unit ensuring they comply with ligature and health and safety requirements for use in an inpatient mental health setting. At the time of writing, the study is in progress and air cleaning units are being installed. The IPCT, air cleaning supplier & Dr Matthew Bulter from CUH, have also presented the study at the recent IPC Knowlex conference.

37.0 Waste Management

During 2022-2023 Q1, the trust rolled out a new waste system in light of the wider NHS Net Zero agenda. Due to the changes of the new waste system there was ongoing risk regarding staff awareness of the new waste management systems and process across the Trust, as a result the IPCT updated in IPC Statutory & Mandatory training sessions. A Clinical Waste Compliance Audit was conducted by Sharpsmart (new clinical waste contractor) for baseline audit data. 43 waste audits were conducted in Q1. 30 staff members have undertaken online OLM waste training.

During Q2, a new waste matters email was launched & signage was sent out to all sites to help clarify the waste streams. The Trust Waste team have ensured that a fundamental change in what is available through our supply chain has been put in to action. It is no longer

possible to buy items that do not specifically relate to the Trusts waste policy. This will help cross contamination, improve value and also help reduce our carbon footprint.

During Q3, there was a period of non-collection of waste at East Ham Care Centre and Primrose Resource Centre. Both sites have been rectified and the problems resolved.

During Q4, there was a period of non-collection of waste at Three Colts Lane and Passmore Edwards. Both sites have been rectified and problems resolved.

At the time of writing, a furniture disposing SOP in Forensics is due to be piloted by a new contractor called Reyooz at John Howard Centre.

During Q4, a re-usable sharps pilot project at Newham Centre for Mental Health is underway. The Waste Matters team are leading on this project and are working directly with clinical staff to ensure the pilot is successful.

38.0 Capital Projects

The IPC team provide IPC advice for new projects and refurbishments to ensure that ward moves / new projects are compliant with IPC standards and clinical sign-off is considered prior to all moves. IPC also receive, review and approve capital bid projects.

IPCT have provided on-going support for the following capital projects in 2022-2023:

- Dunstable Hub
- Crystal Ward – Luton
- Evergreen Ward – New CAMHs service in Luton opened in September 2022
- ECT – Recovery area
- All capital bids approved as per bid approvals
- Dunstable Hub
- E1 Health Centre – Spirometry Clinic
- GP – Spirometry Clinic

39.0 IPC Risk Register

IPC risks are presented to the IPCC meetings. Prioritisation of tasks and activities are discussed. Throughout the year there has been on-going monitoring and management of risk.
During 2022-2023 the following items were reported on IPC risk register:

- Delays of processing microbiological specimens across Luton and Bedfordshire this was affecting patient flow. This was no longer consider a risk and risk closed in Q2.

- On-going risk remains regarding adequate ventilation in some clinical areas (Treatment rooms). This is monitored at the Trust Ventilation Safety Group. Risk mitigations includes updating the Work Place Risk tool on regular basis by service. During COVID-19 outbreaks air conditioning units in treatments rooms to be switched off. The Long term plan is to install air conditioning units, where there is a lack of sufficient ventilation.

- On-going risk regarding staff awareness of waste management systems and processes across the Trust due to a new waste management system implemented in April 2022. To mitigate risk, the waste management process has been updated in IPC Statutory & Mandatory training sessions. Clinical waste compliance audits were conducted by Sharpsmart (new clinical waste contractor) for baseline audit data. 43

waste audits were conducted in Q1. 30 staff members have undertaken OLM waste training in Q1. A new waste matters email was also launched. Signage has been sent out to all sites to help clarify the waste streams. Further work continues on this risk at the time of writing report.

- New risk added in Q4, regarding staffing capacity issues due to sickness & vacancy of specialist IPC nurses, due to high service demand for IPC support and expert advice required. At the time of writing report recruitment is in progress. To mitigate risk, staff can access IPC support via director on call on Saturday and Sunday 9-5pm. IPC policy has been updated and is available on Trust intranet.

40.0 IPC Service

The IPC service has been operating 9am-5pm Monday to Friday. During Q1, the IPC nursing team were operating at full capacity. Agency nurse support remained in place until October 2022. During 2022-2023 the IPC team has a high level of staffing issues related to COVID-19 sickness. However the IPC service was delivered as per usual.

41.0 Conclusion

This report recognizes 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 services will continue to present challenges. Much work has been implemented the year 2022-23 to achieve good standards of infection prevention and control, through shared working with the wider team (estates, clinical teams and contractors).

Infection Prevention and Control in a mental health and community settings requires a different perspective and provides challenges dissimilar to those in acute general hospitals. 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 2022-2023 (Appendix 3) were met, however the service is now reflecting on lessons learnt in the pandemic and planning, reassessing and developing a new plan for 2023-24 as per Driver diagram (Appendix 1) which outlines ELFT priorities for the year ahead. The CQC Board to Floor assurance document continues to be updated as new evidence and guidance emerges.

42.0 Summary of Annual Work Programme 2023-2024

The national priorities for 2023-24, determined by the Department of Health and UKSHA 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 2023-2024 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 2 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 UKSHA as required and appropriate.

43.0 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

44.0 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 and **APPROVE the IPC annual report.**

NB Definitions are as follows:

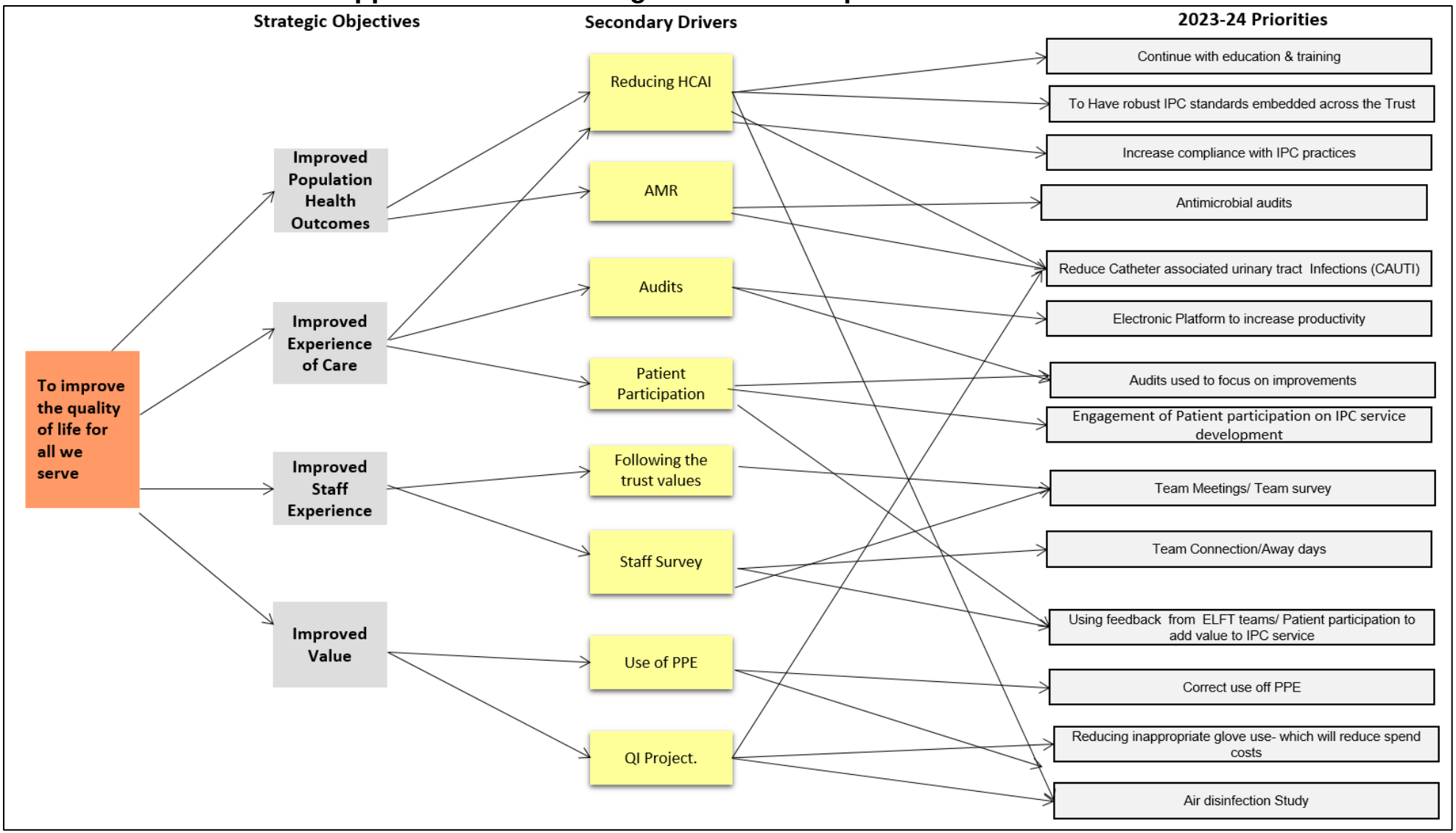
To "approve" - accepting recommendations etc. as satisfactory

To "ratify" - to approve an action/policy formally so that it can come into force

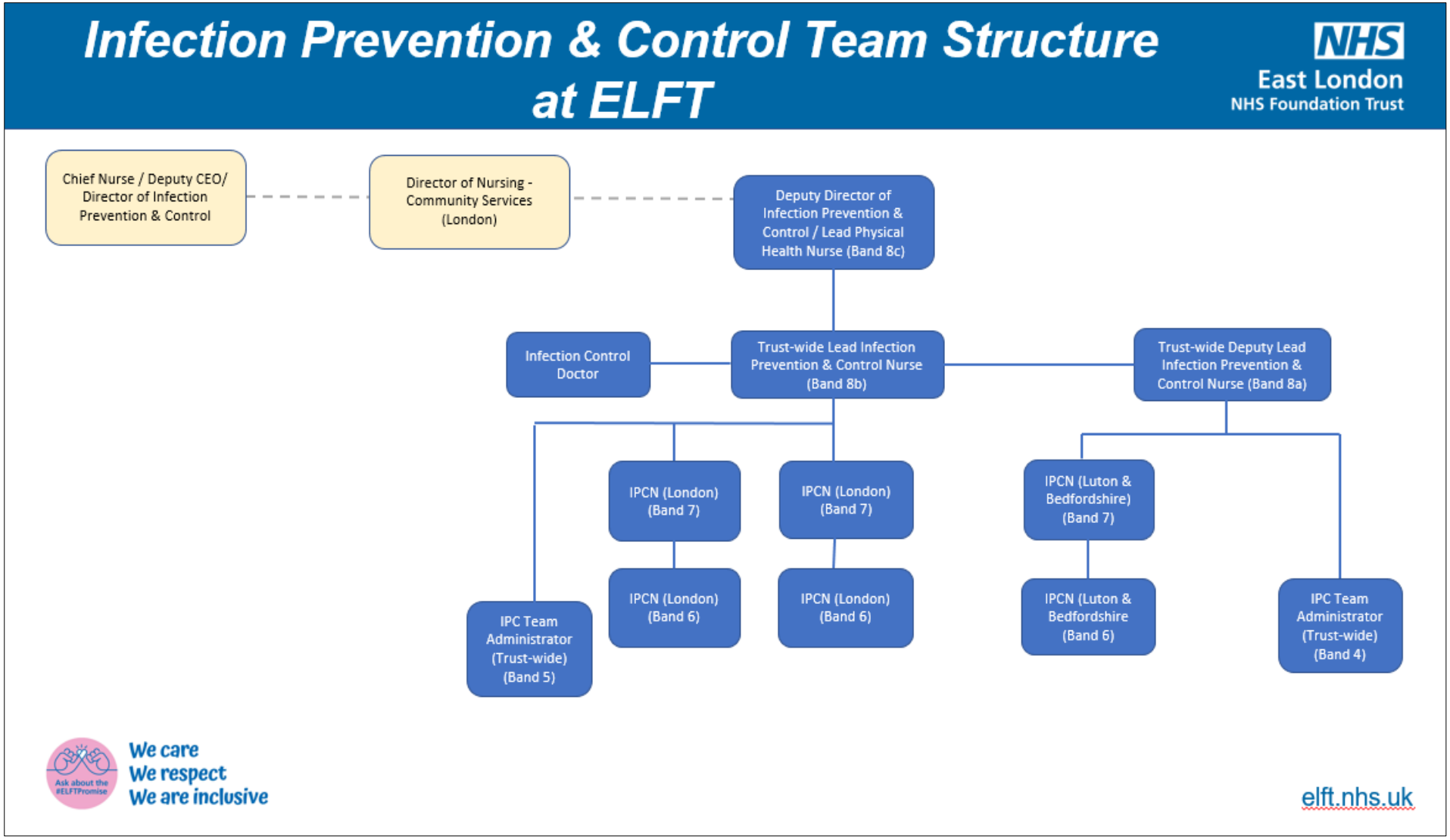
End of Report

APPENDICES

Appendix 1: Driver Diagram - IPC Workplan 2023-2024



Appendix 2: IPC Team Structure Chart



Appendix 3: 2022-2023 IPC Workplan

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/ March 2023	DIPC DDIPC Lead IPCN
	IPC mentioned in all job descriptions	Currently in all job descriptions	Ongoing /March 2023	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/ March 2023	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/ March 2023	DDIPC Lead IPCN'S
	To ensure that adequate IPC involvement is embedded within all new service developments and business cases. IPC team contributes to/ advises on service developments, refurbishments, new builds	Ensure that the IPCT are involved with all tendering of contracts in relation to IPC	Ongoing /March 2023	Directors of Estates / Nursing
		To identify any priority building works areas concerning infection control.	Quarterly /Ongoing	Finance Lead Nurses
		IPC and Estates operational meeting arranged on a quarterly basis. Terms of reference to be reviewed April 2022	Quarterly /Ongoing March 2023	DDIPC 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/ March 2023	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/March 2023	Estates & Facilities DDIPC Lead IPCNS IPC doctor
2. Policy & Guidance Development				
Aim/ Goal	**Current Assurance**	**Action required**	**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/March 2023	DDIPC Lead IPCNs IPC Team
3. Hand Hygiene				
Aim/ Goal	**Current Assurance**	**Action required**	**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	March 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/March 2023	DIPC DDIPC Lead IPCNs Estates & Facilities with support from the IPC Team Procurement
4. Training				
Aim/ Goal	**Current Assurance**	**Action required**	**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/March 2023	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**	**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/Quarterly/March 2023	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/March 2023	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/March 2023	Pharmacy team DIPC DDIPC Lead IPCNs
	PLACE takes place annually in inpatient sites	None	Annually/ March 2023	Facilities with support from the IPC Team
6. Surveillance				
Aim/ Goal	**Current Assurance**	**Action required**	**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/March 2023	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/March 2023	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	Report to PHE where required	Ongoing/ March 2023	Directorate management teams Ward staff with support from the IPC Team

	reported to the PHE. Notification of Infectious disease guidance (NOIDS) is available on trust-net.			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/March 2023	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.	Ongoing/March 2023	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/March 2023	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	Ongoing/March 2023	DIPC DDIPC Lead IPCNs IPC Team With support from the IPC Doctor and IPC Team Support from PHE where required.

		guidelines.		
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/March 2023	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**	**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/March 2023	IPCT
8. Cleanliness				
Aim/ Goal	**Current Assurance**	**Action required**	**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/March 2023	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/ March 2023	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/ March 2023	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 /March 2023	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 /March 2023	DDIPC IPCT Estates
		Ensure there are robust mechanisms in place for assurance to indicate that domestic staff has been trained in IPC.	Ongoing/March 2023	Facilities and cleaning contractor.
9. Waste Management				
Aim/ Goal	**Current Assurance**	**Action required**	**Review date**	**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	Waste Management Policy is available on Trustnet IPC policy which covers the safe handling of waste including sharps	None	Ongoing/March 2023	Estates & Facilities DIPC/DDIPC Directors of nursing Directorate management teams All clinical and staff with support from the IPC Team.

in the environment are properly managed and that duties under environmental law are discharged. *(Health and Social Care Act: 1,2,8)*	IPC policy which covers the safe handling of waste including sharps	None	Ongoing /March 2023	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/ March 2023	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/ March 2023	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 / March 2023	Head of Facilities and procurement
	There is ongoing management and review of waste contracts	None	As required/ Ongoing/ March 2023	Head of Facilities and procurement

	Clinical waste training included at IPC training. Waste training available via E-learning.	None	As required/ Ongoing/ March 2023	IPCT
10. Management of Antimicrobials				
Aim/ Goal	**Current Assurance**	**Action required**	**Review date**	**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 /March 2023	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/ March 2023	Pharmacy department Infection Control Doctor

11. Sharing learning and collaboration				
Aim/ Goal	**Current Assurance**	**Action required**	**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/March 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/March 2023	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/March 2023	ICP Team Communications Department
		To develop an IPC e-newsletter to share lessons learnt / IPC initiatives	April 2023	IPC Team

IPC Annual work plan 2022-2023

Aim/ Goal	Action required	Target Review date	Lead Persons
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 team Pharmacy department support

Appendix 4: IPC Hand-hygiene Roadshow Pictures 2022-2023

Appendix 5: National IPC Week Roadshow Pictures

NHS
East London
NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE - 26 JUNE 2023

Title	**Mental Health Law Annual Report**
Authors	Dominique Merlande, Associate Director of Mental Health Law Jacek Borek, Deputy AD of Mental Health Law/MCA Lead
Accountable Executive Director	David Bridle, Chief Medical Officer

Purpose of the report

Provide an update on mental health law related activities in 2022-23 and to set out work-plan for 2023-24.

Summary of key issues

The report covers the period from 1 April 2022 to 31 March 2023 and examines data and activity in relation to the use of the Mental Health Act (MHA) 1983 and the Mental Capacity Act (MCA) 2005 but also how the Trust discharges its statutory duties and responsibilities under both pieces of legislation.

It highlights how Operations have significantly improved their compliance with Tribunal Rule 32 (Tribunal report timeliness) since November 2022 and issues around compliance with consent to treatment/admission provisions, and Section 132/132A MHA (statutory duty to inform patients of their rights) – for which action plans have been devised.

The Trust 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 had taken place in the Trust to prepare for the implementation of the Mental Capacity (Amendment) Act 2019 and the new Liberty Protection Safeguards, which were expected to replace DoLS in 2023/24, however the implementation has now been postponed indefinitely. There is also no certainty as to what will happen with the MHA reform.

A new Associate Director of Mental Health Law and Deputy/MCA Lead were appointed in September 2022 and have been undertaking a full review of the Mental Health Law function, its governance and assurance frameworks as well as resources.

Strategic priorities this paper supports

Improved population health outcomes	☒	See work plan
Improved experience of care	☒	See work plan
Improved staff experience	☒	See work plan
Improved value	☒	See work plan

Committees/meetings where this item has been considered

Date	**Committee/Meeting**
15/05/2023	Mental Health Law Monitoring Group
31/05/2023	Quality Committee

Implications

Equality Analysis	The report highlights concerns, at national level, around the disproportionate use of the Mental Health Act within the black population.
Risk and Assurance	The report identifies risks of legal challenge around Tribunal Rule 32 compliance, DoLS applications not being granted, consent to treatment/admission and S132/132A compliance.
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 identifies opportunities for further partnerships with neighbouring general hospitals via Mental Health Act Administration Service Level Agreements.

Quality	The report highlights the success achieved by the trust so far in driving up quality e.g. in relation to Tribunal Rule 32 and identifies means to further drive up quality as part of the work plan.

Supporting documents and research material:
MHA Statistics, National Figures for 2021/22
Joint Parliamentary Committee Report on MHA reform
CQC Report on Monitoring the MHA in 2021/22

Abbreviation	In full
AHM	Associate Hospital Manager
CQC	Care Quality Commission
CTO	Community Treatment Order
DoLS	Deprivation of Liberty Safeguards
LPS	Liberty Protection Safeguards
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983
MHLD	Mental Health Law Department
MHLMG	Mental Health Law Monitoring Group
Tribunal	First-Tier Tribunal (Mental Health)

1 Introduction

The report covers the period from 1 April 2022 to 31 March 2023 and examines data and activity in relation to the use of the Mental Health Act (MHA) 1983 and the Mental Capacity Act (MCA) 2005 but also how the Trust discharges its statutory duties and responsibilities under both pieces of legislation.

2 Mental Health Law Leadership and Governance

Some significant changes in terms of Mental Health Law leadership and governance have occurred. The last year has seen the long standing Associate Director of Mental Health Law, Guy Davis, and his Deputy, Jo Turner, retire. The Mental Health Law Monitoring Group (MHLMG) wishes to acknowledge their long service and to thank them for their commitment and dedication to the function.

Following a short gap in service, Dominique Merlande and Jacek Borek joined the Mental Health Law Department (MHLD) as the new Associate Director of Mental Health Law and Deputy Associate Director of Mental Health Law/MCA Lead.

The governance around the MHL function had traditionally been provided via the MHLMG however a gap in governance was identified which led to new arrangements being put in place with Operations whereby:

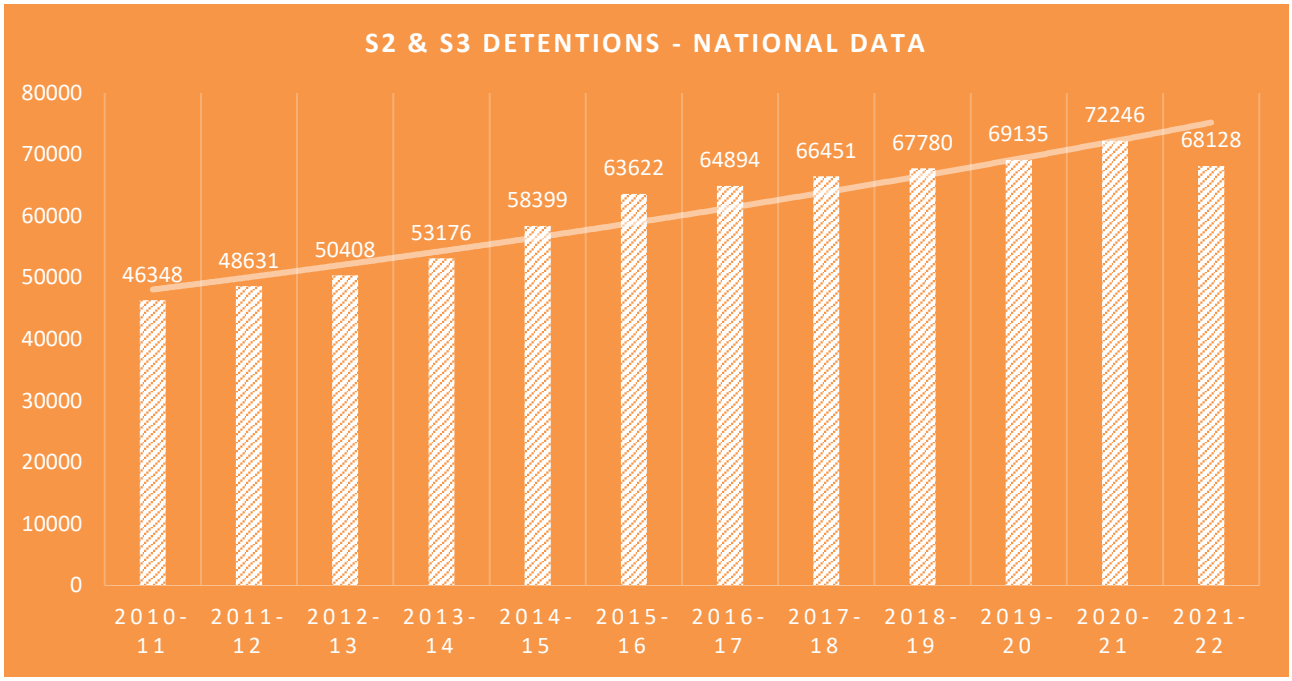
- the MHLD now has a quarterly slot in the DMT meetings within each MH directorate where MHL KPis are discussed;
- an MCA Operational Governance Group has been specifically launched for Primary Care and Community Health Services;
- a Statutory Advocacy Provider Forum has also been launched by the MHLD.

The MHLMG membership and meeting frequency are due to be reviewed in 2023/24.

3 Use of the Mental Health Act 1983

3.1 National Context – Detentions in Hospital and Use of Community Treatment Orders

On 27/10/22 NHS Digital published its MHA Statistics, National Figures for 2021/22. The figures show a decrease in detentions of 5.7% from the previous year. This is the first decrease observed at national level and is being attributed to the pandemic – although no such decrease was observed in 2020/21. The figures also show that rates of detention are over 4 times higher for the Black and Black British Group than they are for the White group (the rates of CTO being over 11 times higher).

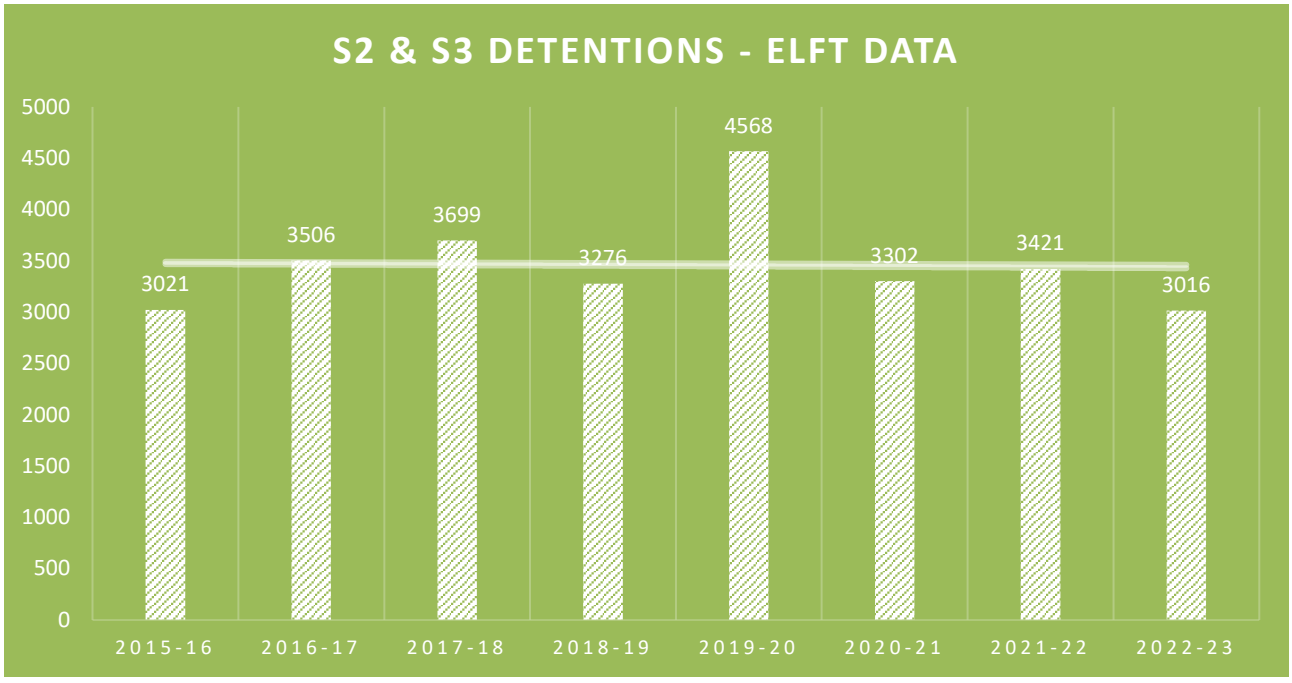


Source: NHS Digital ; Note: Detentions under the MHA figures exclude: short term detention order (Sections 4, 5(2), 5(4), 135 and 136); Detentions following recalls from CTO and conditional discharge.

It is expected that national figures for 2022/23 will be issued by NHS Digital in October 2023.

3.2 ELFT Data - Detentions in Hospital and Use of Community Treatment Orders

In 2021/22, there were a total of **3421** S2 and S3 admissions to ELFT - a 3.6% increase from the previous year which was not in keeping with the national picture - although a 27.7% decrease was observed the year before (at the very start of the pandemic) and an 11.8% decrease has occurred in 2022/23.



On 31 March 2023, there were a total of **790** people subject to the MHA in ELFT. Of these people, **189** were subject to a CTO. The remaining **601** were detained in hospital: 427 were subject to civil sections and 174 to forensic sections. In 2022/23, **186** new CTOs were made in ELFT. The MHLMG has queried whether there might an overrepresentation, at trust level, of Black and Black British people in MHA detentions and Community Treatment Orders, and will be presented with a report in 2023/24. The Mental Health Law Department is working closely with Informatics to build the necessary reports for protected characteristics to be monitored going forward.

3.3 Legal Developments and Impact on ELFT

3.3.1 Mental Health Act Reform

A Mental Health Bill was published on 27/06/2022 together with explanatory notes and a Memorandum to the delegated powers and regulatory reform committee. A Joint Parliamentary Committee was appointed in July 2022 to report on the draft Bill. It heard evidence from a number of expert witnesses including ELFT Consultant Dr Chloe Beale and published its report on 19/01/23. The report makes a series of recommendations, of which the introduction of a statutory mental health watchdog (as an independent voice to advocate for MH SUs), the abolition of CTOs for Part 2 patients and the appointment in each Health organisations of a **responsible person to collect and monitor data on detentions under the MHA, broken down by ethnicity**, with annual figures published by the Government, and to implement policies to reduce inequalities. The full Joint Committee report may be found here.

3.3.2 Special Rules and Procedures introduced with the Pandemic

The First-Tier Tribunal (Mental Health) still operates remotely via its Cloud Video Platform (CVP) and its **Video Hearing Service** (VHS). The ELFT IT department completed checks in 2022 to make sure the ELFT Infrastructure was compatible with VHS.

3.3.3 Associate Hospital Managers

Associate Hospital Managers (AHMs) are lay people, who are appointed by ELFT to review whether the power of discharge ought to be exercised in the cases of patients who are subject to the MHA. Their role and powers are set out in the Code of Practice to the MHA.

There were 28 AHMs in ELFT at the start of the year. There has been **1 resignation** in 2022/23. The AHM Forum would like to thank **Saranna Maynard** for her dedication and commitment to the role. Another 10 AHMs appear to be "inactive". It is proposed to revise the AHMs' terms of appointment in 2023/24 so as to introduce a requirement to attend a minimum of 12 reviews and 2 AHM Forums/training events per annum. **One of the objectives for 2023/24 will be to review whether ELFT needs more AHMs** and to appoint new AHMs if so.

The AHM Forum has agreed to introduce a new KPI whereby AHM reviews must be completed within 8 weeks of their trigger. To achieve this, the ELFT MHLD is reconfiguring its services and launching a dedicated MHA Office for AHMs in 2023/24. This office will report on this KPI to the AHM Forum which reports to the MHLMG.

The AHMs received training on the MHA Reform in January 2023. A comprehensive training programme was agreed with the AHM Forum for 2023/24. Training events will be linked to AHM Forum meetings and will be delivered on a quarterly basis.

AHM reviews have continued to be held remotely in 2022/23. Depending on the outcome of the F2F pilot launched by the Tribunal in Oct 2022, ELFT might consider returning to F2F AHM reviews in some cases. It is however expected that uncontested renewals/extensions (i.e. paper reviews) will continue to be held remotely.

3.4 Care Quality Commission Findings

3.4.1 National Findings

The CQC published its report on "Monitoring the Mental Health Act in 2021/22" on 01/12/2022. The key messages were that:

- Workforce issues and staff shortages mean that people are not getting the level or quality of care they have a right to expect, and the safety of patients and staff is being put at risk;
- Gaps in community mental health care are compounding the rising demand on inpatient services, with delays in admission, transfer and discharge;
- Urgent action is needed to tackle the over-representation of people from some ethnic minority groups and, in particular, the over-representation of Black people on community treatment orders;
- The quality of ward environments is an ongoing concern, with many inpatient environments in need of immediate update and repair.

3.4.2 Findings on ELFT Wards

In 2022/23 the CQC conducted 18 MHA Reviews on the following ELFT wards:

Ward	Locality	Date	Care Plans	S132	S17 Leave	Consent to Treatment/ Admission	Environment	WiFi
Bevan	CH	12/04/2022						
Connolly	CH	12/04/2022						
Gardner	CH	12/04/2022						
Ludgate	FX	05/05/2022						
Ruby	NH	05/05/2022						
Coborn Acute	CAMHS	16/05/2022						
Coborn Galaxy	CAMHS	17/05/2022						
Emerald	NH	29/06/2022						
Broadgate	FX	12/07/2022						
Shoreditch	FX	12/07/2022						
Townsend Court	L&B	27/07/2022						
Sally Sherman	NH	12/08/2022						
MBU	C&H	11/10/2022						
Moorgate	FX	17/11/2022						
Ruth Seifert	C&H	01/02/2023						
Aldgate	FX	07/02/2023						
Cazaubon	TH	10/02/2023						
Clerkenwell	FX	30/03/2023						

	Standard met		Standard not met

The top three concerns raised by the CQC were:

- **Consent**: some assessments of capacity to consent/admission were not evidenced.
- **Environment issues** e.g. ward in need of update or repair, seclusion room not fit for purpose, broken window, lack of viewing panel, pest control issue.
- **S132:** attempts made to explain their rights to patients were not always evidenced.

The MHLD is working closely with Operations to address these three concerns.

3.5 MHA Related Clinical Audits

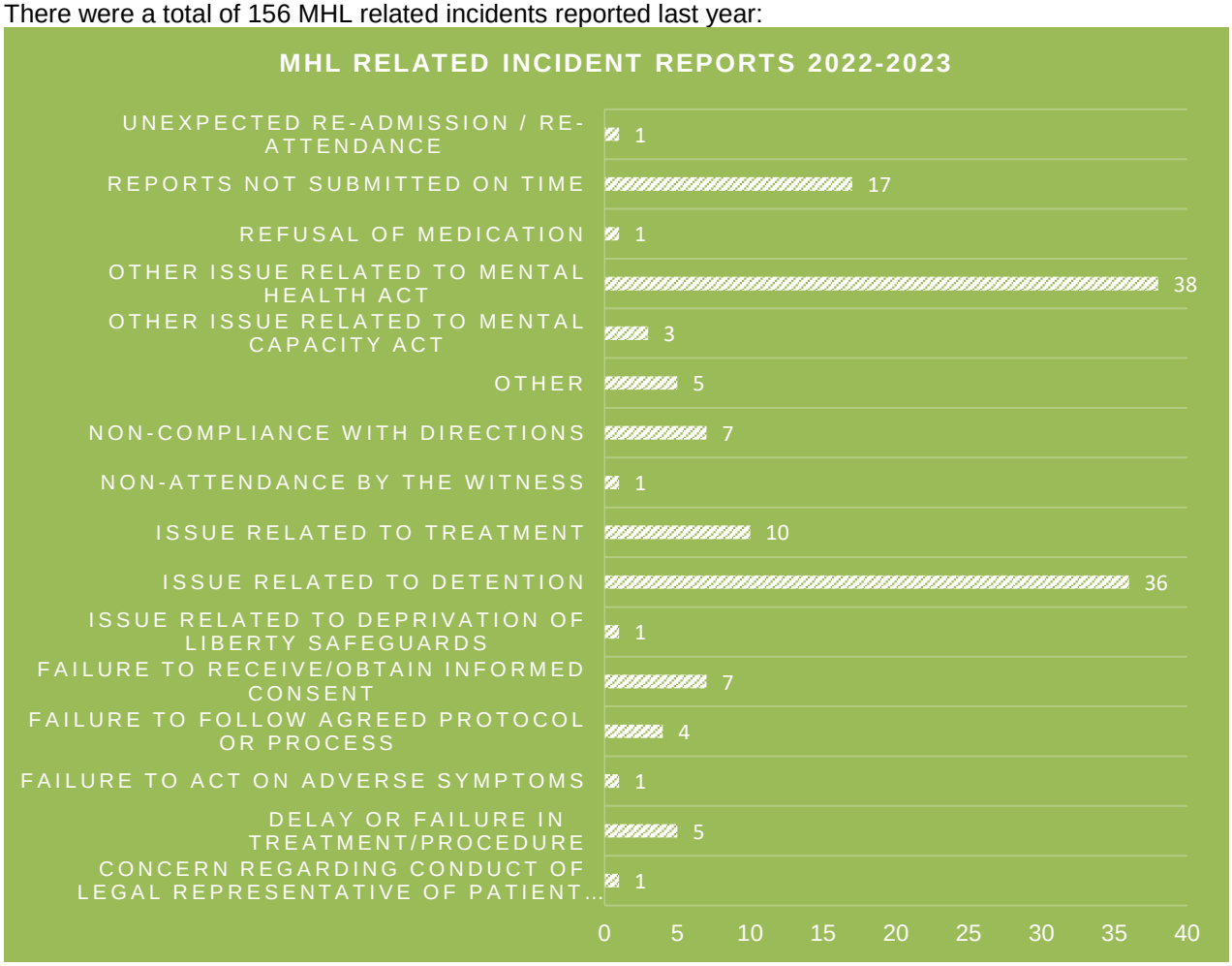
A S132 Quality and Safety spot check conducted in City & Hackney in March 2023 found the following, which, for most wards, confirms the CQC findings:

Ward	S132 attempts made in timely fashion	Unsuccessful S132 attempts recorded	IMHA information included
Bevan	0%	40%	0%
Brett	100%	100%	100%
Conolly	100%	50%	100%
Gardner	0%	0%	0%
Joshua	100%	100%	100%
MBU	100%	100%	100%
Ruth Seifert	50%	50%	50%

A strategy has been devised to improve S132 compliance, which has been added to the risk register.

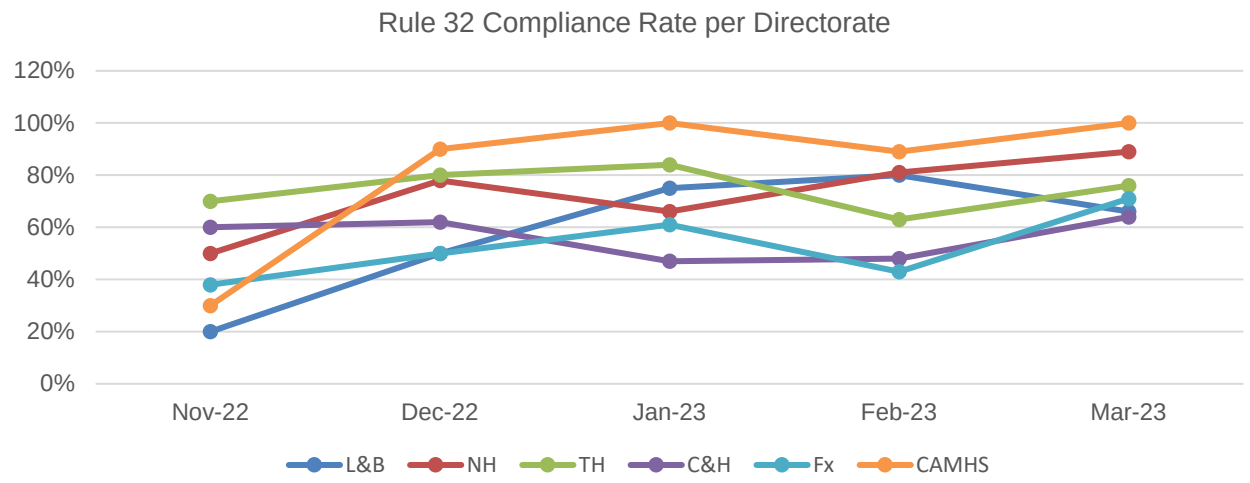
3.6 MHA Related Incidents, Complaints and Claims

There were a total of 156 MHL related incidents reported last year:



The main themes arising are “Other issue related to MHA”, “Issue related to Detention” and “Report not submitted on time”. A new procedure has recently been introduced by the MHLD for a systematic and consistent review of each incident. A root cause analysis approach is now followed to allow trends to be identified and inform discussion with Operations and action plans.

Following a number of complaints received in 2022 from the Tribunal with regards to Tribunal Rule 32 breaches (late submission of reports leading to adjournments), a Quality Improvement (QI) project was launched by ELFT in November to support directorates to improve their performance. New standard operating procedures, for both the Mental Health Act Administration service and report authors, were introduced. The project has been successful so far and has already shown improvements across the board:



ELFT is receiving regular and consistent support from District Judge Wescott on this project which shall continue until a sustained improvement has been demonstrated.

3.7 MHA Training

The MHLD is currently completing a workforce mapping exercise with the Learning & Development department. Current reports show that 58% of ELFT staff are currently compliant with MHA training however it is accepted that the workforce mapping exercise is still ongoing. Operations and the MHLMG are now presented with quarterly data on training compliance.

3.8 MHA Administration Service

Following 6 successful substantive appointments, the MHA Administration service is now provided by 6 WTE Band 5 MHL Supervisors and 8.2 Band 4 MHL Assistants. There are 3 vacancies which are currently filled by Staff Bank workers.

An attempt was made to pool staff into 2 big hubs (one in London, one in Luton) and to adopt a task based model but this failed and staff have been temporarily re-assigned localities until a full review takes place. This has been very unsettling and demotivating for staff, who had been mainly working from home since 2020. Hybrid working was introduced in 2022/23 – initially to clerk F2F Tribunal hearings (which started being piloted in Oct 2022).

Improving staff morale was one of the key priorities for last year and targeted interventions have been carried out by the MHLD in partnership with the Learning & Development Department (e.g. MHL Hub away days). Discrepancies with pay grades and banding have also been addressed. Next year's work plan will focus on reviewing roles and job descriptions (so as to clearly define responsibilities) and refining the training programme for the department staff with a view to support career progression. A 2 monthly Practice Development Forum is already in place and the department attended the Weightmans Annual Mental Health Law Conference in March. It is acknowledged that managers within the department also need support with recruitment and selection, performance/sickness management, appraisal and general leadership skills.

Office accommodations will also be reviewed in 2023/24 to ensure staff are comfortable at work and able to increase their presence on site in an effort to rebuild connections with Operations.

Standardisation of procedures shall be another objective for 2023/24. As a result of the complaints made by the Tribunal in 2022/23, a Standard Operating Procedure on Tribunal Administration has already been developed. A full SOP on all aspects of MHA Administration is due soon.

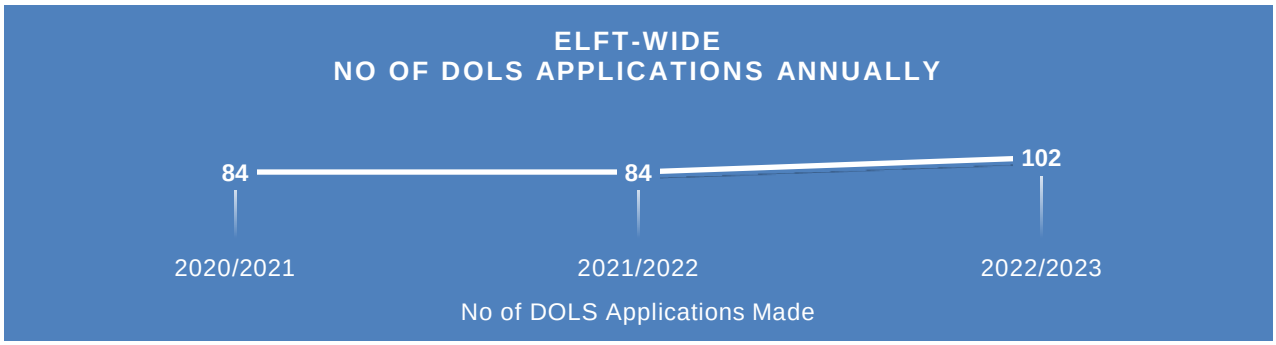
The Trust's MHA administration Service Level Agreements (SLAs) with Bedfordshire Hospitals Trust, Barts Health and the Homerton Hospital Trust are in the process of being reviewed to ensure a robust MHA administration service is provided to our partner general hospitals and on cost.

4 Use of the Mental Capacity Act 2005

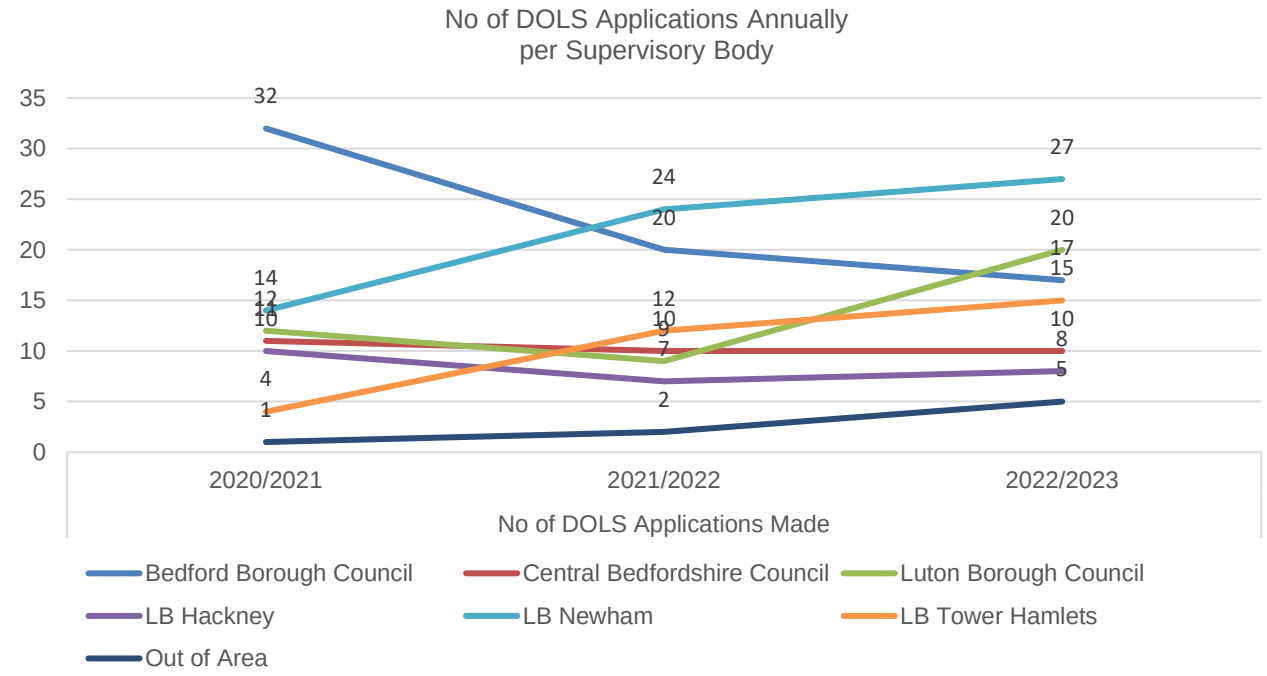
4.1 MCA Activity

The Trust acts as a managing authority, under Schedule 1A to the Mental Capacity Act 2005, which implements the DoLS framework. This means that clinicians must make DoLS applications to the Supervisory Body when a care plan amounts to a deprivation of liberty.

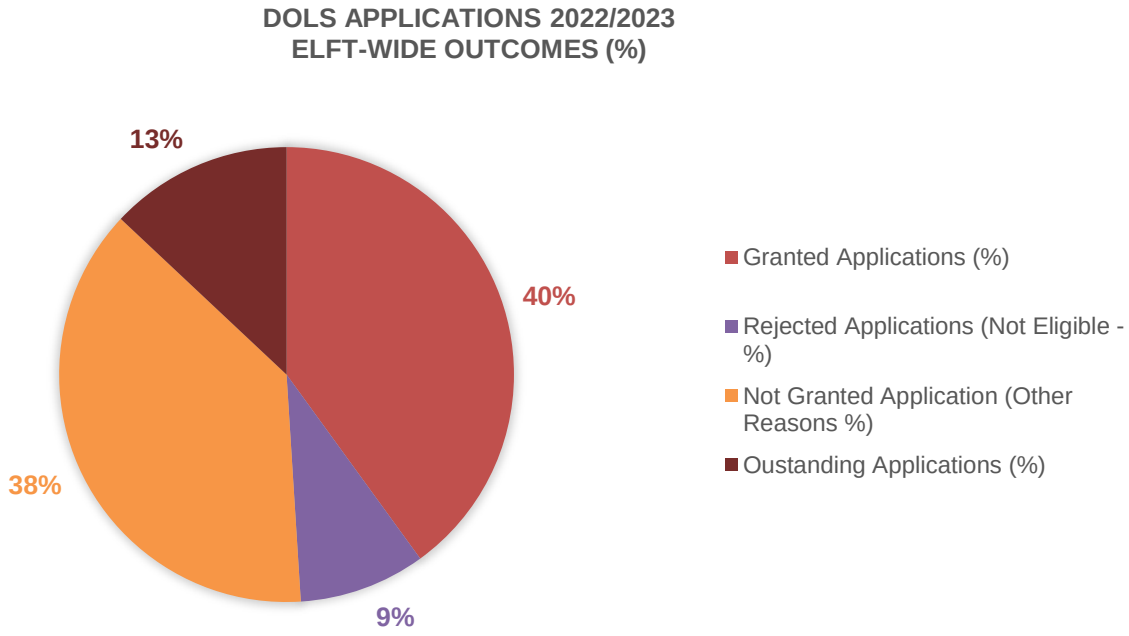
We have seen a 21% increase in DoLS applications made by ELFT in 2022/23.



The most significant increase was for applications made by inpatient wards in Luton and Bedford to Luton Borough Council (140%):



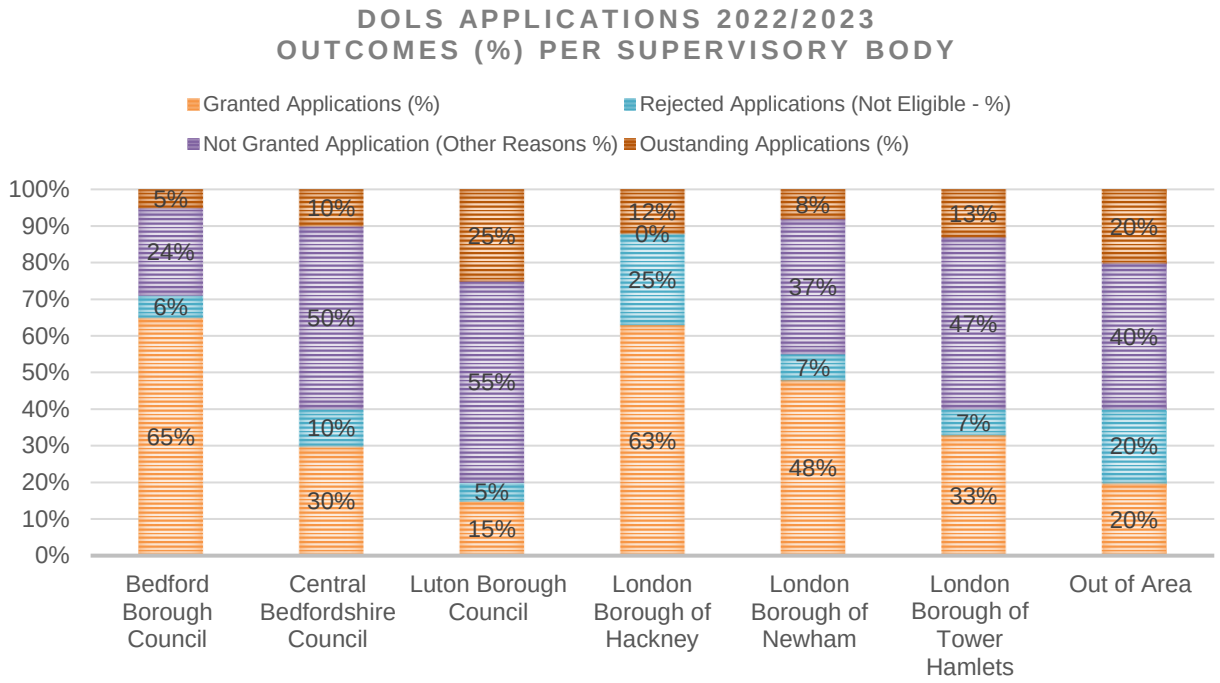
The authorisation rate stands at 40% at the moment – something the MHLD is looking to benchmark against other providers.



Nearly 1 in 10 applications was rejected due to patients not meeting eligibility criteria. This is unexpected in the context of a mental health trust, where staff have a very good command of the Mental Health Act 1983. The MHLD undertook a deep dive and uncovered 3 issues:

- poor level of understanding amongst relevant trust staff of the eligibility criteria as per paragraph 5 of Schedule 1A to the Mental Capacity Act 2005, in relation to objecting mental health patients who are admitted to a mental health unit for the purpose of treatment of mental disorder;
- poor quality recording of the rationale for the application and need for the person to be deprived of their liberty, especially when the person was discharged from detention under MHA and needs to remain on the ward due to complex discharge planning;
- poor interpretation of the statutory framework and understanding of the nature of the treatment, by the Supervisory Body, whilst undertaking the eligibility assessment.

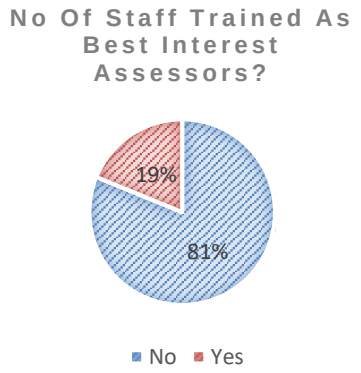
The MCA Lead is working closely with Operations and Supervisory Bodies to address the above concerns.

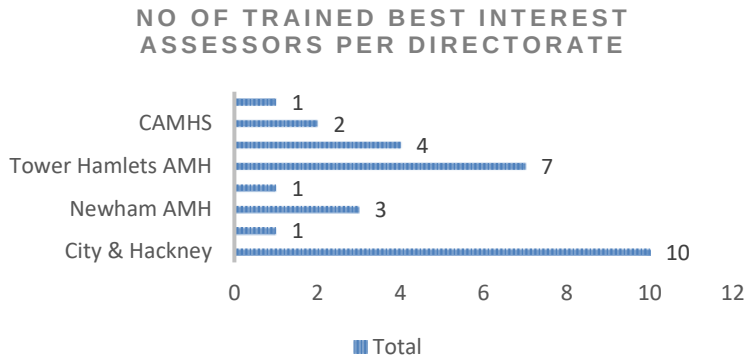


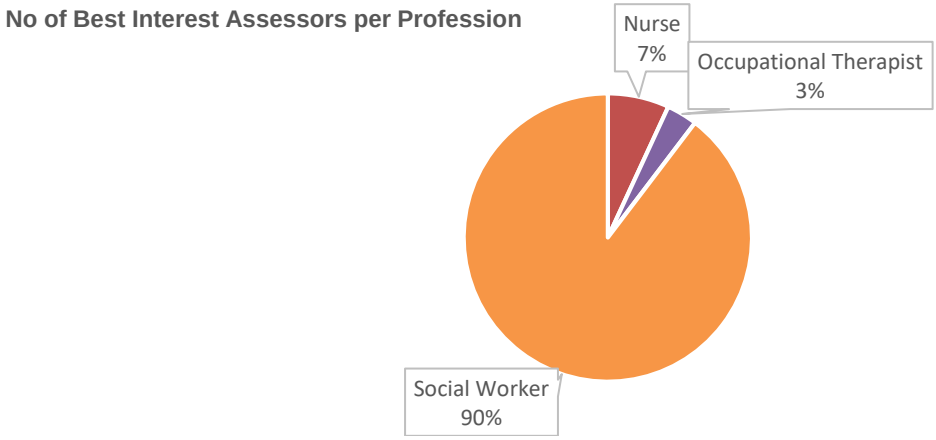
4.2 Preparation for implementation of Liberty Protection Safeguards

Throughout 2022/2023 the MHLD has been working with internal stakeholders and system partners, to prepare for the implementation of the Liberty Protection Safeguards (LPS), as a statutory framework replacing the Deprivation of Liberty Safeguards (DoLS) and authorising deprivation of liberty for the purpose of care and treatment delivery to patients who lack mental capacity to consent to this.

The MCA Lead completed the BIA Scoping Survey to establish the number of practitioners across ELFT who are currently trained as Best Interest Assessors for the purpose of DoLS, and who would be interested in becoming Approved Mental Capacity Professionals (AMCPs). The exercise had broader benefits as it allowed to establish the level of skills and expertise in relation to Mental Capacity Act 2005 across the Trust. This will be taken into consideration when developing more robust MCA support systems for frontline practitioners.







In April 2023, the Department of Health and Social Care announced that LPS will not be implemented until after the next General Election – although it is unclear whether the new Government will pursue the implementation of the LPS.

4.3 MCA Administration service and Workforce Establishment

The MCA related function in its nature differs from the other functions delivered by the Mental Health Law Department as the focus is more on providing advice on complex cases, which often requires a good understanding not just of the MCA but also of associated social care legislation and experience in case management (sometimes from a court proceedings perspective). This usually involves mid- to long-term input with multiple case discussions, analysis of documentation, liaison with legal services in Local Authorities or Integrated Care Board. The MCA Lead has been successful in strengthening integrated working with the ELFT Legal Affairs Department.

A review of the MCA related functions across the Trust has been undertaken. At present the MCA function is delivered by 1 WTE Band 8B MCA Lead/Deputy Associate Director of Mental Health Law, 1 WTE Band 5 Mental Capacity Act Officer and 1 WTE (temporary) Band 4 flexible worker. The volume of work and ever increasing complexity of the queries raised by practitioners make the current staffing levels insufficient and a full staffing review will take place in 2023/24.

4.4 MCA Audits

Staffing pressures have made it difficult to undertake a robust MCA audit cycle however the following spot checks have been completed:

- MCA Quality and Safety Reviews in C&H
- Deep-dive into cases where DoLS applications were not granted on eligibility grounds (see above).

Additionally, the following compliance concerns have been raised by the CQC in MHA reviews (see 2.5.2):

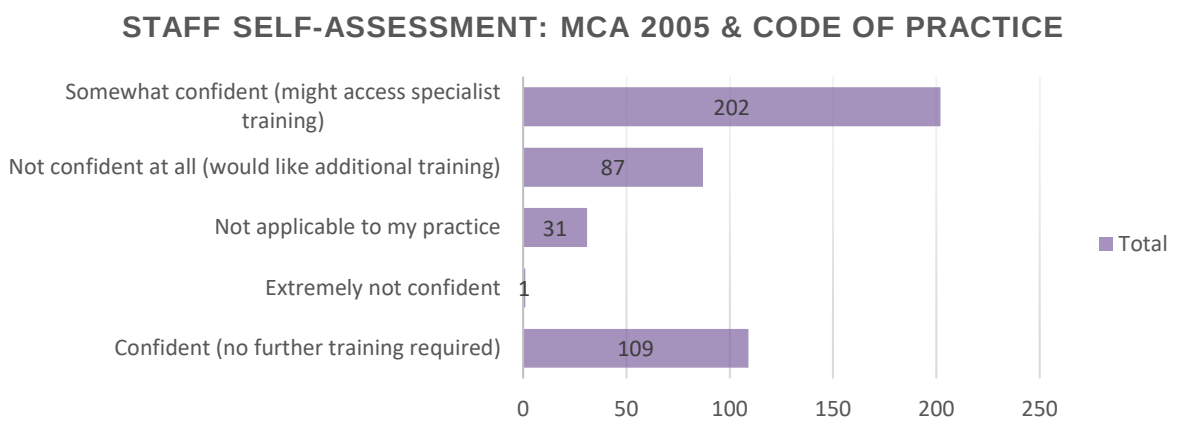
- Lack of and/or poor quality of recordings of assessments of capacity to voluntary admission;
- Lack of and/or poor quality of recordings of assessments of capacity to consent to treatment;
- Lack of recordings of mental capacity assessments and best interest decisions regarding treatment of physical health needs of patients admitted to mental health wards.

The MCA Lead receives regular feedback from the Associate Director of Safeguarding Adults on audits carried out by the Safeguarding Department which include MCA standards. This informs the training and auditing strategy.

4.5 MCA Training Compliance and Training Needs Analysis

As mentioned at 3,8, the MHLD is currently undertaking a workforce mapping exercise with Learning and Development. This will allow the MHLMG to monitor MCA training compliance soon.

Additionally, the MCA Lead undertook a Trust-wide legal literacy survey which shows that 72% of respondents (430 in total) feel either confident or somewhat confident when applying the MCA 2005 related framework.



5 Progress made against 2022/23 Work Plan and new Work Plan for 2023/24

As noted above, changes in Mental Health Law leadership and resulting temporary gap in service have meant that work planning was somewhat tentative. Some of the key priorities identified a year ago were:

- Assist executive, multi-disciplinary and clinical teams to develop meaningful mental health law data reports to improve care;
- Identify and implement enhanced means of communication re MHL matters;
- Monitor and prepare for implementation of Liberty Protection Safeguards;
- Continue to assist in roll-out of Thalamos MHA digital for ELFT and partner practitioners;
- Finalise the workforce establishment of the MHL team.

Key achievements:

- A new communication strategy was launched in 2022/23 including a new department email signature (and autoreply), a review of existing shared mailboxes and a Mental Health Law Newsletter. Work on the intranet and on the public facing website has started.
- Although it is now uncertain whether the government will proceed with the implementation of LPS, the trust has achieved all the preparation work it had set itself to complete.
- The Trust 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. 66% of MHA statutory documents have bene reported to be served on the platform since the launch of the 4th phase in Feb 2023.
- The MHLD structure has been reviewed and posts filled substantively although some vacancies remain and work bases are yet to be confirmed for some department staff (see 3.9).
- Steps to improve co-production have been taken with the successful launch of mental health law service-user and carer forums in Oct 2023.

Some of the unmet challenges:

- Working on building the MHA and MCA apps on Power BI remains ongoing. The MHLD is now holding regular meetings with Informatics. The MHLMG has oversight on this.

5.1 Work-plan for 2023-24

No.	Key Priorities	Key Milestones	Lead(s)	What corporate/DMT is required?	Expected Delivery date / Progress
1	Improve the relationship with and support to Operations through strengthened governance arrangements	Launch of new operational groups	AD of MHL/Deputy AD of MHL	All DMTs	30/04/23
2	Review and Strengthen MCA function	Consolidate policies Devise training and audit strategies Review resources	Deputy AD of MHL		31/07/23
3	Strengthen AHM Function	Launch of new dedicated MHA office Review Terms of Appointment Ascertain whether new appointments needed Deliver training programme Clear backlog	AD of MHL		30/11/23
4	Develop MHL Training Strategy	Identify training needs and resources available	AD of MHL/Deputy AD of MHL	L&OD	30/09/23
5	Implement digital solutions to support Operations and overall governance	Thalamos InPhase Power BI	AD of MHL/Deputy AD of MHL/MHL Managers	QA Informatics	31/12/23
6,	Review Structure, job roles and development pathways for MHLD	Finalise structure based on activity data Revise JDs Launch development programmes	AD of MHL/Senior Supervisors	L&OD Informatics	31/03/23

7.	Consolidate communication strategy	Intranet Public facing website Roadshows	AD of MHL/Deputy AD of MHL	Comms	30/09/23
8.	Review working arrangements and office space for MHLD	Identify space Conduct DSE Risk assessments	Senior Supervisors	H&S DMTs	31/05/23
9.	Review and resurrect SLA with HMCTS		Senior Supervisors		30/04/23
10.	Review SLA with partner acute trusts	Hold introductory meetings Renegotiate terms	AD of MHL/Deputy AD of MHL	Contracts	31/05/23

Reports on progress will be made via the MHL Monitoring group and escalated and adapted accordingly.

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.

6 Action Being Requested

The Board/Committee is asked to approve this report.

East London
NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE
26th JUNE 2023

Title	Annual Report 2022/23 - 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 2022/23 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 2022/23 will also be reviewed and any outstanding actions will be considered and potentially incorporated in the work plan for 2023-24.

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 2022/23. 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 September 2022. This annual assurance process marks compliance against the NHS England Core Standards for EPRR 2023. Based on the 2022 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 continue to be identified as being of a very high standard and continue to be included on the national EPRR database of good practice.

- The last COVID-19 Gold meeting took place in March 2022 with any COVID-19 issues 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 due to the forthcoming winter pressures including bed management and industrial action.

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 2022/23

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 2023 sets out how NHS organisations are to meet their responsibilities and the NHS England EPRR Framework (2022) 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
- Flood Plan
- FuelPlan

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.

3.0 Annual EPRR Assurance

3.1 London

The Trust participated in the Assurance exercise carried out by NHS England (London) EPPR Team in September 2022. This annual assurance process marks compliance against the NHS England Core Standards for EPRR 2023 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 2022 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 (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 continue to be identified as being of a very high standard and continue to be included on the national EPRR database of good practice.

3.2 Luton and Bedfordshire

Organisations which operate across Local Health Resilience Partnerships (LHRP) borders present their completed EPRR self-assessment return to their lead ICB and host LHRP as appropriate. Our self-assessment and subsequent report was shared with BLMK ICB.

4.0 Training

4.1 Training was delivered against the 2022/23 training plan.

4.2 Strategic Leadership in a Crisis Training

In July and September 2022, 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 EMERGO Training

The Trust Emergency Planning Officer recently qualified as an Emergo Senior Instructor in Simulation Exercising in Disaster Medicine and now joins the list of 600 Emergo Training System instructors globally.
The Emergo Training System is an academic/educational simulation system used in several countries around the world for training and testing preparedness and management of emergencies, major incidents and disasters.
This provides the Trust with an exciting opportunity to use the EMERGO training system in testing our Trust Plans and delivering simulation exercises to departments.

4.4 New business continuity plan template and off-the-shelf exercise

With the added winter pressures and increasing need for the Trust/services to provide business continuity/resilience, we have developed a new BCP template for services together with an accompanying BCP handbook to guide services through the template. The new template has been streamlined, resulting in a more user-friendly approach.

During 2023, the EPRR team will be supporting directorates with completion of their BCPs with a number of workshops to encourage directorates and teams to take a localised and focussed approach to testing how resilient teams would be in the event of a business continuity incident.

Furthermore, we have also developed an off-the-shelf exercise workbook and PowerPoint presentation template to enable services to test their BCPs, identify gaps in their resilience and to compile an exercise report and action plan.

Further trust wide BCP workshops will be arranged as part of the annual work plan 2023/24.

4.5 On-Call Director and On-Call Manager Training

The EPRR team has recently begun developing 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 2023.

An On-Call Manager training will also be made available online as part of the annual work plan.

4.6 Loggist Training

The emergency planning officer attended the United Kingdom Health Security Agency (UKHSA) loggist train the trainer training in February 2021. This has enabled us to train

staff within the Trust, and support and assist other Trust's in meeting their loggist training requirements.

The EPRR team has also delivered loggist training to BLMK ICB during this period, and further loggist training will also be provided to NEL ICB in June 2023

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:

	May 2022	June 2022	Aug 2022	Dec 2022
Response Time	**2**	**41**	**2**	**51**

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 <u>Exercise Artemis</u>

5.2.1 The exercise took place via Microsoft Teams on June 17th 2022.allowed a significant number of participants across the Trust to come together to test how effectively the Trust responds to a major incident. Participants included representation from the Strategic (Gold) and Tactical (Silver) on call rotas, information governance, and the Trust ICT department.

5.2.2 The aim of the exercise was to evaluate how the Trust responds in the event of an ICT major incident, requiring the implementation of a strategic, tactical, and operational command structure, together with the activation of the trust IT Disaster Recovery and Trust Business Continuity Plans. The exercise would also test business continuity impacts and escalation processes in a major incident affecting IT, Information Governance (IG) and Human Resources (HR).

5.2.3 The opening scenario involved The Trust being notified by the National Crime Agency (NCA) and National Cyber Security Centre (NCSC) that confidential patient records with the Trusts branding are being hosted for sale on the 'Dark Web', with details suggesting these have been extracted over the last three months. It is uncertain how the attacker obtained the information, or if the attacker is still able to access the systems.

5.2.4 Further injects about staff inappropriate use of the Trust email system and high staff absence levels were also added to the exercise, prompting discussions about multi-layer contingencies.

5.2.5 This table-top exercise provided a realistic and very worthwhile exercise with each participant playing a pivotal role in the exercise. This exercise was well received and found to be extremely useful to all those who took part when questioned at the conclusion of the hot debrief.

5.2.6 The objectives of the exercise (ensuring the ICT Disaster Recovery and departmental Business Continuity Plans were fit for purpose and to devise appropriate routes of escalation) were both achieved. In addition, further opportunities have been identified to increase and augment effective information communication, command and control in the Trust's emergency response and preparedness.

5.2.7 Taking into account the exercise feedback received, the following lessons and actions were identified and have been incorporated into the annual work plan.

- Conduct a communication exercise test of the IT system.
- Review the Major Incident Communications Strategy and Plan including the use of Twitter during major incidents.
- Schedule six-monthly cyber security exercise.

5.3 The Trust took part in Exercise Arctic Willow which was a distributed tabletop exercise sponsored by NHS England Resilience, held between November and December 2022. It was designed to provide health and social care organisations with an opportunity to explore their response to multiple, concurrent operational and winter pressures, as well as review their interdependencies with Local Resilience Forum partners when responding to such pressures.

5.3.1 We await the final report which will include a number of important identified lessons identified. These lessons will be addressed through an action plan, to further improve our planning and our response to the operational challenges presented.

6.0 Major Incidents and Activation of Emergency or Business Continuity Plans

6.1 In October 2022, extensive work was undertaken as part of our strategic programme to move to a resilient cloud-based service. The majority of our clinical systems for direct patient care were not affected by this work. The preparation work had been ongoing for several months including the development of a planning group to ensure that system resilience was in place.

6.2 A Level 4 weather warning was declared by the Met Office on 18th July 2022.This is reached when a heatwave is so severe and/or prolonged that its effects extend outside the health and social care system, such as power or water shortages, and/or where the integrity of health and social care systems is threatened.

As a result, the Trust invoked its heatwave plan which included visiting or contacting people in high-risk categories, issuing communication messages to provide updates and advice and checking temperatures.

6.3 Throughout this reporting period there were a number of days of industrial action. For both the RCN and UNISON ballots, ELFT did not reach the threshold for strike action. In contrast, junior doctors at ELFT took industrial action from13-15 March 2023. In

response, the Trust invoked its Business Continuity Plan together with local services invoking theirs. Local mitigation included senior medical cover, re-scheduling of appointments and re-deployment of staff to crisis services

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 On 19th May 2022, NHS England and NHS Improvement downgraded the UK's overall Covid alert level from Level 4 (National) to Level 3 (Regional).

8.2 Arrangements remain 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.

8.3 The last Gold meeting took place in March 2022 with any COVID-19 issues 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 due to the forthcoming winter pressures.

8.4 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 (weekly)
- Staff Asymptomatic Coronavirus Lateral Flow Test Device Sitrep (weekly)
- Staff Lateral Flow Device Test Results Sitrep (weekly)
- Community Health Services Sitrep (monthly)

8.5 The UK COVID-19 Inquiry was established in June 2022 with Module 3 of the Inquiry examining the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland.

In December 2022, The UK Covid-19 Public Inquiry wrote to trusts with a request for initial information to help the Public Inquiry develop its thinking for Module 3. The questions were broad in nature so the Public Inquiry can familiarise itself with the healthcare sector in England.

9.0 ELFT EPRR progress against work plan 2022/23

KEY ACTION	STATUS AT 31/03/2023
Review all plans relating to emergencies and business continuity to ensure they reflect current guidance and legislation.	Completed – 28th September 2022
Update emergency contact list to ensure it is up to date.	Completed – 15th February 2023
Continue multi-agency working (LHRPs, Luton and Bedfordshire patch LHRP, Borough Resilience Forums, NHS England (London) NENC Network Meetings)	Completed – ongoing – bi monthly
Annual audit of all Trust Incident Control Centre.	Completed – 18th November 2022
Review and updating of all service business continuity plans	Completed - ongoing
Gold (strategic) training to be provided to directors on-call	Completed – 15th March 2023
Undertake Immediate Operational response training (Hazmat) to community health centres.	Completed – 18th January 2023
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	Completed – 17th June 2023
Quarterly reports to Quality Committee	Completed – ongoing- quarterly
Identify further staff to attend PHE loggist training.	Completed – 12th December 2022
Identify staff to attend the PHE 'loggist train the trainer 'course	Completed – 15th May 2022

9.1 A new Sitrep work stream was established to undertake the requirement of 7-day reporting three specific reports to NHSEI. These were successfully completed throughout the pandemic, and continue to do so, without additional resourcing.

9.2 We were able to deliver and support against the Trust strategy work in relation to population health requirement.

9.3 We have been able to provide routine assurance to the Trust, NHSEI and ICBs on the EPRR Framework to respond to both business continuity and major incidents.

9.4 Emergency Planning Team were able to complete 90% of actions against the work plan for this reporting period.

10.0 Work plan for 2023/24

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.	30th September 2023	Emergency Planning Manager
Continue to review and develop local business continuity plans in conjunction with new template	Local plans in place.	30th November 2023	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.	31st October 2023	Emergency Planning Manager with senior managers

Identify further staff to attend in-house loggist training.	Staff complete the training.	31st December 2023	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	30th June 2023	Emergency Planning manager and IT
Conduct a communication exercise of the IT system	Completed exercise and lessons learnt	30th September 2023	Emergency Planning manager and IT
Undertake Immediate Operational response training (Hazmat) to community health centres.	Identified staff complete the training	14th February 2024	Emergency Planning Manager
Director on-call e-learning package uploaded to Learning Academy	Learning package uploaded.	September 2023	Emergency Planning Manager/Officer

10.1 From 19th July 2023, the Trust will be subject of an internal audit to assess whether effective Disaster Recovery and Business Continuity arrangements are in place to minimise disruption, maintain service continuity of key information and clinical systems and protect the integrity of critical data. The audit will last one week and a report produced, shared with all relevant parties and any recommendations added to the annual work plan.

10.2 All progress against the work plan will be reported to the Quality Committee in the form of quarterly reports.

11.0 **Action being requested**

11.1 The Committee is asked to RECEIVE and APPROVE report and the associated work plan for 2023/24 set out in section 10.0.

East London
NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE
26 June 2023

Title	Health, Safety and Security Annual Report 2022-23
Author	Richard Harwin, Health, Safety, Security and Emergency Planning Manager
Accountable Executive Director	Lorraine Sunduza, Chief Nurse/ Deputy CEO

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
17.05.2023	Health, Safety and Security Committee

Key messages

The attached report identifies the work undertaken during the period 01.04.2022 to 31.03.2023. The following key points are detailed:

- The Health, Safety and Security Committee has now returned to the original bi-monthly meeting schedule. The Committee is well attended by relevant departments including a strong representation from staff side.

- A total of 51 RIDDORs were reported, of which physical assaults accounted for 71%. This was a reduction from 74% for the same period in 2021-22

- For the period of 2022-23, 297 incidents of violence and aggression were reported to the police for further investigation – this was a significant decrease from 507 for 2021-22. To address this, the Trust will be proposing, via the quarterly Senior Managers and Police Mental Health liaison Group, to implement Operation Cavell.

- 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.

- The Health & Safety team has worked collaboratively with NEBOSH (The National Examination Board in Occupational Safety and Health) to attain their endorsement of the trust's Risk Officer training course. As a result, ELFT is now the **first** NHS Trust to have their health & safety learning programme endorsed by NEBOSH.

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.

Health, Safety and Security
Annual Report 2022/23

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, Chief People Officer, 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 and from July 2022, the meeting returned to bi-monthly as the risk from covid lessened.

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.

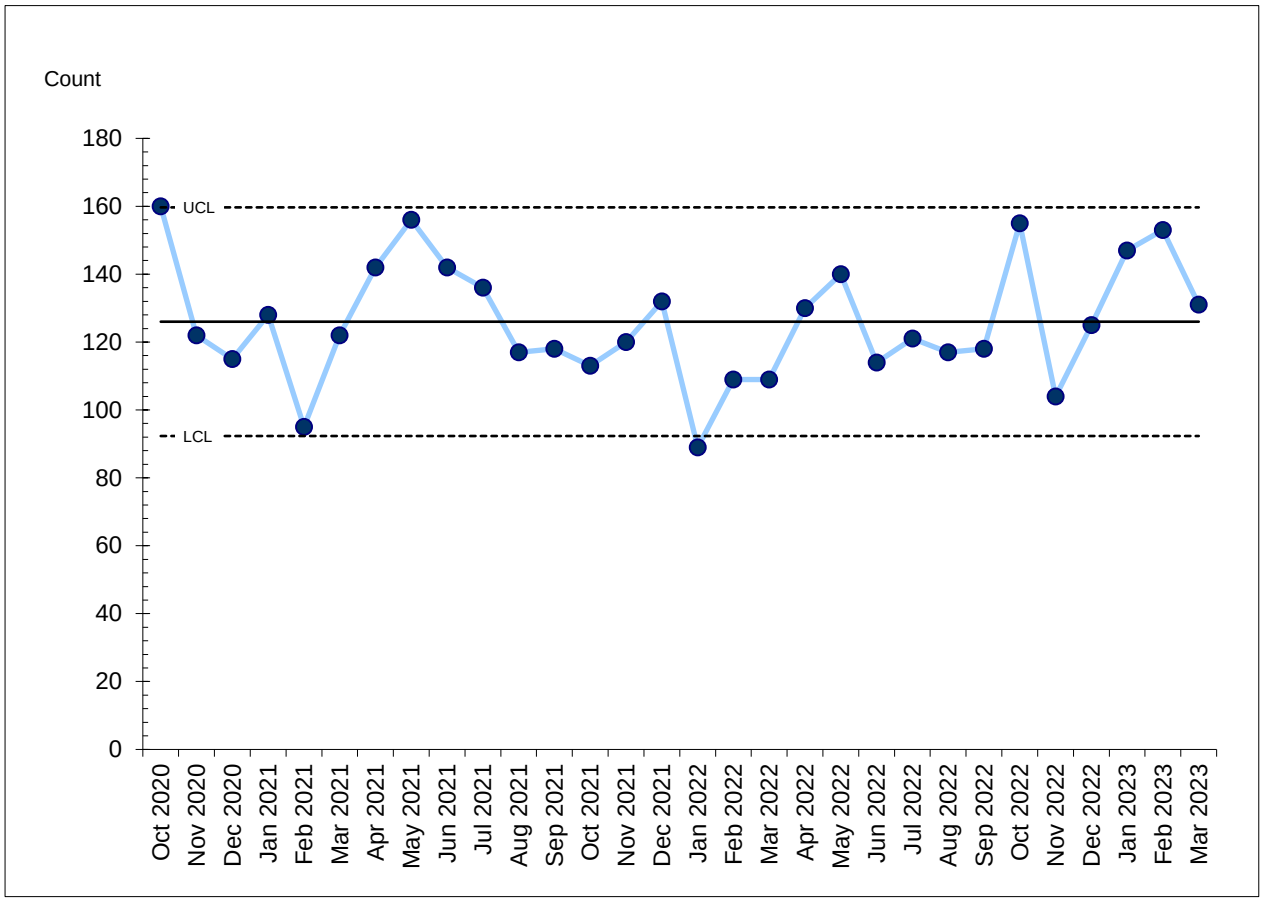
Additionally, the H&S and Security Team is automatically notified of all H&S and security incidents so that they can be followed up to ensure that appropriate action is being taken to implement assessments and control measures to minimise future reoccurrence of similar situations.

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

Health, Safety and Security incidents

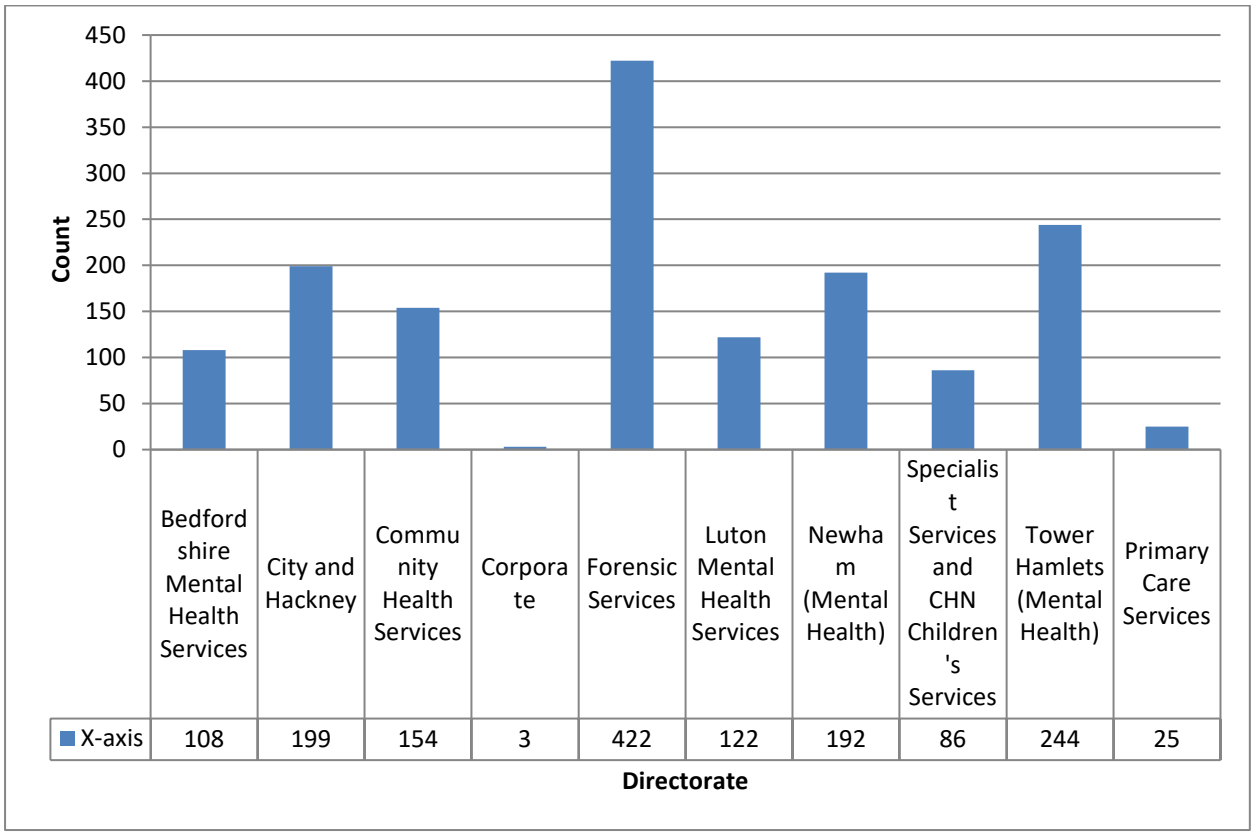
All reported Health, Safety and Security incidents – Trust wide:



A total of 1555 Health, Safety & Security incidents were reported for 2022/23. This has risen slightly in comparison with the 1481 reported incidents in 2021/22.

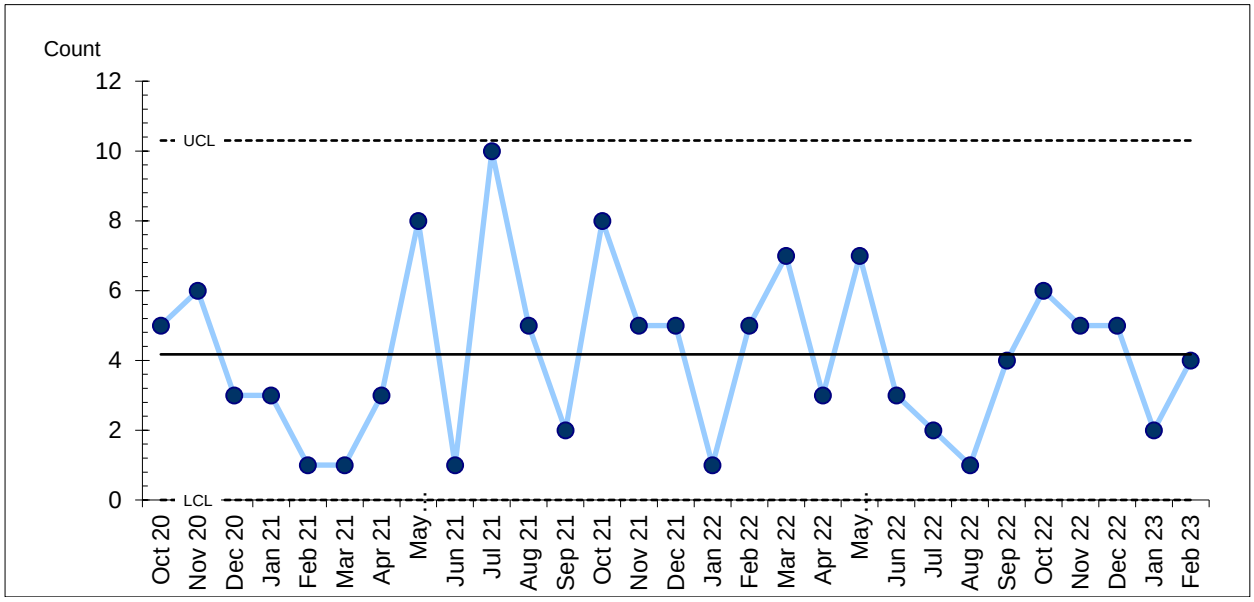
There was no obvious trend for site or type for the peaks in October 2022 and February 2023.

All reported Health, Safety and Security incidents by Directorate April 22- March 23



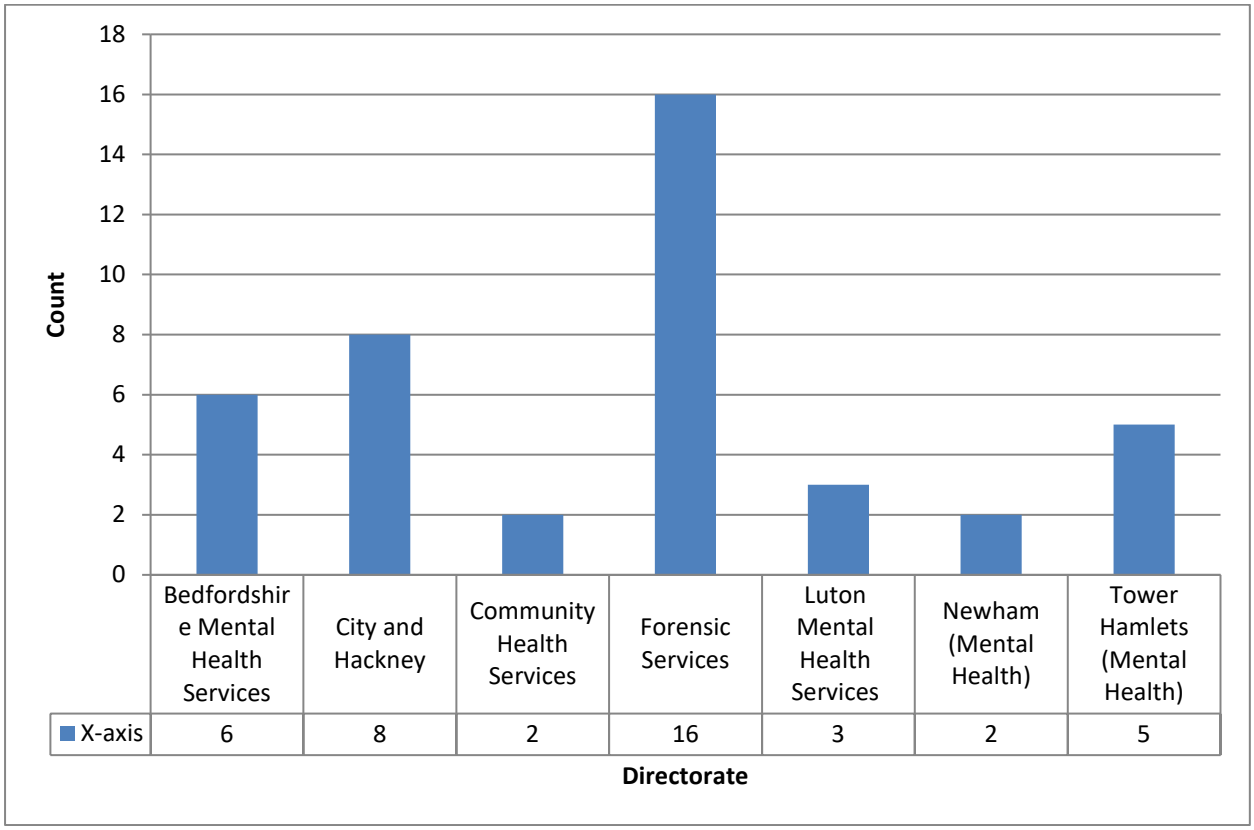
The significantly larger number of incidents within forensic services reflect security breaches such as reports of finding prohibited items as well as other breaches such as doors being left unlocked and associated housekeeping. The comparatively large number of these incidents within forensic services 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 May 2022.

Smoking in an unauthorised area by Directorate April 22- March 23

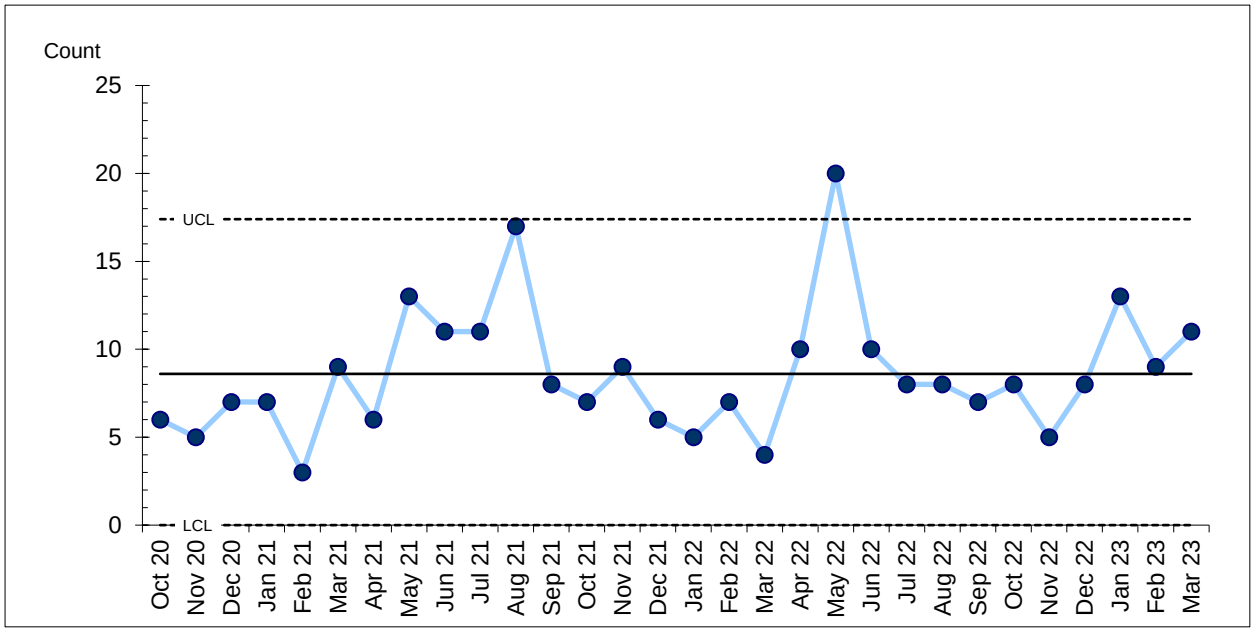


Most incidents of smoking in an unauthorised area tend to occur in the forensic directorate predominantly due to the nature of the service and its patient population.

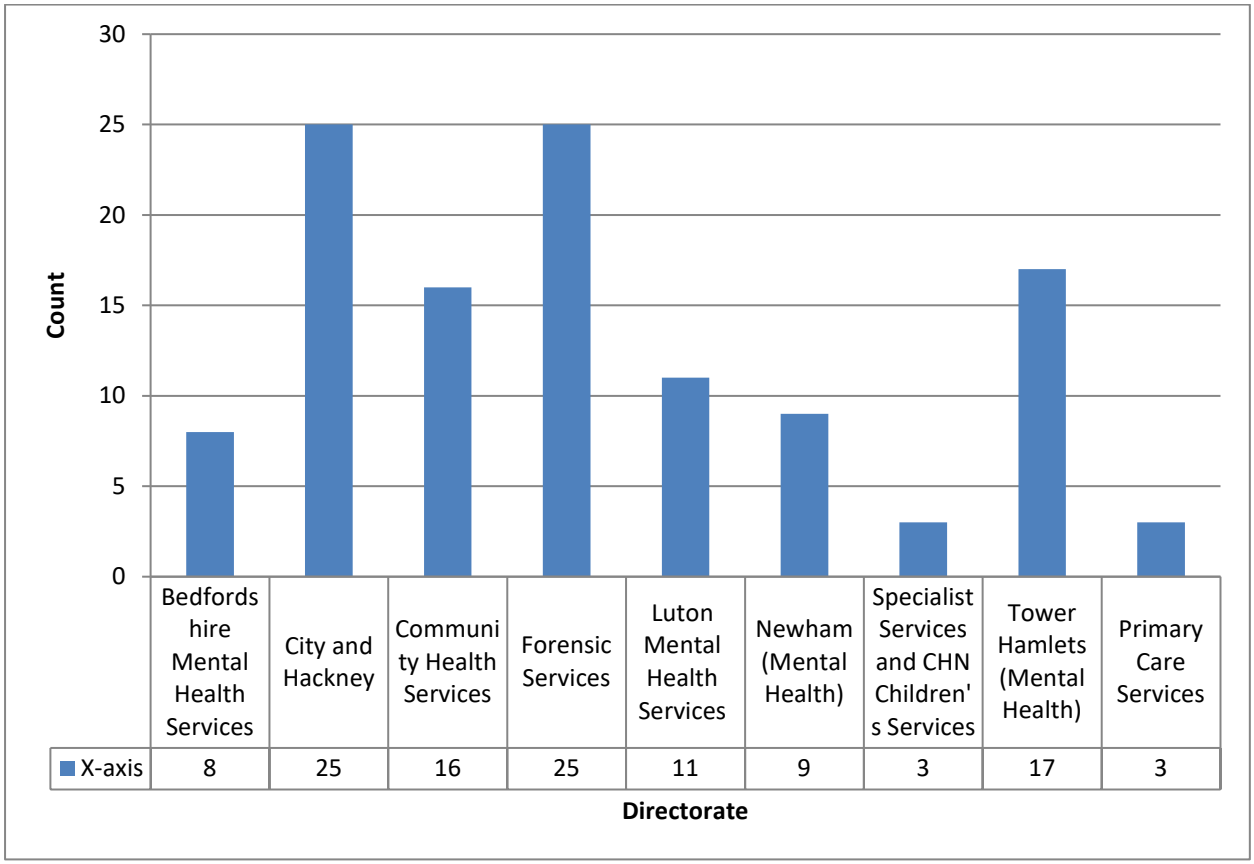
Since 2016, the Trust has moved to a no-smoking environment on all sites.

Fire incidents - All fire incidents reported

All fire incidents (including false alarms) reported Trust-wide:

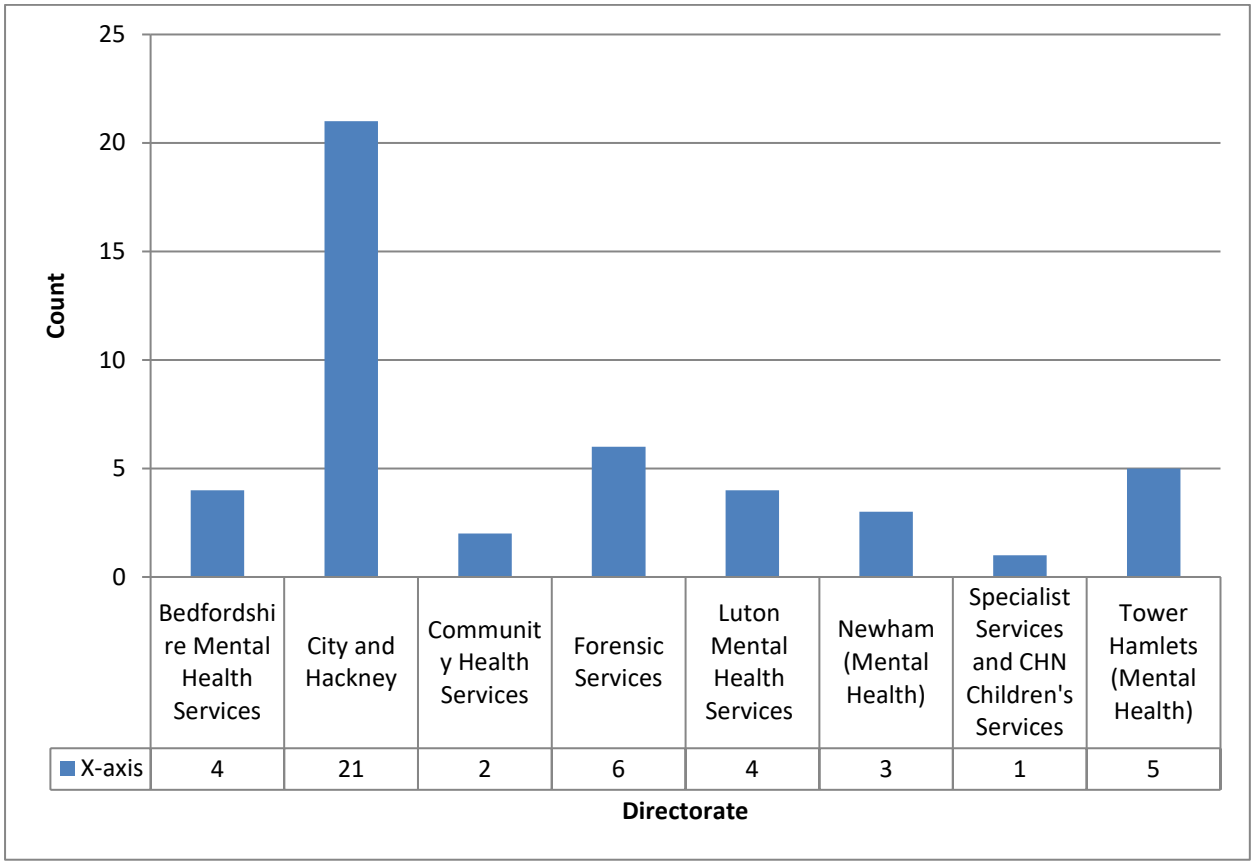


All reported fire incidents (including false alarms) by Directorate April 21- March 22



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 22- March 23:



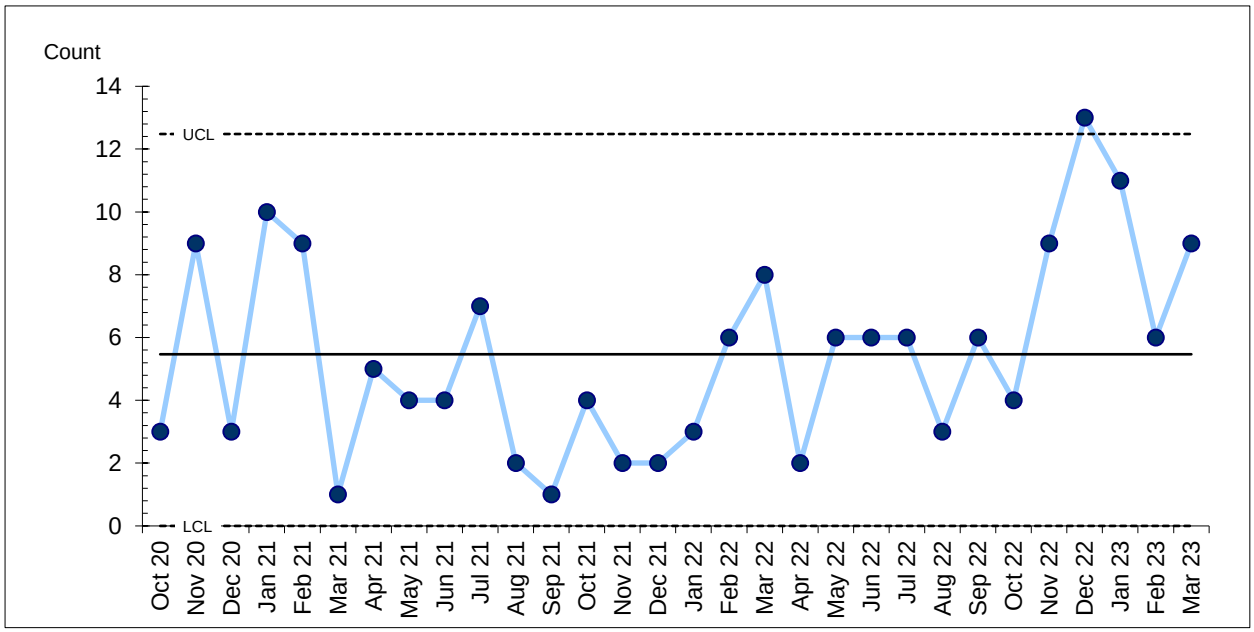
All fire incidents reported are reviewed by the Trust Fire Safety Advisors and, where deemed appropriate, a fire investigation is carried out with a report detailing the details of the occurrence, the cause and any issues relating to building or staff performance. From this, recommendations may arise.

Whilst the number of actual fires in City & Hackney is 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.

There were no incidents within the category of a 'serious nature' (i.e. resulting patient or staff injury).

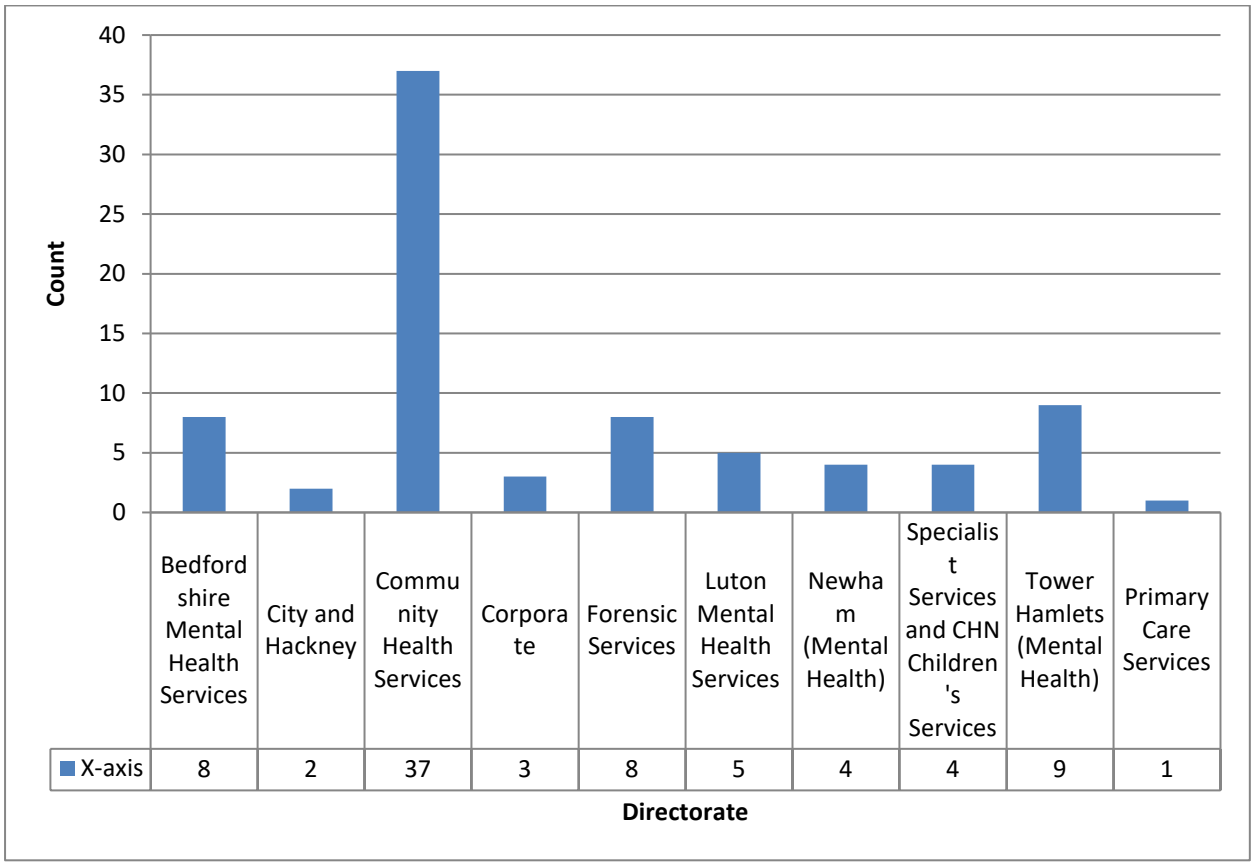
Slips, trips and falls – non-clinical (as a result of accident or hazard)

All reported non-clinical slips, trips and falls – Trust-wide:



During the peak of December 2022, 4 incidents were caused by staff slipping on snow/ice whilst visiting patients.

All reported non-clinical slips, trips and falls by directorate April 22- March 23:



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 but they tend to be whilst visiting patients in the community

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	2020/21	2021/22	2022/23
Bedfordshire Community Health Services	**5**	**0**	**1**
CAMHS	**4**	**6**	**4**
City & Hackney	**9**	**4**	**5**
Community Health Newham	**3**	**1**	**2**
Corporate	**0**	**0**	**1**
Forensic Services	**23**	**14**	**10**
Luton & Beds (Mental Health)	**11**	**5**	**9**
Newham (Mental Health)	**14**	**13**	**12**
Specialist Services	**0**	**0**	**0**
Tower Hamlets (Mental Health)	**6**	**7**	**7**
Tower Hamlets Community Health Services	**2**	**0**	**0**
Primary Care	**0**	**0**	**0**
Total	**77**	**50**	**51**

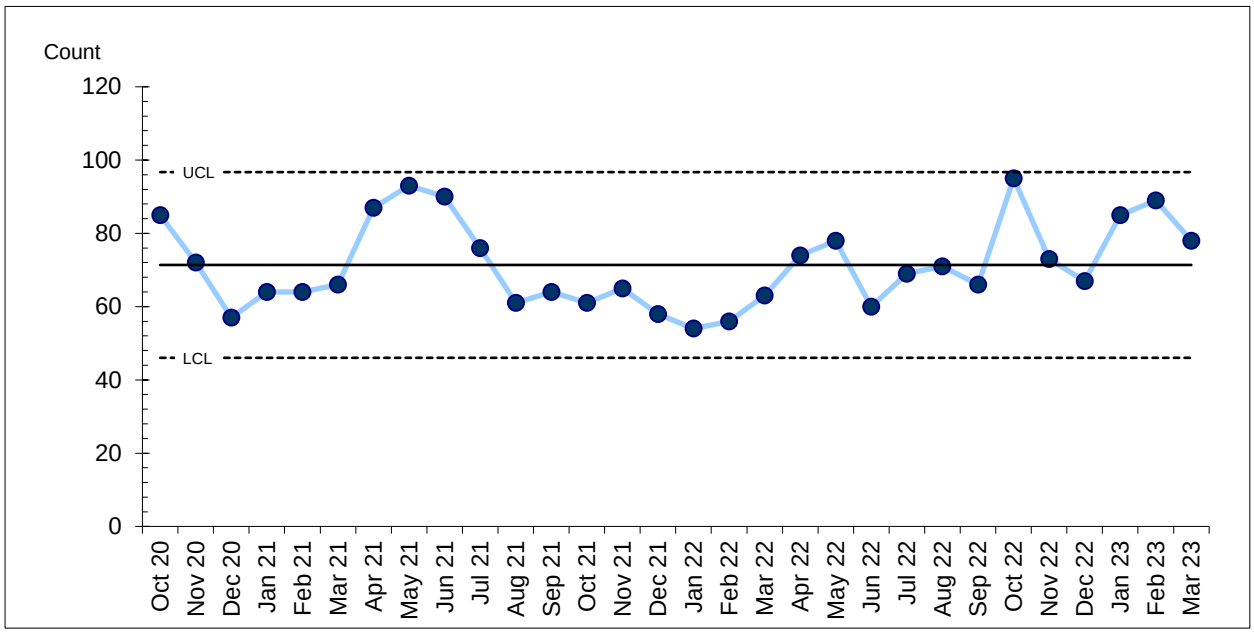
The Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) require the reporting of work-related accidents, diseases and dangerous occurrences to the Health and Safety Executive (HSE). RIDDOR puts duties on employers, the self-employed and people in control of work premises to 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 71% (36) of all RIDDOR reports in 2022/23 - of these, 12 were reported from Newham (Mental Health) and 10 from Forensics. This is not unusual due to the nature of the service and acuity of the wards. The second most common type of H & S related incident reported within the Trust were slips, trips and falls which accounted for 22% (11) of all RIDDOR reports submitted to HSE. The remaining incidents were related to manual handling which accounted for 7% (4). The total number of RIDDOR reports for the period were 51.

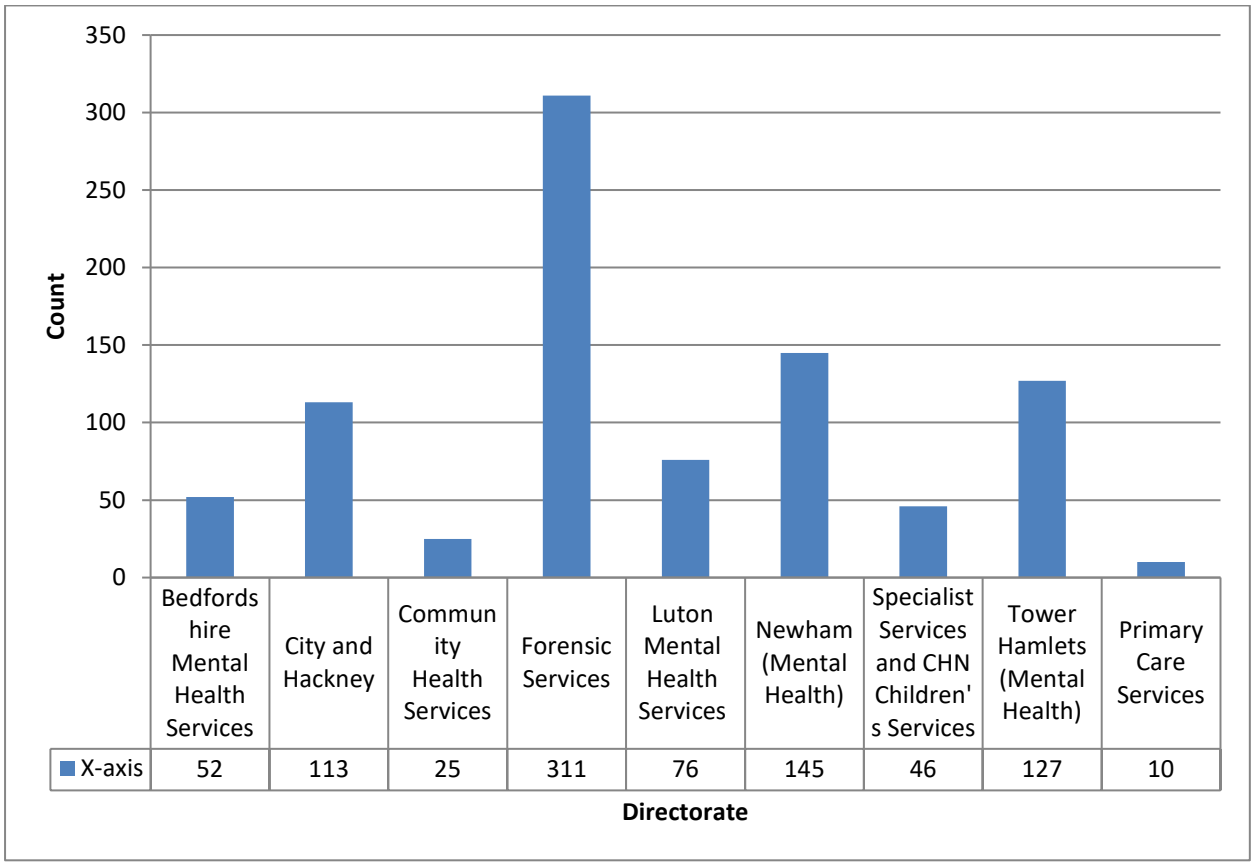
Security Incidents

All reported security incidents – Trust-wide:



For the October 2022 peak, 32 of the incidents were for the surrendering of contraband items or for those discovered during a search.

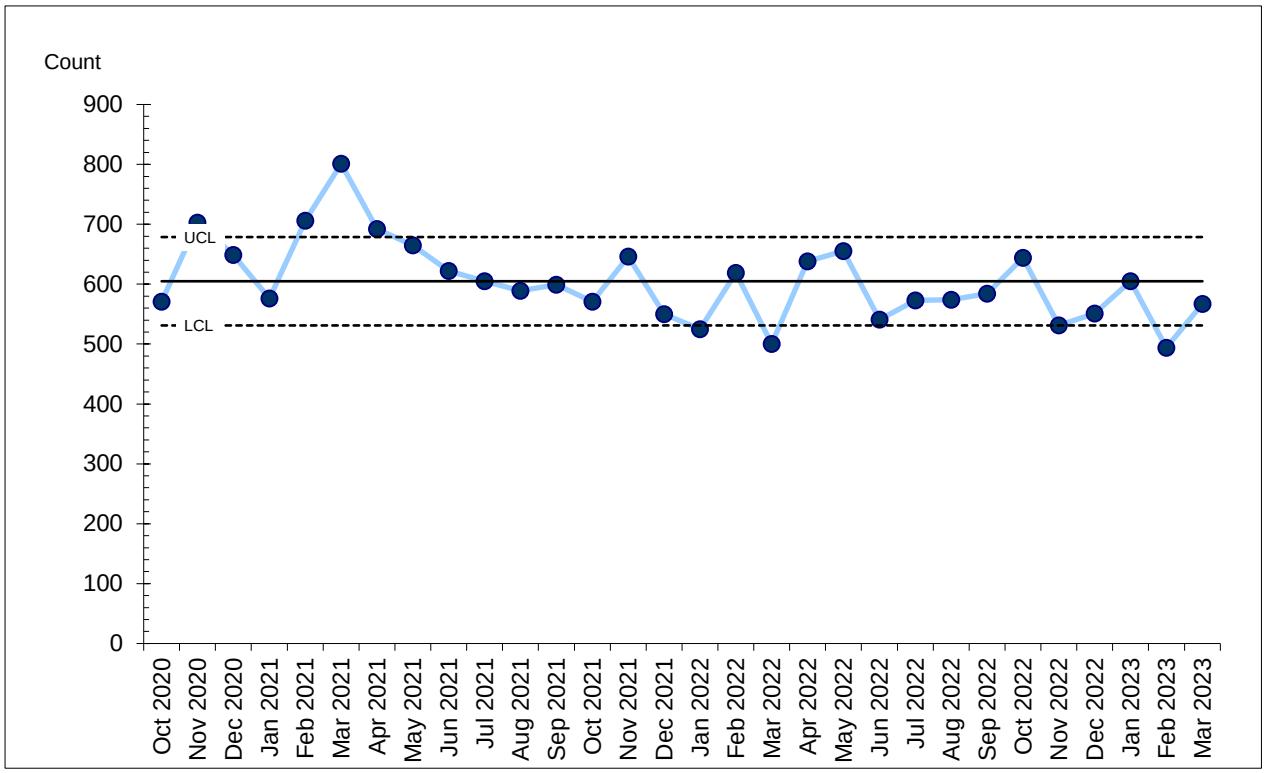
All reported security incidents by directorate April 22- March 23:



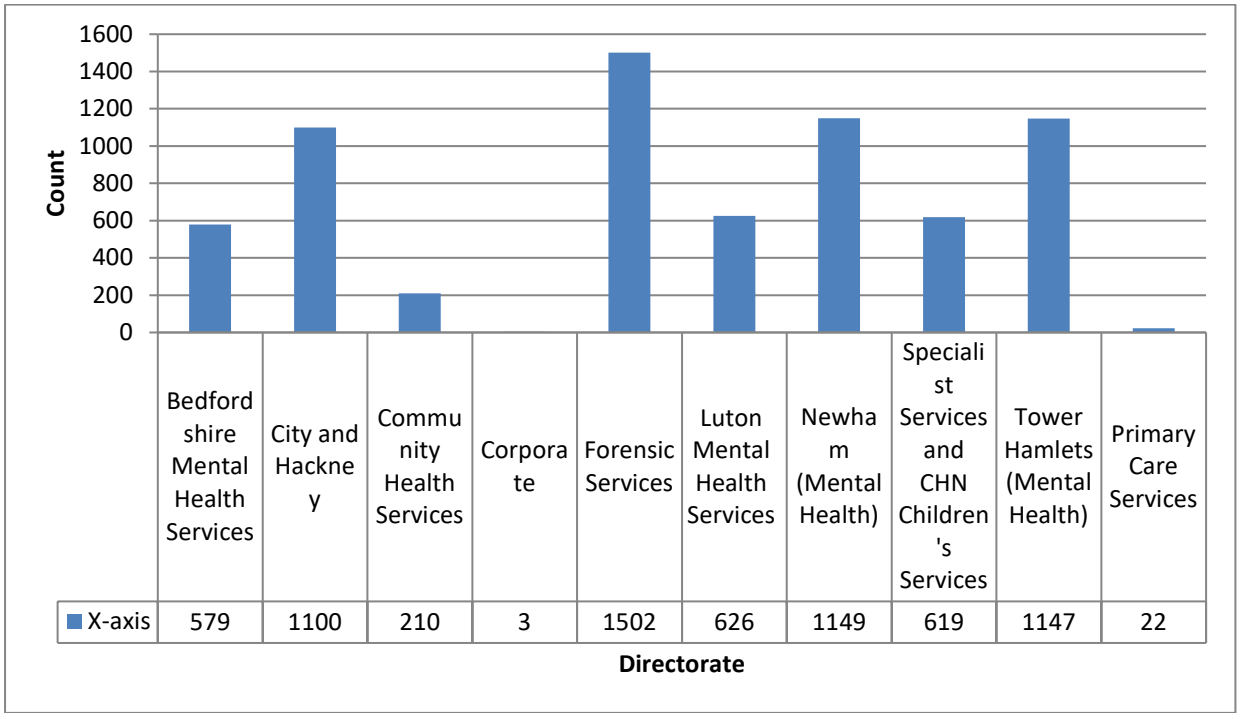
The higher numbers in forensic services reflect security breaches such as reports of the finding of prohibited items, e.g., lighters and tobacco, during both random searches, in line with medium and low security safety procedures and as part of risk management initiatives. Other breaches include internal 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 22 - March 23



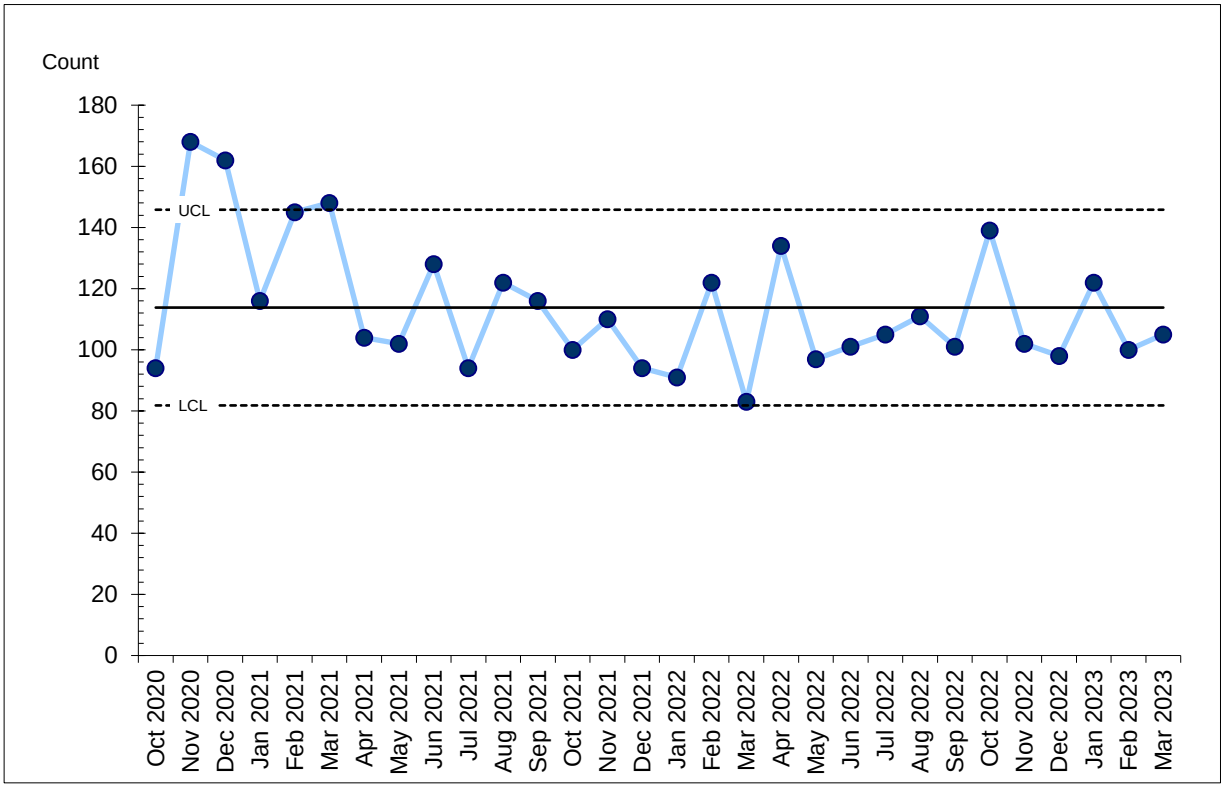
All Violence and Aggression Incidents comparison

Directorate	Incidents Reported 2020/21	Incidents Reported 2021/22	Incidents Reported 2022/23
Bedfordshire Community Health Services	**36**	**36**	**43**
Bedford (MH)	**381**	**360**	**579**
City & Hackney	**1333**	**1197**	**1100**
Community Health Newham	**106**	**121**	**115**
Corporate	**4**	**2**	**3**
Forensic Services	**1882**	**1795**	**1502**
Luton (MH)	**862**	**729**	**626**
Newham (Mental Health)	**935**	**1093**	**1149**
Tower Hamlets (Mental Health)	**915**	**1110**	**1147**
Tower Hamlets Community Health Services	**23**	**39**	**52**
Specialist Services and CHN Children	**1105**	**680**	**619**
Primary Care Services	**6**	**16**	**22**
Total	**7588**	**7179**	**6957**

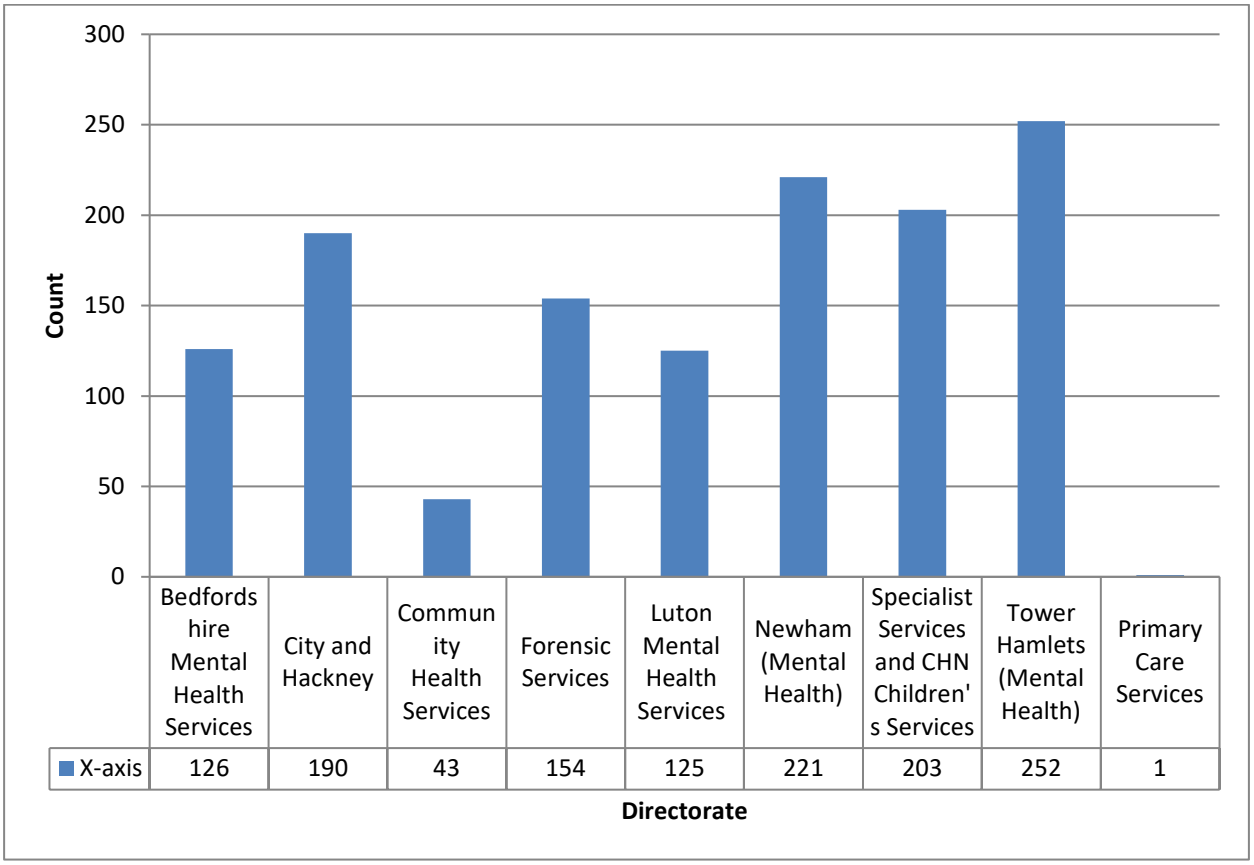
Directorates actively report criminal damage and non-physical incidents, such as threatening and verbally abusive behaviours as well as racial aggression. Furthermore, staff are actively encouraged to report all incidents where they, a colleague or a service user has felt threatened or intimidated.

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 22- March 23:



The peak in October 2022 is mainly attributed to an increase in physical violence at Newham Centre for Mental Health during that month, particularly on Sapphire ward. This ward in particular had been extremely busy by way of the number of admissions, the significant number of patients with challenging behaviours and general acuity on the unit.

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 2022-23, 297 incidents of violence and aggression were reported to the police for further investigation – this was a decrease from 507 for 2021-22. It is difficult to attribute this to a particular reason but to address this issue, the Trust will be proposing via the quarterly Senior Managers and Police Mental Health liaison Group, to implement Operation Cavell (See 9.3).

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.

N.E. BCU currently has one MH liaison officer who is part of their safeguarding team. He 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 two such recent incidents for this period and 3 during 2021-22. 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 police officers during our quarterly Senior Managers and Police Mental Health Liaison Group and as a result, a protocol has been agreed upon by both MPS and NHS. The over-arching principle is that people with an acute mental health need should be cared for in a healthcare environment wherever possible and should not spend any more time in custody than is necessary. This protocol will be reviewed in September 2023.

9.3 Operation Cavell

Currently there is no Trust oversight of incidents which are reported to the police often resulting in police investigations becoming elongated and subject to significant delays with victims often not being informed of any outcome – the result is staff then becoming disillusioned with the entire process. Furthermore, staff are finding that police are closing cases with no consultation with either the victim or responsible clinician.

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.

Key changes:

- Promulgating excellent practice across police, NHS and CPS.
- All NHS victims to be treated as priority victims – contact within 24 hours.
- CID to investigate any reports of 'actual bodily harm' and above.
- Linking in with NHS SPOCs to capture best evidence early – including CCTV, statements etc.
- Use of toolkit of 'tried and tested' evidential documents – fitness to be interviewed, loser statement (for use in criminal damage), public interest statement, community impact statement.
- Introduction of single point of contact mailbox at the Trust
- Use of shared resources to save evidential evidence.
- Use of 'Assault on Emergency Workers Act 2018' when seeking a charge
- Use of ward space for interviews (where appropriate)
- Victim/staff satisfaction survey.
- Operation Cavell crime tracker to be discussed at monthly meeting of LSMS, Operation Cavell officers and operational leads

Key benefits:

- Staff retention
- Providing safe environment for both staff and patients
- Improve staff well-being
- Improving overall relationship with police

The Trust will be proposing this via the implementation of this at our Senior Managers and Police Mental Health Liaison Group.

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 Liaison 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 feeds into the Crisis Care Concordat Strategic Group meetings.

9.5 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.

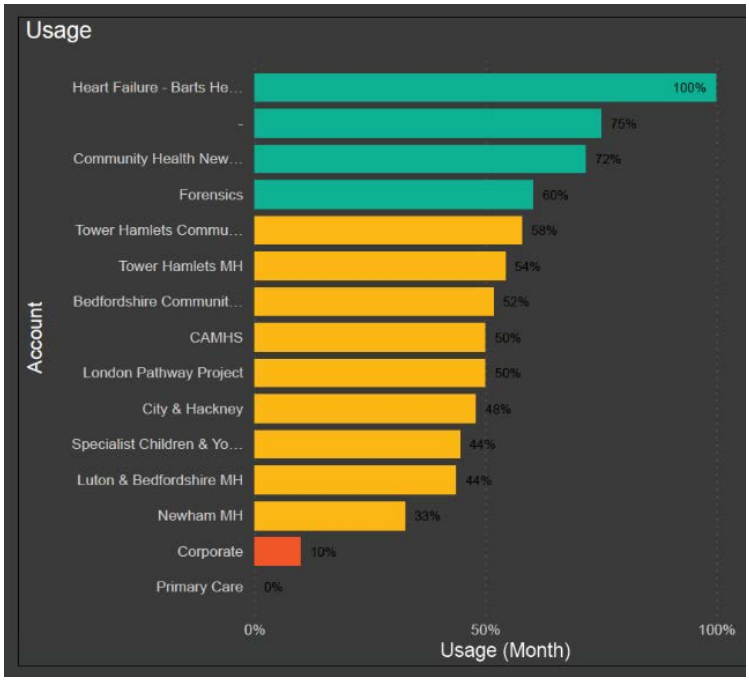
ELFT staff within the Bedfordshire Police Mental Health Hub have also supported the police with several bespoke training days for response officers and the Force Contact Centre.

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 opposite shows the current percentage compliance by directorate for 2022-2023.



We currently have 1226 lone workers who have uploaded the app and in order 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 were identified and a series of online training is ongoing to provide localities access to 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.

- The Peoplesafe team have created a number of personalised training programmes for ELFT which is available on the ELFT intranet

- An online link has now been created for staff to activate the app- this is a swifter process – formerly, spreadsheets had to be sent to Peoplesafe – this new process to enables staff to activate the app themselves and will encourage other staff to do so too.

- The H&S Team have updated the trust's intranet page highlighting and focusing on key features of the Peoplesafe app as well as sharing staff stories and their personal experiences of the risks of lone working and the benefits of using the app. This page is allows easy access to all available training material.

- Monthly Peoplesafe forums and webinars have been established for staff to discuss any issues they may be having with the lone worker app as well as providing a platform with which to share learning and good practice.

To date, Trust-wide compliance for the Lone Worker App is at 75% which is a slight increase from 73% for the same period last year.

11.0 Monthly Health & Safety Bulletin

The H&S Team are now publishing a series of 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 in April 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.

In response to changing guidance especially as regards Covid-19, the Trust's WPRA guidance and template has been updated in consultation with staff side, the infection control team and estates.

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.

- The WPRAs will be uploaded and audited by the Trust's new Quality Assurance Digital Management System in the autumn of 2023.

14.0 Remote working/Display Screen Equipment (DSE)

As an employer, we must protect our staff from the health risks of working with display screen equipment (DSE), such as PCs, laptops, tablets and smartphones - we have the same health and safety responsibilities for home workers as for any other workers.

The H&S Team has developed a new training package and process for DSE/workstation assessments which has been uploaded to the Learning Academy. This provides guidance for safe working at workstations, a self-assessment and streamlined process with which to order recommended equipment

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.

15.2 Risk Officer Training (NEBOSH endorsed)

The Health & Safety team have worked collaboratively with NEBOSH (The National Examination Board in Occupational Safety and Health) to attain their endorsement of the trust's Risk Officer training course. As a result, ELFT is now the first NHS Trust to have their health & safety learning programme endorsed by NEBOSH.

The benefits to ELFT of this endorsement are:

- Recognition from NEBOSH of in-house, tailored learning programs
- More cost effective than delivering an accredited qualification
- Customised certification.
- Focus on the Learning Impact to emphasise the Organisational and Learner objectives with a measurable outcome

15.3 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 / appraisal meeting at site of employment	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 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 2022/23

KEY ACTION	STATUS AS AT 31/03/2022
Review all policies relating to health & safety to ensure they reflect current guidance and legislation.	Completed – 15th February 2023
Quarterly/exception reports to Quality Committee	Completed – ongoing - quarterly
RIDDOR reports submitted to timescale	Completed - ongoing
Risk facilitators and officers in place	Completed – 18th January 2023
Risk officer training needs analysis completed, and training completed	Completed – 19th January 2023
Ensure completion of all annual H&S environmental inspection forms	Carried forward
Ensure review of all workplace risk assessments considering COVID-19.	Completed – 21st September 2022
Delivery of Peoplesafe smartphone app training and webinars	Completed – 6th March 2023
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 and other events.
- Providing increased support to services who have a seen a rise in violence and aggression.

17.0 Key Priorities to be taken forward during 2023-24

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.	31st December 2023	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	31st July 2023	H&S Manager
Risk officer training review and delivered	Training delivered and attendance recorded	30th September 2023	H&S Manager
Ensure completion of all annual H&S environmental inspection forms	Completion of all annual H&S inspection forms	30th September 2023	H&S Manager
Ensure review of all workplace risk assessments	Completion of review of all workplace risk assessments	31st August 2023	H&S Manager
Continued implementation of Peoplesafe Smartphone App alarm	Trust wide implementation completed.	30th September 2023	H&S Manager / IT
Delivery of Peoplesafe training Webinars	Delivery of webinar	Ongoing	H&S Manager
Delivery of staff safety workshops to community staff	Workshops delivered and attendance recorded	31st October 2023	H&S Manager
Co-lead on QI project to improve reporting of assaults to police	QI team in place with presentable data	30th September 2023	H&S Manager / Ward team

17.1 During 2023/24 the Health and Safety team will co-lead a QI Project to improve reporting of assaults to police.

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 2023/24 set out in section 17

East London
NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE

26 June 2023

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 2021/22 deadline was deferred from March 31st to 30th June 2022. The Trust received a fully compliant rating across all Assertions, unlike many Trusts where an action plan was formally requested. This was reported to QAC in September 2022. The revised timetable has an impact on the 2022/23 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 April 2023 (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 2023.

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 2023 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 35% 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 47 on March 31st 2023. 51% have been responded to on time. This is lower than the last financial year's 63%ı

	2020 – 21	2021 - 2022	2022 - 23
Total no. requests received	342	442	522
Total no. closed	299	401	511
No. closed / responded to on time	191 (64%)	251 (63%)	260 (51%)
No. closed / responded to late	108 (36%)	150 (37%)	251 (49%)
No. where full exemptions were applied	30	103	157
No. where partial exemptions were applied	30	42	95
No. not relevant to the Trust	21	52	66
No. requests for review	01	01	08
No. escalated to ICO by requester	01	0	01

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 slightly over the last three years by 4% from 1672 in 2020/21 to 1734 in 2022/23. The number of requests received compared to last year has decreased by 17% from 2095 to 1734 (although we are aware not all services report on activity). 85% of requests have been responded to on time within one calendar month whilst a further 37 complex requests were processed with an agreed extension of up to three months (as permitted under the Data Protection Act.) Response rates have been poorer this year compared to last year due to a number of different factors including responsible clinician sign off and staff shortages. The number of staff requests decreased from 31 in 2021/22 to 24 in 2022/23. One of these included numerous repeat / revised requests which have been recorded as one request. Staff SARs are often in response to grievance or other action and are time consuming and potentially litigious.

SARs	2020 – 2021	2021 - 2022	2022 - 2023
Total no. SARs received	1672	2095	1734
Total no. SARs responded to	1362	1910	1707
Total no. responded to on time within one calendar month	1292 (94%)	1720 (90%)	1446 (85%)
No. responded to with an agreed extension of 2 – 3 months	09	06	37
No. responded to late	70	190	224
No. staff requests	19	31	24
No. escalated to ICO by requester	Not recorded	08	06

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. Actions are taken when an incident is reported including training and support. Four incidents met the serious incident reporting framework, a considerable decrease on the previous year's 13. Only one met the threshold for notification to the Information Commissioner – a pre assessment questionnaire sent by the children's services (SCYPS) speech and language therapy team to a parent, following a referral from the child's GP. The service received a voicemail stating that the mother had tried to complete the referral form on line using the QR code in the referral letter. A relative of the parent (her sister) subsequently advised the parent was approached by someone purporting to be a SCYPS Doctor who asked inappropriate and intrusive questions about the child, allegedly via What's App. Further investigation identified that the mother had shared her child's information via various WhatsApp Groups, that the call was not traced to ELFT and that the Doctor did not work for ELFT, therefore the ICO closed the case on the basis that ELFT had reported an incident in good faith that was not attributable to the Trust.

Data security breaches	2020 – 2021	2021 - 2022	2022 - 2023
Total no. data security / confidentiality incidents in period	520	556	600
Total no. data security / confidentiality 48 hour reports requested	35	32	27
Total no, reported to the DSPT	20	13	04
Total no. subsequently reported to ICO	01	04	01

ICO complaints / decision notices – seven complaints were made to the Information Commissioner. One was an FOI complaint regarding an overdue request. Six related to handling of requests for personal information. Of those, two related to Luton, one to Newham, two to Specialist Services and one was a staff complaint. 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	2020 – 2021	2021 - 2022	2022 - 23
No. new ISAs approved	28	19	27
No. existing ISAs renewed	03	0	01
Total no. ISAs approved	31	19	28
No. new 3rd party access agreements approved	10	05	10

No. existing 3rd party access agreements approved	01	01	0
Total no. 3rd party access agreements approved	11	06	10
Total ISAs / 3rd party access agreements approved	42	25	38

Data Protection Impact Assessments – DPIAS are required where high risk processing could take place. 38 DPIAs have been completed during the year, an increase of .

DPIAS	2020 – 2021	2021 - 2022	2022- 2023
Total no. DPIAs approved	31	24	38

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	2020 – 2021	2021 - 2022	2022- 2023
No. contracts / DPAs approved - ELFT as Provider	27	48	107
No. contracts / DPAs approved - ELFT as Commissioner	59	58	46
Total no. contracts / DPAs approved	86	106	153

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. Exercise Phoenix is planned and will take place in June 2023.

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, Microsoft, Darktrace AI and Sophos but urgently needs to expand its Cyber team to match the increasing risk in this critical risk area, and the 365 - 24/7 nature of the cyber threat and response. The Trust has also enrolled into other NHS programmes such as the Microsoft ATP deployment, initiating rolling out Multi-factor Authentication across the trusts NHSmail and implementing ISO27001 framework together ensure the Trust has taken appropriate integrated 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 years.

Darktrace Artificial Intelligence – The Trust received national funding for Darktrace in 2022, an Artificial intelligence (AI) system that monitors the network for normal patterns and responds and blocks any potential cyber-attack. This Cyber Self-Learning AI works by constantly evolving its understanding of both IT infrastructure and operational technologies, allowing it to identify the subtle, emerging signs of a cyber-threat and take targeted action to interrupt encroaching attacks.

Cyber security audit - 2022 Secure Remote Working, Information Security and Operational Resilience audit was received by the SIRO, following a subsequent meeting with the Digital Team & CDO, an action plan was reviewed and completed to the satisfaction of the Auditor, 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 – this year we have concentrated on clearing our internal records stores, enabling them to be repurposed for clinical areas.
We project managed clearing internal records stores. Mile End records store has been completely cleared (records past their retention date securely destroyed and in date records correctly labelled prior to sending to Iron Mountain) to use as a clinical space for the perinatal team. City & Hackney records store is in the process of being cleared for clinical space and Newham Centre for Mental Health is considering a similar project to clear a room to store on demand clinical equipment.

Information governance team– an information governance restructure took place in 2021 to realign responsibilities and increase resilience. Appointments were made to the two newly created posts (Information Rights Manager and Information Rights Coordinator). The posts were successful although the appointments were less successful. The Information Rights Manager left the role in December 2022 and the Information Rights Coordinator returned to their substantive post in January 2023. We have successfully recruited to both posts.
In November 2022 responsibility for Tower Hamlets subject access requests was transferred to the direct management of the information governance function to provide professional support. This has had significant benefit in terms of reduced complaints and more timely responses. Additionally, as the access to records team undertakes redactions this has benefitted Tower Hamlets clinical staff who previously were responsible for redactions.

Multi-Factor Authentication (MFA) for NHSmail – is a very large security and change management project that will affect all the trust staff. Multi-factor authentication is crucial to strengthening our collective cyber security within the Trust. Compromised NHS emails are a significant risk as NHS compromised email addresses are taken over by hackers, who then use these NHS emails to launch phishing attacks or cyber fraud. The planned roll-out across the Trust will involve initial trials with test groups, then formally rolled out with every member of the trust. This will decrease our risk with compromised accounts and reduce this element of phishing and fraud. Once our staff have MFA enabled and log into NHSmail, they are prompted for their username and password (the first factor– 'what they know'), and an authentication response from their MFA device – through text, Microsoft App or smartcard (the second factor– 'what they have). If the system verifies the password, it connects to NHSmail. This ensures that

if an NHS email password has been compromised, then the hacker cannot set-up or log into that NHSmail account preventing clandestine misuse of that email account because of MFA.

Security Patching – Fixes vulnerabilities on our software and applications that are susceptible to cyberattacks and supports system up-time. The Trust has on average 7,500 devices and 100 servers on our network anytime and our average compliance in over 90%. These security patches include regular Microsoft OEM security updates, vendor application security updates and zero-day exploit updates. Zero-day exploits are previously unknown to those who should be interested in its mitigation, like the vendor of the target software. The Trust has received 2 zero data exploit notices in 2023 to date. A robust security patching management program is key to a secure environment within the trust, and we are improving our performance and reaction.

Enterprise Voice migration - has fundamental problems with disparate, out-of-date telephony provisions that have reached end-of-life or\and are not fit-for-purpose. The current infrastructure is unable to handle agile voice and has limited to no resilience or business continuity measures in place. This has proved extremely challenging to make effective and urgent arrangements to manage Trust services. Over the next 2 years, we will implement a single telephony platform, built on MS Teams as the front end - for familiar staff experience, serving multiple stakeholders to provide location independent telephony, video calling, image and document sharing, automation of messages and triages. Our innovative system will provide seamless access to clinicians and care providers regardless of their location whilst enabling the clerical and admin functions to share resources during peak times to maximising efficiency. This will be integrated via cloud-based functionality with the ability for Trust staff to customise the menus for patients suited to the business needs. It will dramatically reduce the need for physical phones on desks. This new system will have all the telephony functions using softphones, enabling answering via headsets and\or mobile (via an app) – giving maximum flexibility. It will be available to all the Trust staff and integrate with other voice solutions. In emergency scenarios the remote access element can be extended to avoid further individual investments being made.

URL Filtering – The Trust 'CISCO FIREPOWER' Firewalls have been upgraded and configured to provide advanced URL filtering, which is undergoing user testing. URL Filtering will automatically restrict websites and content that staff can access. This will reduce cybersecurity attacks and prevent fraud. The URL filtering takes the restriction list from a leading security provider that updates the risk levels constantly. This typically prevents staff from visiting websites that could affect the Trust from operating as usual, such as sites containing illegal or inappropriate content, sites that could be high risk, malicious or related to phishing attacks and fraud. This will provide security and assurance to the Trust and our staff.

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, AWS and Telefonica Tech UK private cloud. 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 AWS and private cloud. The full benefit realisation and risk governance and tracking of this substantial investment in infrastructure. UKClouds exit in the marketplace last year had initiated an emergency migration of data to AWS to ensure uninterrupted access with private cloud resilience expected to be complete this year.

VDI deployment program - A multi-year deployment of desktops hosted in cloud datacentres by AWS and Telefonica Tech UK. This solution will provide a more secure end user compute environment at the Trust as it ensures all data is securely housed in the cloud and not on local endpoints that may get lost/stolen/misplaced. The ability to scale out, extend resources, always have access to fast machines and data, continue to consume endpoints without the need for a regular refresh cycle and considerably easier security patching via a central endpoint are other advantages for VDI over continuing to purchase expensive end devices that need to be looked after and maintained individually. Year one allocation is for 500 endpoints, we estimate this will cover up to 1,000 users at the Trust. Currently, the system is in low-level design phase, and we expect to start testing the second half of this financial year.

Social Media and Artificial Intelligence Apps – social media within the trust provides healthy and informative communication but with the introduction of new threats from state actors like China, social media is becoming a new threat vector. A small study is being undertaken to understand the types of social media being used within the trust and the associated increase of risk, this will be presented at June IGSG. The trust can control the corporate devices but there is an increase of work-related activity on social media on personal devices, which will be a challenge meet with exemplar education. Artificial intelligence is at its infancy but already having impacts on the cybersecurity landscape, the Trust will monitor this rise in technology and adapt to defend against the new threat.

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

Archiving – continuation of archiving pilots on a business as usual basis was not taken forward due partially to supplier engagement together with the need to create a robust in depth business case.

FOI – there has been a considerable backlog of overdue FOI requests due to a number of factors (staffing complexities referred to above, increase in numbers of requests, engagement with some corporate teams / lack of responses from corporate teams). A recovery plan has been put in place but this has had an impact on the substantive roles of the Information Governance Manager and the Associate Director of IG, both of whom have been extensively involved in clearing the backlog.

Locality audits –concentration on an FOI recovery plan affected the number of supportive data security audits that took place .

2.4 Any notable risks further to the above

In March 2023 there were seven information governance risks. There are mitigating actions for each risk. The risk register is available on request.

In year activity:

- Closed x 2 (shown below as Green)
- Unchanged x 4 (all Amber)
- Increased x 1 (increased from Amber to Red)
- New x 0

IG4	Amber	Amber	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	Unchanged
IG7	Amber	Amber	if the Trust does not manage subject access requests effectively and respond appropriately, data subjects may complain to the ICO resulting in regulatory action	Unchanged
IG8	Amber	Amber	if the Trust does not undertake a programme of reviewing its records with a view to retention or deletion it will not comply with the requirements of GDPR and it will continue to incur unnecessary external archiving costs. Work has taken place in house to identify records stored internally and beyond their retention period	Unchanged
IG11	Amber	Green	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	Closed
IG12	Amber	Amber	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. This was added as a result of changed priorities during the pandemic, in particular the difficulties of undertaking training remotely. There are further challenges in unavailability of data to support compliance metrics	Unchanged
IG14	Amber	Green	if the Trust does not manage data security breaches effectively this may result in regulatory action from the ICO / Commissioners. This was in response to a high number of email data security breaches, mitigated through training, strengthened procedures etc	Closed
IG15	Amber	Red	if the Trust fails to address the FOI backlog effectively it may encounter ICO regulatory action & reputational damage. The backlog has reduced significantly since October 2021 when it was added to the risk register and continues to reduce to manageable levels	Increased

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

- The monthly Cybersecurity Board
- IT System Health Check by NHS Digital and Dionach
- Patching and security updates – ongoing – software patching and annual external vulnerability testing by Crest registered Penetration Tester.
- Staff Feedback through our dedicated email elft.cyber@nhs.net
- Collaboration with other NHS Security teams and the wider industry for 'Best Practice' and threat analysis
- Benchmarking security capabaility

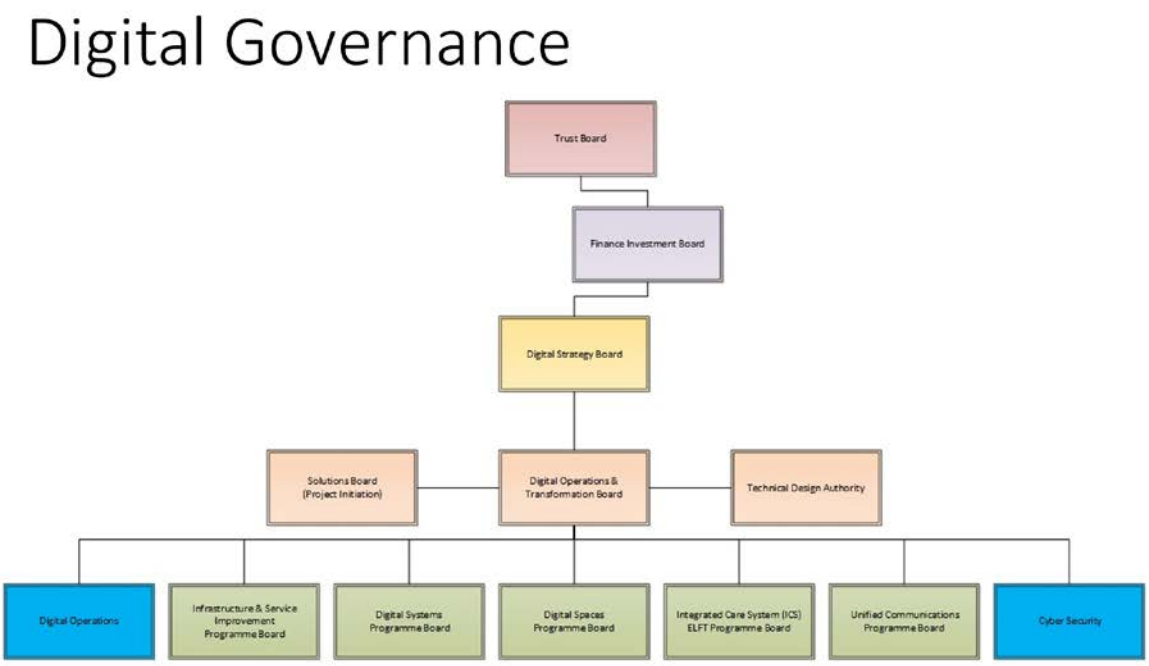
Infrastructure risks (datacentre) operations & security risks

- NHS secure boundary security operations centre
- Assessing all flows of PID that are occurring across the Trust – such as the IoT management and weaknesses in infrastructure of safe delivery of PID containing items.
- NHS Digital and Darktrace AI Security Operations Centre

Digital governance risks

- Creation of the Cybersecurity Board and Trust Cybersecurity Strategy

- 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 Action taken and planned in response to gaps in implementation or other risks identified

All risks are routinely assessed and actions described above.

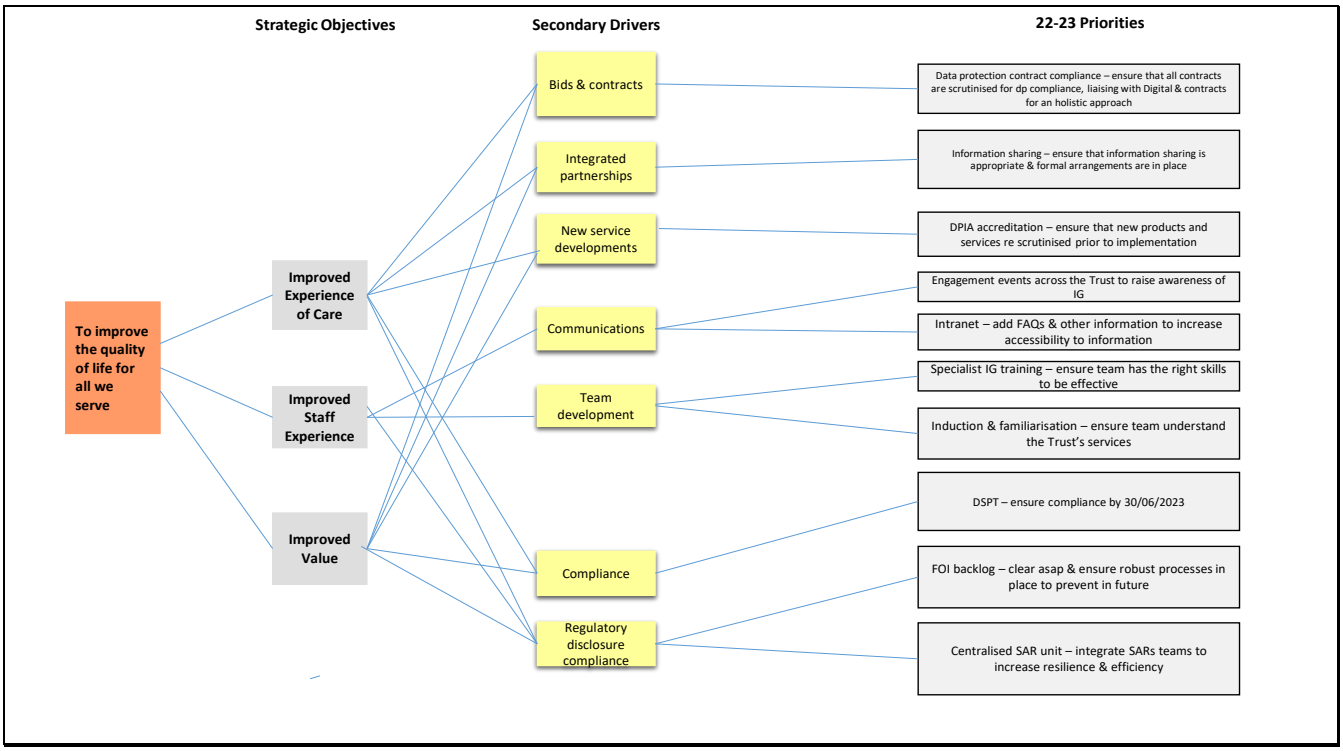
3.0 Workplan for the coming financial year

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
- Effectively scrutinised an increased number of contracts / data processing agreements
- Increase locality audits
- Support archiving projects
- Support service developments
- Work with partners to support integrated DIGITAL systems
- Improve information governance communications – intranet, training, engagement events

3.2 IG links to Trust objectives



3.3 Digital key priorities

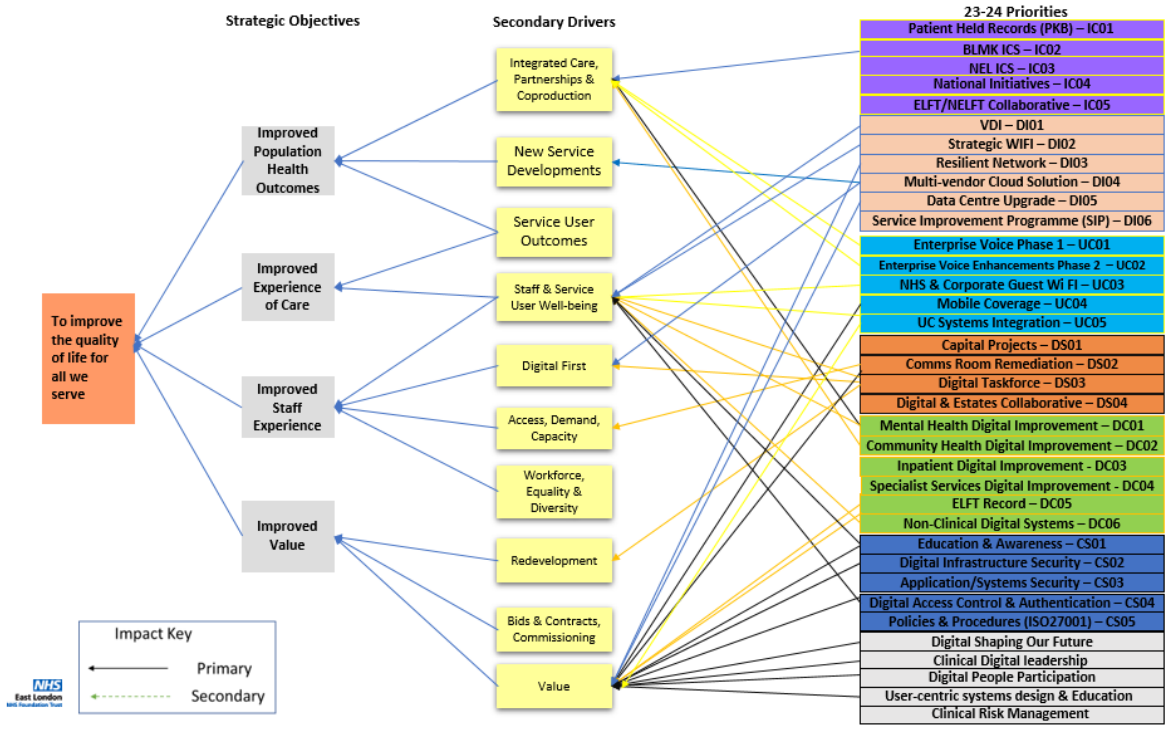
Digital Programme Priority Workstreams

Digital Programme	Quarterly milestones				Measures for tracking progress over time
	Q1	Q2	Q3	Q4	

Integrated Care Board Programme (IC)	• Planning, Discovery & Engagement	• BLMK ShCR	• PKB P1
			• National Initiatives (NHSE/D)
				• PKB P2
				• ELFT/NELFT Collaborative
					Governance
					• Monthly Programme Board
					• Weekly Portfolio Team Meetings
					• Bi-Monthly Digital Operations & Transformation Board (DOTB)
					• Bi-Monthly Digital Solutions Board (DSB)
					• Monthly Capital Projects Steering Group (CPSG)
					• Bi-Monthly Digital Strategy Board
					
					Measures
					Digital PMO Tracking the project lifecycle
					• Service Now KPI/SLA Reporting
					• Benefit identification/Tracking realization
					• Finance and Budget Tracking
					• Project/Programme highlight report
					  • Project Status (RAG) with route to green
					  • Milestones & Gateway
					  • RAID Mgt
					  • Resource Mgt
					
					*UT - User Testing
					*Imp - Implementation

Digital Infrastructure Programme (DI)	• Planning, Discovery & Engagement • Resilient Network Design	• Data Centre Upgrade Design	• Data Centre Upgrade DC 2	• VDI - DI01 • WIFI - DI02 • Resilient Network - DI03 • Cloud Solution - DI04 • Data Centre Upgrade - DI05	
Voice & Unified Communications Programme (UC)	• Planning, Discovery & Engagement	• Business Case & Procurement	• Enterprise Voice (UCaaS \ CCaaS) Commence Phase 1 - UC01	• Explore Enterprise Voice Phase 2 Enhanced Features - UC02 • NHS Wi-Fi Guest - UC03 • Mobile Coverage Vodafone IBC - UC04	
Digital Spaces Programme (DS)	• Planning, Discovery & Engagement • Digital Taskforce	• Capital Projects	• Comms Room Remediation	• Digital Estates Collaborative (DocLan)	
Digital & Clinical Systems Programme (DC)	• Planning	• Discovery & Engagement • TIE • Strategy Creation & Governance	• Strategy Sign Off	• Corporate Systems • Order Comms & Results Reporting	
Digital Cybersecurity Programme (CS)	• Planning, Discovery & Engagement	• Osirium PAM - UT & Review • Digital Runbooks – Imp - CS03 • Cyber E-learning – Imp - CS04	• MFA - CS06 • Digital Runbooks – UT & Feedback • Cyber E-learning • Vulnerability Management -	• ISO27001 -2013 – Imp - CS08 • SIEM – Imp - CS09	

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 3.6 above, direct contact and regular communications briefings.

3.8 Resourcing requirements or other risks to implementation

Information rights resource – we intend to further centralise the subject access requests function. This is likely to require additional resource given the SARs team will redact clinical records to save clinicians having to do this

Information governance resource – given the significant increase in the number of contracts scrutinised and resourced, we have created resource for an information governance compliance manager. 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.

East London NHS Foundation Trust

ANNUAL REPORT TO THE QUALITY COMMITTEE

26 June 2023

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

Purpose of the report

To provide data on working hours of doctors in training in the Trust.

Summary of key issues

- In 2022/2023, 158 exception reports were submitted (compared with the 2021/2022 figure of 157 reports).
- Most relate to 1 or 2 hours worked over the rostered hours.
- Where patterns of exceptions have emerged, timetables have been revised at an individual level
- There were 6 breaches of working hours contract rules leading to Guardian fines. The second on call rota in Bedfordshire continues to work well to reduce the number of breaches of the minimum rest period for their non-residential on call rota.
- 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	☒	Assurance of safe rota patterns.
Improved staff experience	☒	Provides assurance about monitoring of working hours with impact on junior doctor experience.
Improved value	☐	

Committees/meetings where this item has been considered

Date	Committee/Meeting
-	-

Implications

Equality Analysis	Reporting applies to all doctors in training on the 2016 contract. Discussions have begun on including staff and associate specialist doctors in the exception reporting process.
Risk and Assurance	Unfilled vacancies and rota gaps are a risk to patient safety, with assurance provided through monitoring.
Service User/Carer/Staff	No implications.
Financial	There are no financial implications attached to this report
Quality	No implications

Supporting documents and research material

a.
b.

Glossary

Abbreviation	In full
N/A	

1.0 Introduction

1.1 This is the sixth 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 2022 to 31 March 2023.

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. There are currently 153 junior doctors employed by ELFT across all grades. There are 11 junior doctor training vacancies across ELFT. Some posts are shared by less than full time trainees.

2.2 Exception reports (2022/2023): 158 reports in total in this 12 month period (compares to 157 in 21/22 and 119 in 20/21) can be considered a healthy number within the expected range. Exception reporting has allowed us to identify and resolve issues with individual posts and wards.

Exception reports (by directorate) 2022/2023					
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Totals**
City and Hackney	9	15	9	33	66
Tower Hamlets	6	4	16	10	36
Luton / Beds	2	8	1	2	13
Newham	11	17	6	4	38
CAMHS	0	0	5	0	5
Total	28	44	37	49	158

2.3 Exception reports by grade (2022/23): 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 2022/2023					
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Totals**
FY	0	4	6	0	10
GP	11	15	5	3	34
CT	10	15	13	21	59
HT	7	10	13	25	55
Total	28	44	37	49	158

2.4 Exception reports by action and response time (2022/2023). 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.

4 of the breaches were on the Bedfordshire and Luton rota due trainees not being able to have their minimum rest period of 5 hours per out of hours shift. There second on call rota remains in place in Bedfordshire to ensure that trainees have access to protected rest in the middle of the night.

The remaining 2 breaches were within City and Hackney due to a doctor in training exceeding the maximum shift length of 13 hours to ensure a safe clinical handover and due to a doctor not having their protected rest due to being woken up in error by switchboard. These reports have been addressed with their clinical management teams.

Exception reports by Action 2022/23	
Guardian fine	6
Time Off In Lieu	53
Payment (standard rate)	89
No action required	10

Exception reports by Response Time 2022/23	
Resolved in < 48	34
Resolved in < 7 days	44
Resolved in > 7 days	80

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. A total of 1323 out of hours shifts required locum or agency cover in 2022/23 compared with 1008 in 2021/22.

The majority of locum bookings were covered by clinicians already employed by ELFT, rather than through external agencies. The percentage of shifts covered by an agency doctor was 9% which is a reduction from previous years (17% in 2020/21 to 14% in 2021/2).

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	46 (5)	36 (6)	39 (14)	36 (3)	157 (28)
Tower Hamlets	CT	34(1)	64 (13)	87 (14)	53 (3)	238 (31)
Newham	CT	70 (4)	47(8)	56(9)	23(2)	196 (23)
City and Hackney (incl. Forensics)	HT	31 (3)	40 (1)	39 (0)	26(0)	136 (4)
Newham / TH	HT	56(1)	39 (1)	32 (0)	27 (0)	154 (2)
Luton / Beds	CT /HT	145(5)	136 (2)	56 (0)	71(0)	408 (7)
CAMHS	HT	20(20)	11 (0)	3 (0)	0 (0)	34(20)
Total		**402 (39)**	**373 (31)**	**312 (37)**	**236 (8)**	**1323 (115)**

3.0 Narrative

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 2022/23 Junior Doctors continue to exception report at a reasonable rate across the ELFT. The CAMHS rota continues to have a lower rate of reporting than would be expected. The Guardian has run exception reporting refresher training in CAMHS and has attended their medical meetings to try to address this concern.

3.3 There was an increase in the number of on call shifts requiring locum bookings and a reduction in the percentage of agency rota. It is reassuring to see a reduction in percentage of agency use – as internal cover from ELFT clinicians is preferred both from a patient safety and financial perspective.

3.4 Improvement has been made this year with the response times with around half of all reports being responded to within the 7 day target. Initial contact is made with almost all 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 representation, 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. Attendance at the forum varies and a variety of strategies have been considered to help increase attendance. This has included changing the scheduled time/ day and working with medical education to support trainee engagement. 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 Ongoing Risks

4.1 There are no notable risks in relation to the above.

5.1 Workplan for the coming financial year

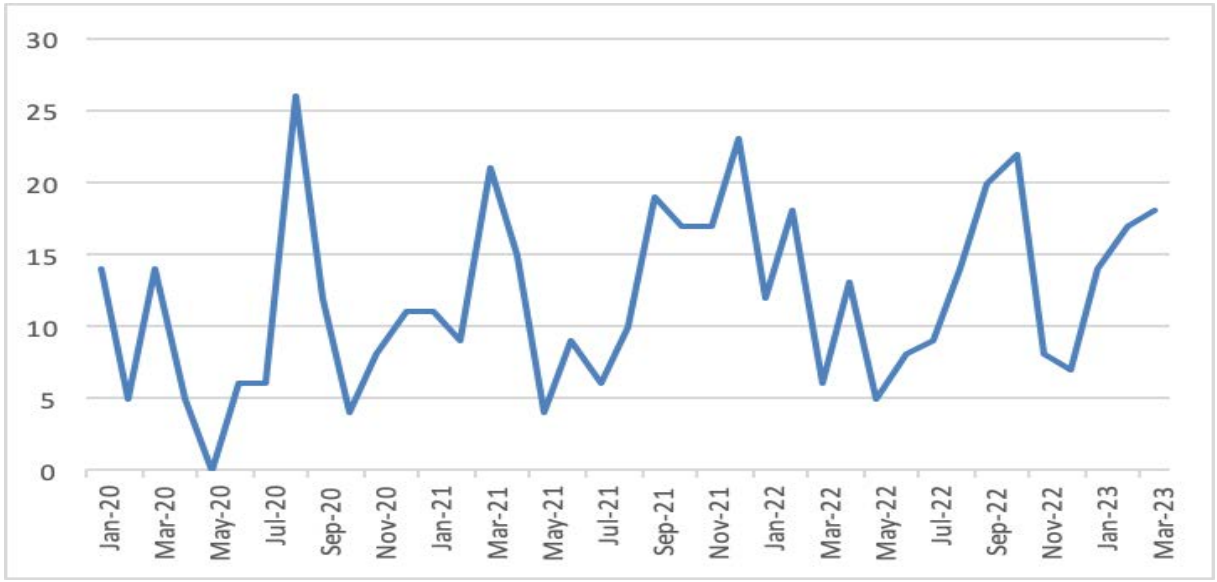
5.1 Key priorities remain encouraging reporting and receiving feedback on successful resolution of reports. To report on priorities, we will include feedback on resolution as part of our reporting.

6.1**Action Being Requested**

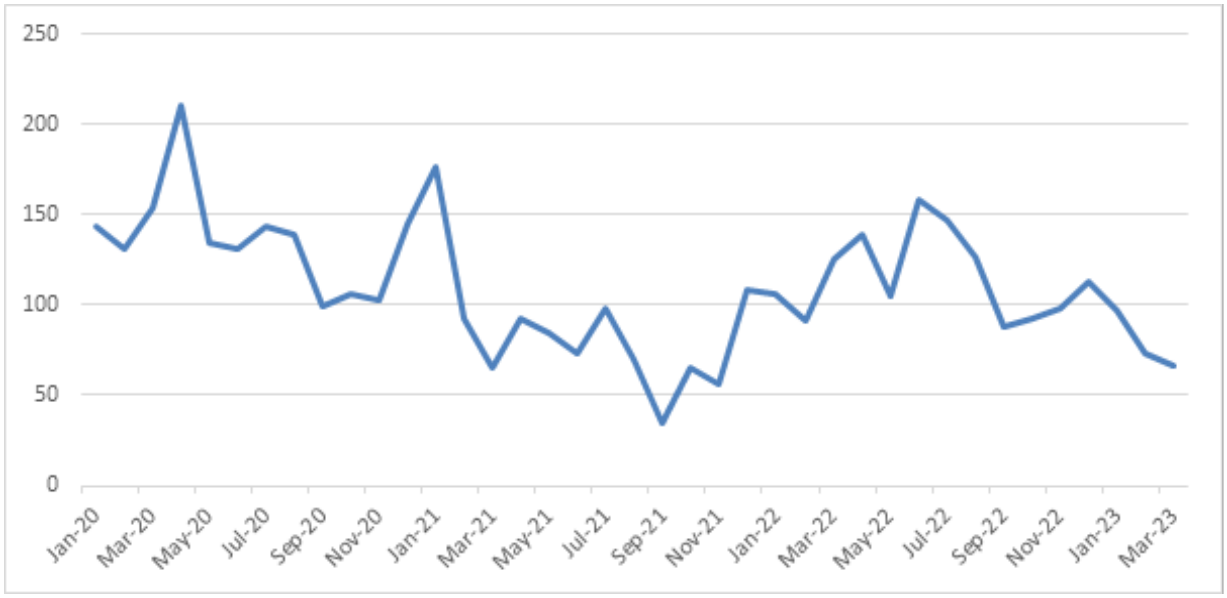
.The Board/Committee is asked to RECEIVE and NOTE this report.

Appendix 1

Total exception reports, by number, by month, January 2020 – March 2023
East London NHS FT



Appendix 2
Total number of vacant shifts offered as locums, January 2020 – March 2023, East London NHS
FT



East London
NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE
26th June 2023

Title	Freedom to Speak Up Annual Report 2022-2023
Author	Freedom to Speak Up Guardian – Anita Hynes
Accountable Executive Director	Chief Nurse/Deputy CEO - Lorraine Sunduza

Purpose of the report

To brief the Trust Board on the Freedom to Speak Up activity from April 1st 2022 to March 31st 2023, 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 172 concerns from 1st April 2022 to 31st March 2023.
This is an increase of 53.6% on the previous reporting year.

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

- Number of cases raised anonymously
- Patient Safety/Quality of Care
- Worker Safety and/or Worker Wellbeing
- Bullying or Harassment
- Inappropriate attitudes or behaviours
- Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up is indicated

The NGO also requests data on the numbers of cases brought by professional groups.

The highest number of cases fall under Processes/Organisational Structure/ Other, with such examples being concerns around work areas, HR processes, training/professional development, fraud, service policy, recruitment, disability and impact and on site security.

The second highest number of cases falls under Worker Safety and/or Worker Wellbeing, with such examples being working environment, staffing levels, unresolved issues with staff, management behaviours and impact on staff, safety at work, financial stress, undermining and victimisation.

The highest number of cases from professional groups were Nursing and Midwifery registered (47 cases) and Administrative and Clerical (46 cases).

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, escalated and resolved.
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. However, 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 staff experience.
Risk and Assurance	There are a number of potential risks associated with Freedom to Speak Up cases, including reputational damage, financial risk and adverse impact on morale. These risks are being managed by corporate and directorate management teams, with oversight of the Executive team.
Service User/ Carer/Staff	FTSU promotes the importance of staff speaking up; providing high quality, cost effective, compassionate services and to continuously improve in partnership with people who use our services, their carers, 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

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015).

These recommendations were made as Sir Robert Francis found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

The Trust appointed to the FTSUG role 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.

Freedom to Speak Guardians are regulated by the National Guardian's Office. The National Guardian's Office is an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The office is not a regulator, but is jointly funded by the CQC, NHS England and Improvement.

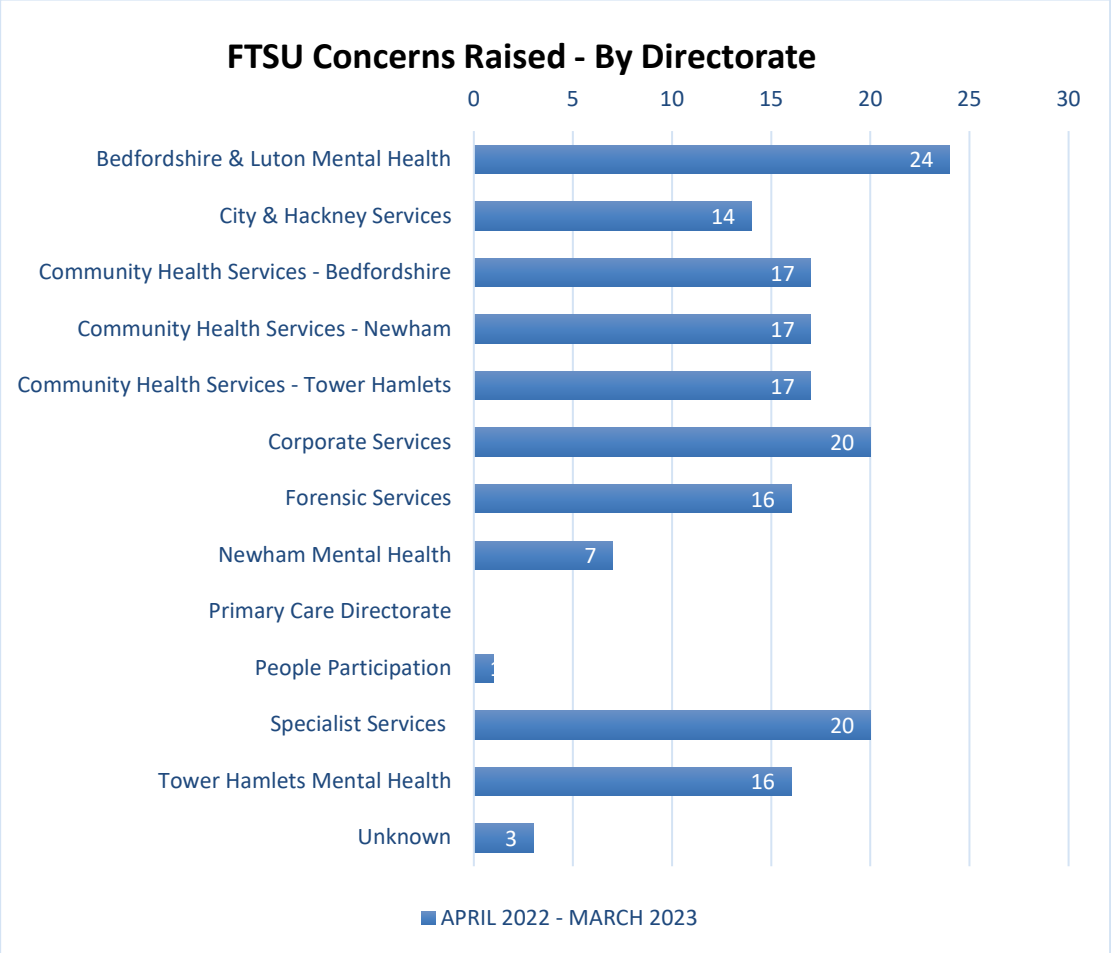
2.0 Freedom to Speak Up Data 2022-2023

2.1 Directorates

FTSU received 172 concerns during this reporting year. This is an increase of 53.6% on the previous reporting year.

Though generally evenly distributed across all Directorates, the majority came from the Community Health Services and were mostly linked to some element of change. This increase is not unusual when organisations are undergoing changes in services. Learning from these cases has helped the Trust look at it processes and review how staff are supported and information is communicated during times of change.
No concerns were raised in the Primary Care Directorate and is a focus for training and publicising Freedom to Speak Up in 2023-2024.

Graph 1: FTSU concerns raised by Directorate



2.2 **Broad Themes**

37% of cases raised involved concerns relating to Processes/Organisational Structure/ Other, with such examples being concerns around work areas, People & Culture processes, training/professional development, fraud, service policy, recruitment, disability and impact and on site security.

19.1% of cases raised involved concerns relating to Worker Safety and/or Worker Wellbeing, with such examples being working environment, staffing levels, unresolved issues with staff, management behaviours and impact on staff, safety at work, financial stress, undermining and victimisation.

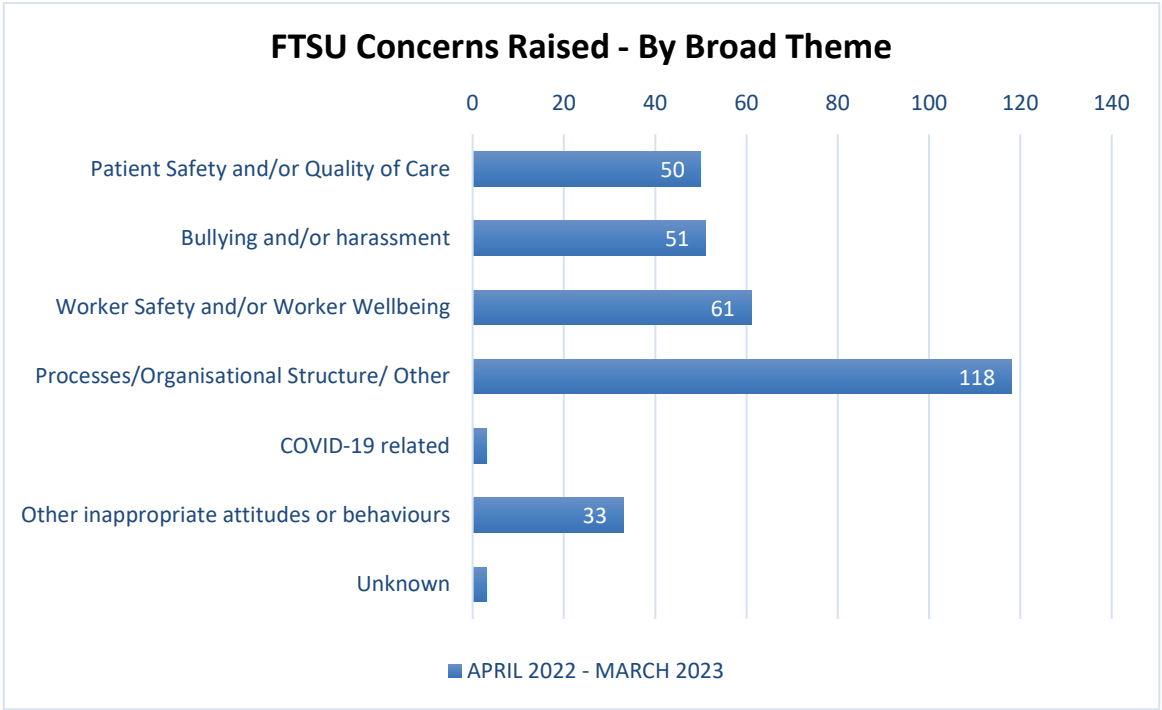
All concerns raised are escalated to Service Directors, senior managers and/or People & Culture, as appropriate to the nature of the concern.

The working completed 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 People & Culture, managers and FTSU). Respectful Resolution is a toolkit to support with resolving these concerns before they become a formal process (Dignity at Work). The work to embed this across the Trust is ongoing.

We continued to monitor concerns directly related to COVID-19. Those concerns have decreased significantly since the pandemic began in 2020. In this reporting period, 3 of the concerns raised were linked to COVID-19.

Graph 2: FTSU concerns raised by Broad Theme



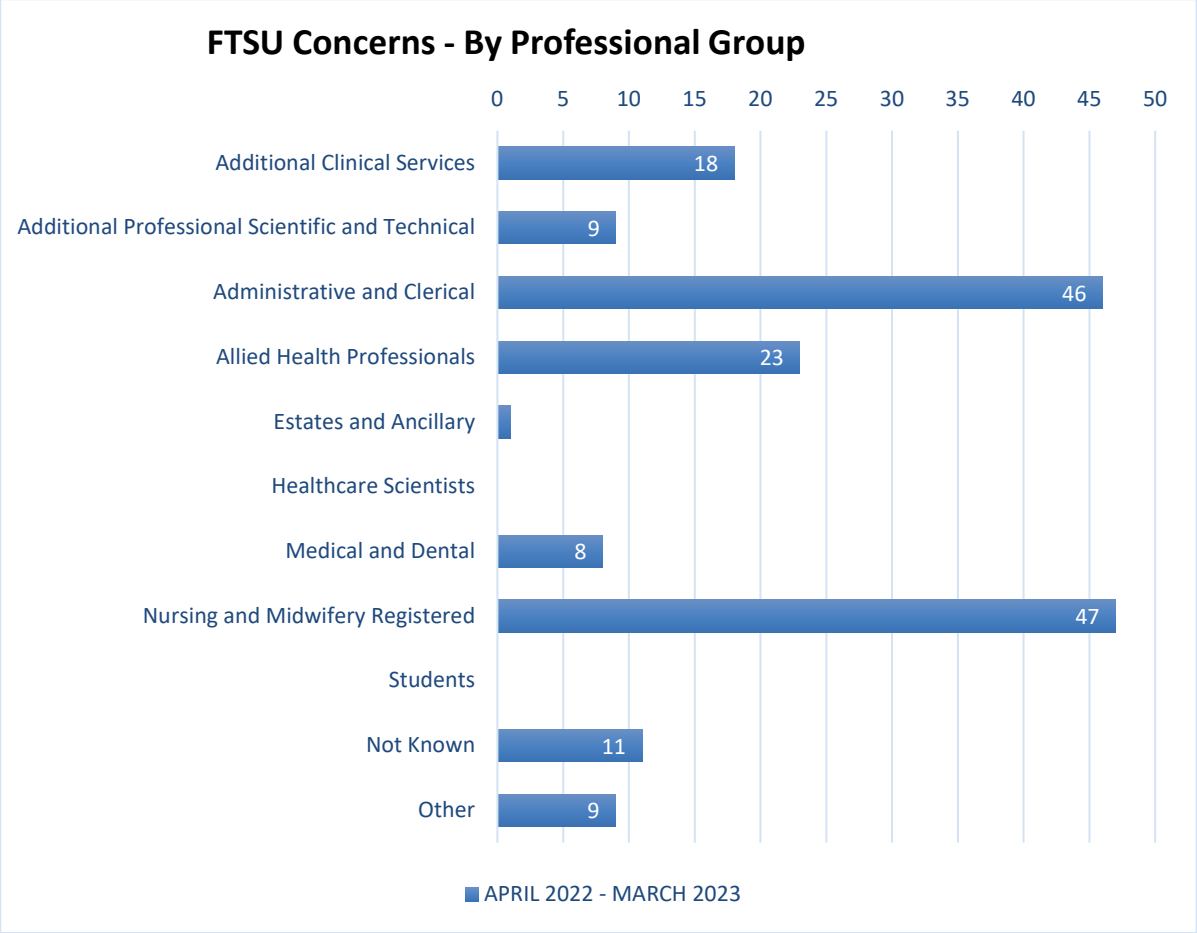
2.3 **Professional Groups**

27.3% of FTSU concerns raised are from Nursing and Midwifery Registered, which were mostly around the themes of processes/organisational structure, patient safety/quality of care and worker safety and wellbeing.

26.7% of FTSU concerns raised are from Administrative and Clerical staff. Those concerns were around the themes of processes/organisational structure/other, bullying and/or harassment and worker safety and wellbeing.

30.2% of concerns were raised by staff with management responsibility and 62.3% were raised by staff without management responsibility.

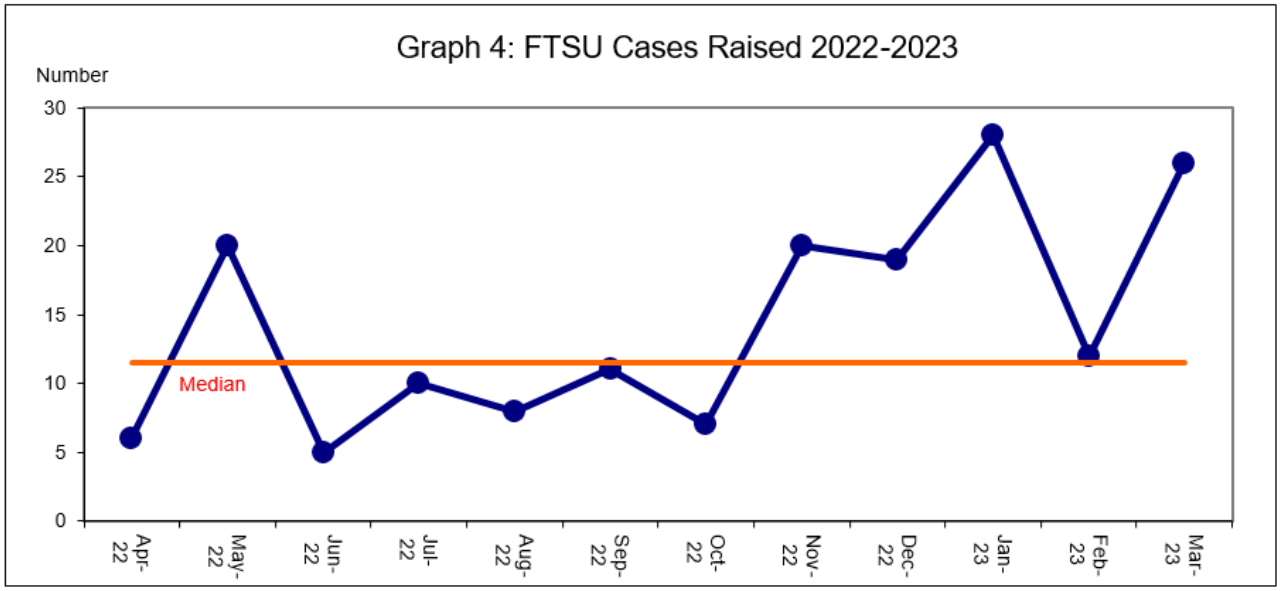
Graph 3: FTSU concerns raised by Professional Group



2.4 **Freedom to Speak Up Cases Raised**

The chart demonstrates the elevated number of concerns raised in November, December, January and March corresponded to the communications campaign around Freedom to Speak Up. This consisted of direct Comms emails to staff from Freedom to Speak Up, a signposting document shared across the Trust as to where colleagues can bring their concerns and regularly updating the intranet FTSU page with further information.

Graph 4: FTSU concerns raised each month April 2022 – March 2023

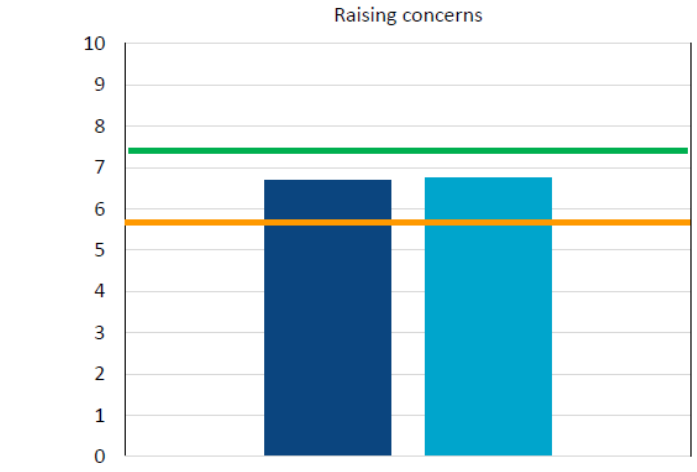


3.0 NHS Staff Survey 2022 – Raising Concerns

3.1 The NHS Staff Survey was complete by 1699 staff, giving a response rate of 33%. ELFT is benchmarked against Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, of which there are 51 organisations in the group.

The questions related to raising concerns fall under the People Promise element “We each have a voice that counts”.
They are:
Q19a I would feel secure raising concerns about unsafe clinical practice.
Q19b I am confident that my organisation would address my concern.
Q23e I feel safe to speak up about anything that concerns me in this organisation.
Q23f If I spoke up about something that concerned me I am confident my organisation would address my concern.

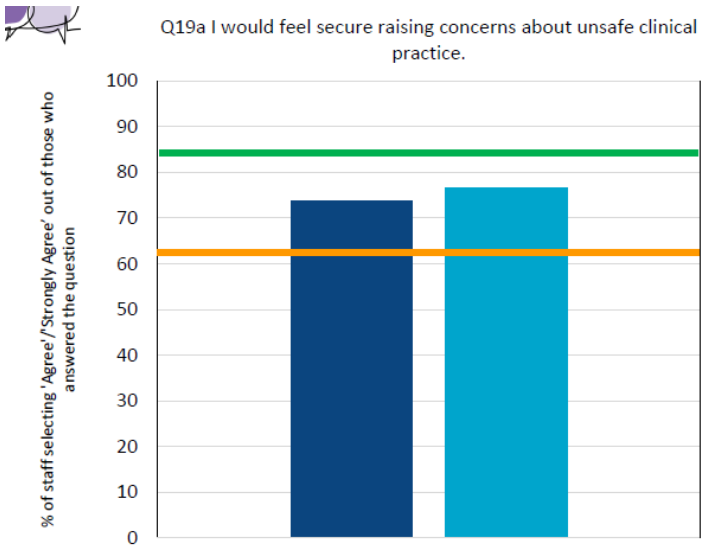
3.2 **Graph 5: From the NHS Staff Survey 2022**
Promise element 3: We each have a voice that counts



	2022
Your org	6.7
Best	7.4
Average	6.8
Worst	5.7
Responses	1685

ELFT is just below the overall average of the benchmarking groups. In 2021, ELFT was 6.9. Nationally, the sub-score for raising concerns declined from 6.5 in 2021 to 6.4 this year.

3.3 **Graph 6: From the NHS Staff Survey 2022**
Q19a I would feel secure raising concerns about unsafe clinical practice.



	2022
Your org	73.7%
Best	84.3%
Average	76.7%
Worst	62.5%
Responses	1688

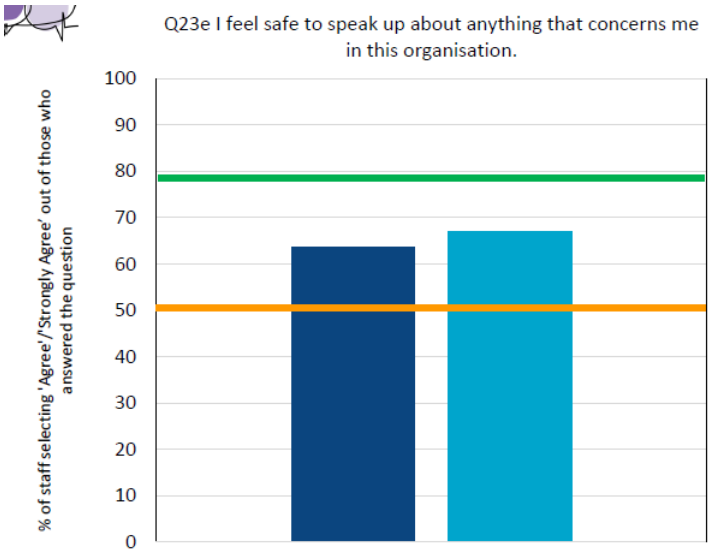
At 73.7%, ELFT is below the overall average of the benchmarking groups. In 2021 ELFT was 78% and in 2020 75.2%.

3.4 **Graph 7: From the NHS Staff Survey 2022**
Q19b I am confident that my organisation would address my concern.

	2022
Your org	61.8%
Best	76.7%
Average	61.5%
Worst	38.9%
Responses	1686

At 61.8%, ELFT is on par with the overall average of the benchmarking groups. In 2021 ELFT was 67.4% and in 2020, 65.2%.

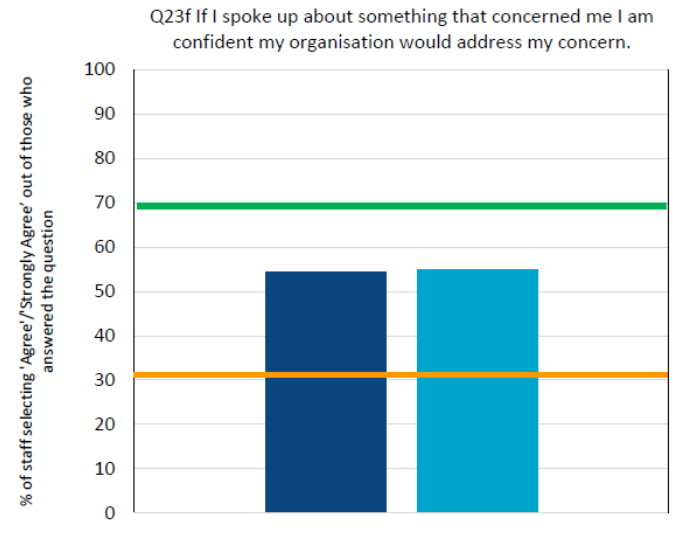
3.5 **Graph 8: From the NHS Staff Survey 2022**
Q23e I feel safe to speak up about anything that concerns me in this organisation.



	2022
Your org	63.6%
Best	78.5%
Average	67.0%
Worst	50.5%
Responses	1691

At 63.6%, ELFT is below the overall average of the benchmarking groups. In 2021 ELFT was 66.5% and in 2020, 66.8%.

3.6 **Graph 9: From the NHS Staff Survey 2022**
Q23f If I spoke up about something that concerned me I am confident my organisation would address my concern.

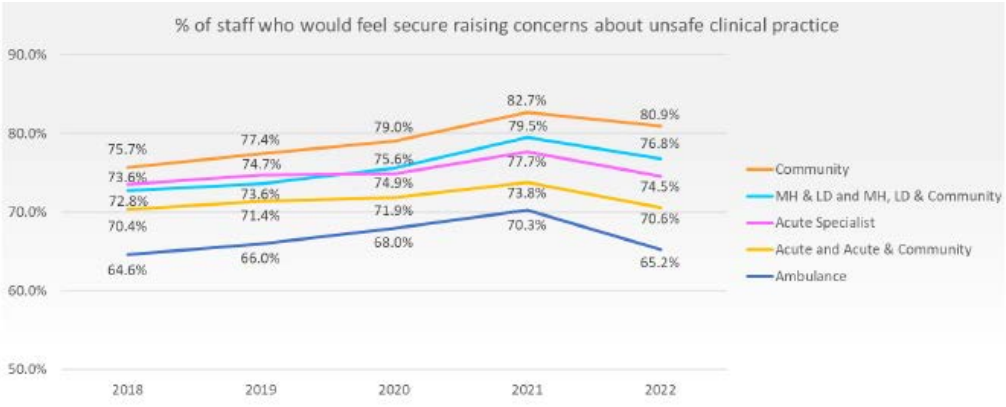


	2022
Your org	54.5%
Best	69.2%
Average	55.0%
Worst	31.1%
Responses	1688

At 54.5%, ELFT is just below the overall average of the benchmarking groups. In 2021, ELFT was 58.1%.

3.7 Nationally**,** there were declines on all measures relating to raising concerns, both relating to raising concerns about clinical safety and speaking up more generally.
The greatest deterioration was seen in the percentage of staff who would feel secure raising concerns about unsafe clinical practice. Having improved between 2019 and 2021, this measure declined by 3.1 percentage points from 75.0% to 71.9%, with a return to the 2019 level. There was a decline across all types of Trust, although agreement remains highest in Community Trusts (80.9%) and Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts (76.8%).

Graph 10: From the NHS Staff Survey 2022
Percentage of staff who would feel secure raising concerns about unsafe clinical practice



3.8 On reading the national results for the speaking up questions in the NHS Staff Survey, the National Guardian, Dr Jayne Chidgey-Clark said:
"It is disappointing that the staff survey results reflect a decrease in workers' confidence to speak up, and especially concerning that this includes about clinical matters.
However, fostering a culture where speaking up is supported, and actions taken as a result is the responsibility of each and every one of us. Whether you are a government minister, a regulator, a board member or senior leader; whether you work in a department, in a team, on a ward, or in a GP practice. No one should feel they cannot speak up to protect their patients or their colleagues. These survey results must be a wakeup call to leaders at all levels that Freedom to Speak Up is not just a 'nice to have' – it is essential for safe services."

4.0 Triangulation of data

Work has begun on triangulating information from Complaints & PALS data and People & Culture exit interview data to understand if there are any trends or similar themes identified in all areas of work.

4.1 Complaints and PALS

Complaints - Top 10 themes:	**PALS - Top 10 themes:**
▪ Attitude of staff ▪ Communication ▪ Clinical management of mental health ▪ Medication ▪ Care planning (mental health) ▪ Assessment ▪ Confidentiality ▪ Violence and aggression ▪ Diagnosis ▪ Appointment times/delays	▪ Communications ▪ Attitude of staff ▪ Appointment delays ▪ Waiting times/delays ▪ Care Planning (mental health) ▪ Assessment ▪ Confidentiality ▪ Care planning (physical health) ▪ Medication ▪ Discharge planning/arrangements

Work is continuing with Complaints & PALS to interrogate the data more rigorously to establish if patterns emerge regarding similar locations, services, staffing groups and themes of concerns raised with FTSU.

4.2 Exit interview data

There are some overlaps with FTSU themes and reasons given for leaving in the exit surveys completed. Of the responses received, 5% said Incompatible Working Relationships, 15% said Work Life Balance.
In further comments, interviewees mentioned staffing levels, bullying culture, did not feel valued, appreciated or respected, which are also themes reflected in FTSU concerns raised.

4.3 Guardian of Safe Working

Discussions take place 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 this reporting year

5.0 Speaking Up & Whistleblowing Policy

5.1 The Speaking Up & Whistleblowing Policy was reviewed and updated to reflect the revised national Freedom to Speak Up policy released in 2022 by NHSEI in conjunction with NGO. The updated policy is designed to support staff by showing them the many ways in which concerns can be raised and escalated, and support resolution of concerns by managers wherever possible.
The Speaking Up & Whistleblowing Policy was ratified by the Joint Staff Committee November 2022.

5.2 A document titled 'Signposting – Where to bring your concern or complaint in ELFT' was created and shared with staff to highlight the many ways in which we can raise/escalate concerns, signposting key contacts and policies as well as the clear parameters of FTSU and People & Culture processes.

6.0 FTSU Training

6.1 FTSU training delivered this reporting year:

- Monthly Corporate Induction
- FTSU information stall at the ELFT Ability Conference November 2022
- Delivered FTSU session at the BAME Network Conference September 2022
- Listening Event with the Newham Continuing Healthcare Team
- Luton and South Bedfordshire Older Persons Services
- Newham Mental Health Induction
- Pharmacy Team and Hackney Pharmacy Team
- Tower Hamlets Talking Therapies - Equalities Whole Service Meeting
- Tower Hamlets Crisis Pathway
- Community Rehab Team – Hackney
- Bedford & Luton Anti-Racism Steering Group Tackling Inequalities
- Estates Team
- Community Health Services Newham- Continuing Healthcare Team
- Monthly Forensic Induction
- Wards and Teams across City & Hackney and Forensics

7.0 Progress against work plan

7.1

Key priorities April 2022 – March 2023	Timescale	Outcome
Triangulation of concerns and themes with Trusts' protected characteristics. To add ethnicity data collection when a concern is raised (unless raised anonymously). Carry out analysis of concerns data, taking into consideration the protected characteristics	Commence April 2022.	Started to capture this data from feedback survey. Updating this reporting year to collect demographics when a concern is initially raised. Will be able to report on the demographics of those who raise concerns more broadly across the Trust.
The FTSU team to develop new ways of **sharing learning from 'speaking up**' across the Trust	Ongoing	Regular meetings with the FTSU Champions support this.

Key priorities April 2022 – March 2023	Timescale	Outcome
specifically explore learning that could benefit staff across all directorates.		FTSUG meeting colleagues on site, which is also supporting. Also communicating through FTSU emails to all staff via Comms.
Freedom To Speak Up Conference	June 2023	The conference is taking place October 2023.
Update the current **FTSU Board self-assessment**. Complete gaps identified by the self-assessment and report regularly within identified governance framework.	2022-2023	Not completed. Will review for 2023.
FTSU 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 – is for managers There is a targeted training module for leadership teams and stakeholders. 3. The third module – Follow Up - is aimed at all senior leaders including Executive Directors, 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	2022	Incomplete. Carrying forward to 2023-2024.
Complete a **FTSU Pulse survey** with all staff to assess: ▪ Understanding of FTSU and what it is ▪ How to access FTSU support ▪ If they have availed of the service previously, their feedback on their experience of FTSU and how the service can be improved. Survey repeated 6-9 months later to ascertain improvements in understanding of and accessibility of FTSU, and to assess for further improvements.	2022/2023.	Did not take place. Carrying forward to 2023-2024.
The **FTSU Newsletter** is moving to Comms email format, which will be sent to all staff.	2022-2023	Completed and ongoing. This format worked very well, with an increase with staff engagement around FTSU following each publication.
Whistleblowing Training for Guardian and Champions, via Protect.	2022-2023	Completed August 2022.

8.0 Key Priorities April 2023 – March 2024

8.1 The priorities above that are ongoing or being carried forward.

8.2 Using the FTSU data 2022-2023 and that of the NHS Staff Survey 2022, identify localities that need support with FTSU training and set a plan of delivery.

8.3 Working with People & Culture, develop guidance to support colleagues involved with resolving FTSU concerns.

Will include an expectation on timeliness for response and resolution. Will also include guidance for colleagues involved on time expectations and where the response/resolution/investigation completion confirmation and all feedback relating FTSU concerns raised are relayed to.

8.4 Review the resource available for FTSU in line with the increase in cases and take a work plan forward so that we can ensure:

- the FTSU service can continue to cater for the increased level of engagement from staff
- we can meet the demand of the increased number of colleagues raising concerns with FTSU
- improve the speed at which concerns are resolved and feedback shared whilst simultaneously:
    - maintaining good availability and support for FTSU training and advice across the Trust
    - Continuing to expand the FTSU Champion team, recruit, train and develop FTSU Champions and support them with their endeavours to make 'Speaking Up' business as usual in their teams.

9.0 Action Being Requested

9.1 The Board/Committee is asked to:

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

East London NHS Foundation Trust

Annual Report To The Quality Assurance Committee

26 June 2023

Title	Patient Safety Learning from Complaints, PALS & Compliments Annual Report 2022/2023
Author	Eileen Bryant, Director of Nursing – Primary Care & CHS (Bedfordshire) Tribuven Sharma, Head of Complaints and PALS Salma Ahmed, Manager Complaints and PALS
Accountable Executive Director	Lorraine Sunduza, Deputy Chief Executive / Chief Nurse

Purpose of the report

To provide the Trust Board with an overview of the Trust's management of complaints & Patient Advice and Liaison Service (PALS), MP enquiries and compliments for the year 2022-23.

To outline the proposed work plan, aims and objectives for the next financial year 2023-24.

Summary of key issues

- **427** formal complaints were raised in this reporting period, a decrease of 14% (70) compared with the previous year of **497**.
- The Trust closed **370** formal complaints in total. Out of this 213 were closed within the 25 working days (58%) an increase of 7% from the previous year which was 51%.
- 107 (29%) complaints were breached (not closed within 25 working days) this was 1% decrease compared to the previous year which was 30%
- The remainder of 50 cases were either withdrawn or followed onto the next financial year.
- 320 cases (75%) were resolved under stage 1 local resolution, out of this 193 (60%) were on time, 94 (29%) breached and 33 (10%) were either escalated to stage 2 or withdrawn.
- 988 PALS inquiries were received by the Trust, this is a decrease of 105 inquires compared to the previous year.
- 977 compliments were formally recorded, this was an increase of 342 compliments compared to the previous year.

Top 10 themes from Complaints and PALS:

No	**Top 10 Complaints themes**	No	**Top 10 PALS themes**
1	Attitude of staff	1	Communications
2	Communication		Attitude of staff
3	Clinical management of mental health		Appointment delays
4	Medication		Waiting times/delays
5	Care planning (mental health)		Care Planning (mental health)
6	Assessment		Assessment
7	Confidentiality		Confidentiality
8	Violence and aggression		Care planning (physical health)

	9	Diagnosis		Medication	
	10	Appointment times/delays		Discharge planning/arrangements	

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 Regulations 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 and quality of the patients' experience.
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.

Committees/meetings where this item has been considered

Date	Committee/Meeting
31 May 2023	Quality Committee Meeting
21 June 2023	Quality Committee Meeting

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 and PALS have implications for service users, carers, staff and services across the organization.
Financial	There are financial implications regarding resource management & potential for litigation.
Quality	The recommendations and action plans relating to complaints and PALS are proposed with the view of improving the overall quality of the service for the Trust and service users.

Supporting documents and research material

a. ELFT Complaints and PALS Policy Version 9.0; October 2020.
b. 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. These regulations are also reflected in the Trust's Complaints Policy.

1.2 The Trust is committed to improving the services and care that we provide; the feedback we receive from patients, their families and carers, helps us to identify the areas where we need to improve and ensure that actions are taken to address any learning to prevent the same things happening again.

1.3 Complaints, compliments and the Patient Advice and Liaison Service (PALS), are only three of the ways in which the Trust receives feedback about its services. Information from the complaints and PALS service is also included in the Trust integrated patient safety report, which triangulates information from other sources including serious incidents, inquests and incidents.

1.4 This report covers all complaints and compliments received by the Trust in the period from 1 April 2022 to 31 March 2023.

2.0 Trust Activity

2.1 Complaints Management

2.1.1 Complaints are overseen and supported by a dedicated Corporate Complaints & PALS team to ensure that processes and outcomes are impartial, fair, flexible and conciliatory. This team, which used to be part of the Risk and Governance team, is now a separate team/department within the Trust and reports to a Director of Nursing. This new arrangement aims to raise the profile and focus of complaints as a key source of feedback in the Trust.

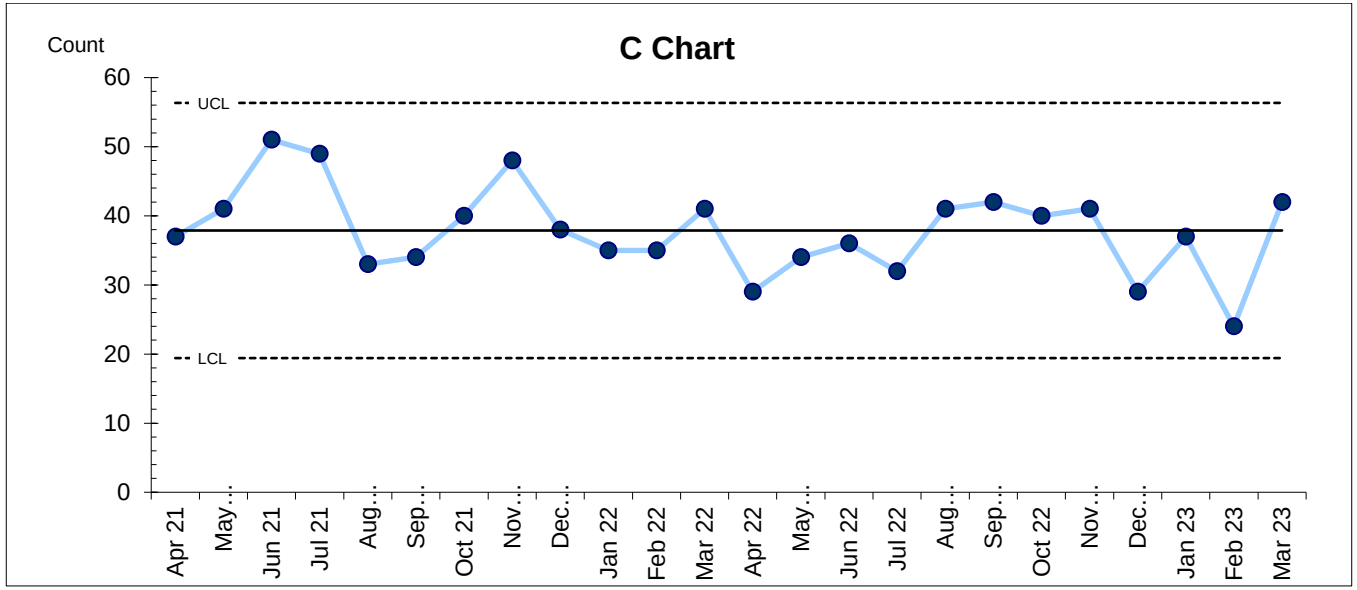
2.1.2 The Complaints & PALS team supports those wishing to complain, or make a comment about the services received, being listened to, and remaining confident that they will not be discriminated against for making a complaint. It also supports staff and managers within the services, to effectively manage and respond appropriately to complaints made about their services.

2.1.3 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 from a different service, to provide objectivity. The investigating officer undertakes a thorough investigation with the service, and provides a full response with areas for learning and actions to address any issues identified

2.1.4 The Trust's Chief Executive Officer oversees and reviews all Stage 2 – complaint responses and signs off the final responses. This is 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.

2.2 **Chart 1 Complaints over time (1st April 2022 to 31st March 2023)**



427

Formal complaints were received by ELFT during this reporting period.

The average monthly number of complaints received was **35,** which was the same as the previous year.

Table 1 - Complaints to population ratio (No. Complaints: 100,000)

Period	Apr 22	May 22	June 212	July 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Population (approx.)	**1,441,199**											
Total Complaints	29	34	37	32	41	42	40	41	28	38	23	42
Ratio:100,000	0.5	0.42	0.39	0.45	0.35	0.34	0.36	0.35	0.51	0.38	0.63	0.34

Table 2 - Complaints by Directorate

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Bedfordshire Mental Health Services	8	3	3	3	8	9	5	6	6	7	7	7	72
City and Hackney	4	4	9	4	6	4	7	8	6	5	3	4	64
Community Health Services	2	5	4	5	4	2	3	5	4	6	3	4	47
Corporate	0	0	0	0	1	0	0	1	0	1	0	0	3
Forensic Services	0	2	1	0	1	1	1	2	0	0	1	0	9
Luton Mental Health Services	2	5	2	2	6	4	4	3	1	4	1	5	39
Newham (Mental Health)	4	4	4	5	6	8	5	6	4	3	0	2	51
Specialist Services and CHN Children's Services	3	5	7	2	1	5	4	2	2	5	3	6	45
Tower Hamlets (Mental Health)	5	3	7	11	8	8	10	8	5	6	5	13	89
Primary Care Services	1	3	0	0	0	1	1	0	0	1	0	1	8
Total	29	34	37	32	41	42	40	41	28	38	23	42	427

Table 3 – Complaints by theme and Source

Complaints top 10 themes:

1. Attitude of staff
2. Communication
3. Clinical management of mental health
4. Medication
5. Care planning (mental health)
6. Assessment
7. Confidentiality
8. Violence and aggression
9. Diagnosis
10. Appointment times/delays

Complaints by Source	Complaint distribution
Email	207
Letter	29
Phone Call	27
Via PALS	28
Via an Advocate	39
Via an MP/Councillor	23
Via Solicitor	3
Via CQC	40
Via another NHS Trust	24
Other	7
TOTAL	**427**

2.3 Adherence to complaints process and timescales*

The 2009 Complaints Regulations 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 22	May 22	June 22	July 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Total Complaints	29	34	37	32	41	42	40	41	28	38	23	42
No. Acknowledged in three working days	29	34	37	32	41	42	40	41	28	38	23	42
Percentage	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Chart 4 - **Formal complaints acknowledged within three working days**

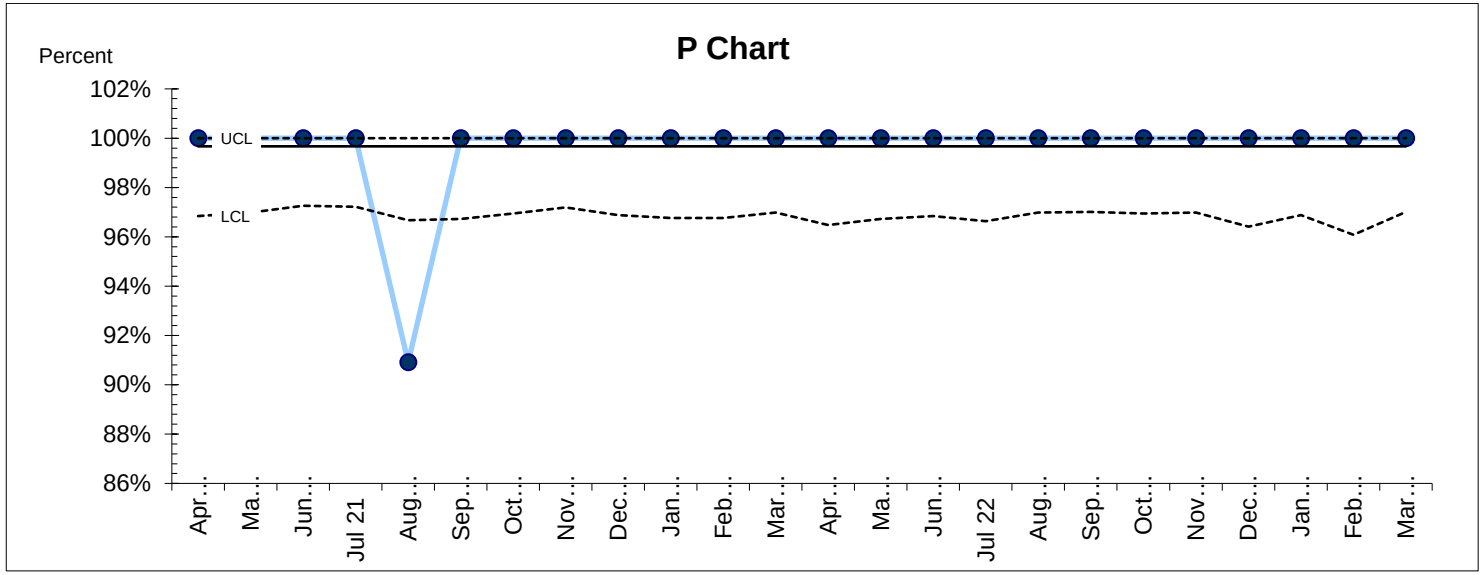
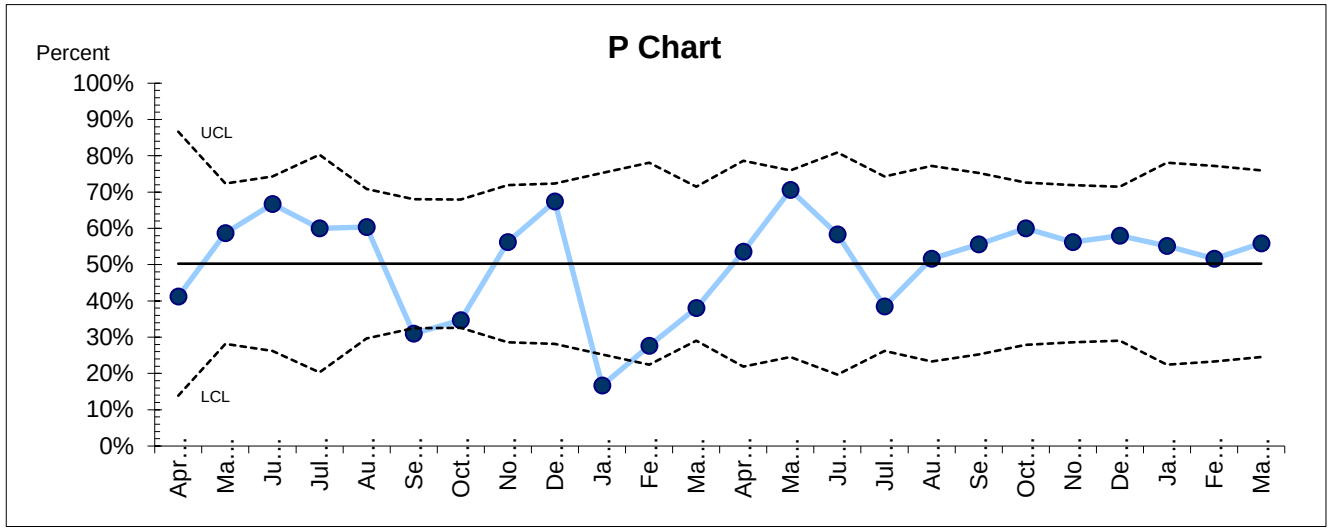


Table 5 – Complaints timescales

The Trust agrees a timescale of response with the complainant, based on the complexity of the complaint.

	Apr 22	May 22	June 22	July 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Total Complaints closed	28	34	24	39	31	36	45	48	50	29	31	34
No % Response sent within agreed timescale	15 (54%)	24 (71%)	14 (58%)	15 (38%)	16 (52%)	20 (56%)	27 (60%)	27 (56%)	29 (58%)	16 (55%)	16 (52%)	19 (56%)
No % Response breached agreed timescale	13 (46%)	10 (29%)	10 (42%)	24 (62%)	15 (48%)	16 (44%)	18 (40%)	21 (44%)	21 (42%)	13 (45%)	15 (48%)	15 (44%)

Chart 4 – Complaints produced to timescale



During this reporting period, the Trust responded to/closed **370** formal complaints (91% of all complaints received). 213 of these (58%) were closed within their agreed timescale and 107 (29%) breached their agreed timeframe*

3.0 Progress against Work Plan during last financial year

3.1 Key Outcomes

The key outcomes of the cases investigated and closed in this period were as follows:

29 Resulted in changes to Trust policies and processes -6 6% (previous year 87)

7 Recommended training for staff-75% (previous year 29)

65 Recognised errors or gaps in care and full apologies were given +54% (previous year 42)

196 Provided explanations of services, treatment, plans or processes -46% (previous year 365)

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

3.2.1 Learning Lessons

There was a Trust wide Learning Lessons Seminar which took place via Microsoft Teams on 6 December 2022. This highlighted themes, lessons learnt from complaints and changes to practice and services which resulted from complaints information, including the rise of persistent complainants and finding ways to manage these. 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.

There is a bi-monthly meeting which is attended by the Governance Co-ordinators from mental health in London and Complaints and PALS team, this meeting picks up on themes identified at the last Complaints QI to ensure recommendations were followed through and also to discuss what works well and any gaps. Currently some directorates are engaging better than others, and our aim this year is to encourage representation from each directorate across the Trust.

3.2.2 Complaints Quality Improvement (QI) Project from 21/22 Annual Plan

A working group was formed following the review of the QI Project where it was agreed there was a need to ensure recommendations are being followed through. This is done via the bi-monthly complaints meeting held with the Governance Co-ordinators.

QI Project Aim : To improve the experience of carers of service users within Luton CMHTs

This project was launched as a response to a complaint highlighting concerns about support available to carer and their ability to access these services. It was aimed at improving access to services for carers and involving them more in care delivery and decisions, as well as ensuring they are getting the right support. It was identified there was a need for better collaboration with the wider trust and with other carer representatives.

The Complaints Manager is part of this project in an advisory role to help the group achieve the above goal. This is an on-going project and we will be able to provide an update on the results and learning at the next annual meeting.

QI Project: Bedfordshire Community Services (BCHS) Complaints process

This project is aimed at clarifying and improving the complaints process within BCHS. The goal includes to train staff on how to effectively deal with complaints and communicate with complainants, by offering training to staff on how to carry out investigations and write satisfactory complaint responses.

The Complaints Manager is an active member of the project team, sharing useful information to help with local processes.

Recently, a survey was sent out to all the staff to help capture feedback. The feedback was collected from 97 members of staff, the key points raised were:

- 92% felt supported by their colleagues and management when handling concerns or complaints
- 69% felt the current procedure for managing complaints was effective.
- 65% emphasised the importance of regular training as a key resource for feeling more confident and capable in handling complaints.
- 60 % were confident in their knowledge of the Trust procedures for dealing with a complaint/concern.
- 58% said they were ‘somewhat’ competent in handling complaints.

This was recognised as a very useful exercise. The Complaints Team will use the feedback to roll out a training programme which will aim to address the concerns and gaps and enable staff to manage complaints more confidently and effectively.

3.2.3 Complaints and PALS Training for Staff

Complaints training has continued to be delivered on a bi-monthly basis via Microsoft Teams. 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. There has been requests for local training which will be delivered at away days and team meeting on an ad hoc basis.

3.2.4 Complaints Reporting and Management System - Datix

The complaints action module was successfully implemented last year. This system is now being replaced by InPhase, the Complaints Department is working closely with

the Project Team to ensure a smooth transition and help develop a more user friendly interface with effective reporting tools.

3.2.5 **Complaints pathway**

Stage 1 local resolution is always encouraged to resolve a complaint. The team routinely works with governance leads to raise awareness of this. This is explained to the services by the complaints handler and has also been implemented into the complaints training programme. This approach has proved to be received very positive for the services as it still captures key elements such as learnings but in less time consuming and informal manner. It has also improved the patient experience as their issues are resolved quickly at stage 1.

3.2.6 **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.

3.2.7 **Sample of complaints and learning**

<u>Complaint made when a service user attending a clinic overheard staff members discuss another service user's suicidal ideations.</u>

Staff were not aware that the conversation could be heard, they were expressing concerns about a service user's presentation in a clinical area which was attended by other people. The supervisor for the staff in question discussed the matter and reminded them to be mindful of patient confidentiality. As part of the action plan training was delivered to the wider team within the service via away days using this complaint as an example to learn from.

<u>Complaint about staff being rude to a service user who had made a query about their medication.</u>

Staff offered their apology and explained that in some instances there were cases of miscommunication. The service shared the experience with the wider team to ensure this did not reoccur. Changes to ward processes were implemented as part of the actions agreed.

<u>Complaint from family expressing lack of support for their son's ADHD assessment from CAMHS and long delay since any contact was made from the service.</u>

The service acknowledged that the system in place for assessments was not useful as there were long delays in communication. The service made changes to the system which included closer liaison with the school. The service user was assigned a new care co-ordinator to arrange the ADHD assessment.

<u>Complaint from family about service user who is under community health (Learning Disabilities Team) but had concerns relating to self-harm</u>

The service had recorded the incidents and made changes to the service user's medication however the family were not aware of this. The service took on board the views of the family and put a recommendation in place so that families/carers/representatives are involved when assessment are carried out and care plans are developed, so that their views can be considered and they know what has been put in place.

3.3 What wasn't achieved, and what have we understood about the reasons for this?

3.3.1 Actions Plans and Learning

A key priority for the annual plan 2021/22 was and continues to be reviewing and implementing action plans and learning. We are working closely with the Risk & Governance Team to ensure we are incorporating this within the implementation of the Patient Safety Incident Response Framework (PSIRF). The PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. The complaints team has led a two-phase process. Phase 1 is collating action plans (both at the initial and completed stage) and requesting the relevant department to update complainants. Phase 2 is the process of transferring completed actions and themes onto Datix; enabling triangulation with serious incident trends and themes. Both phases had commenced but are presently on hold. This is because the Trust is ending its use of the Datix system and moving to a new system InPhase. The project will re-commence once we have successfully migrated the data from Datix to InPhase.

3.3.2 PALS Clinics

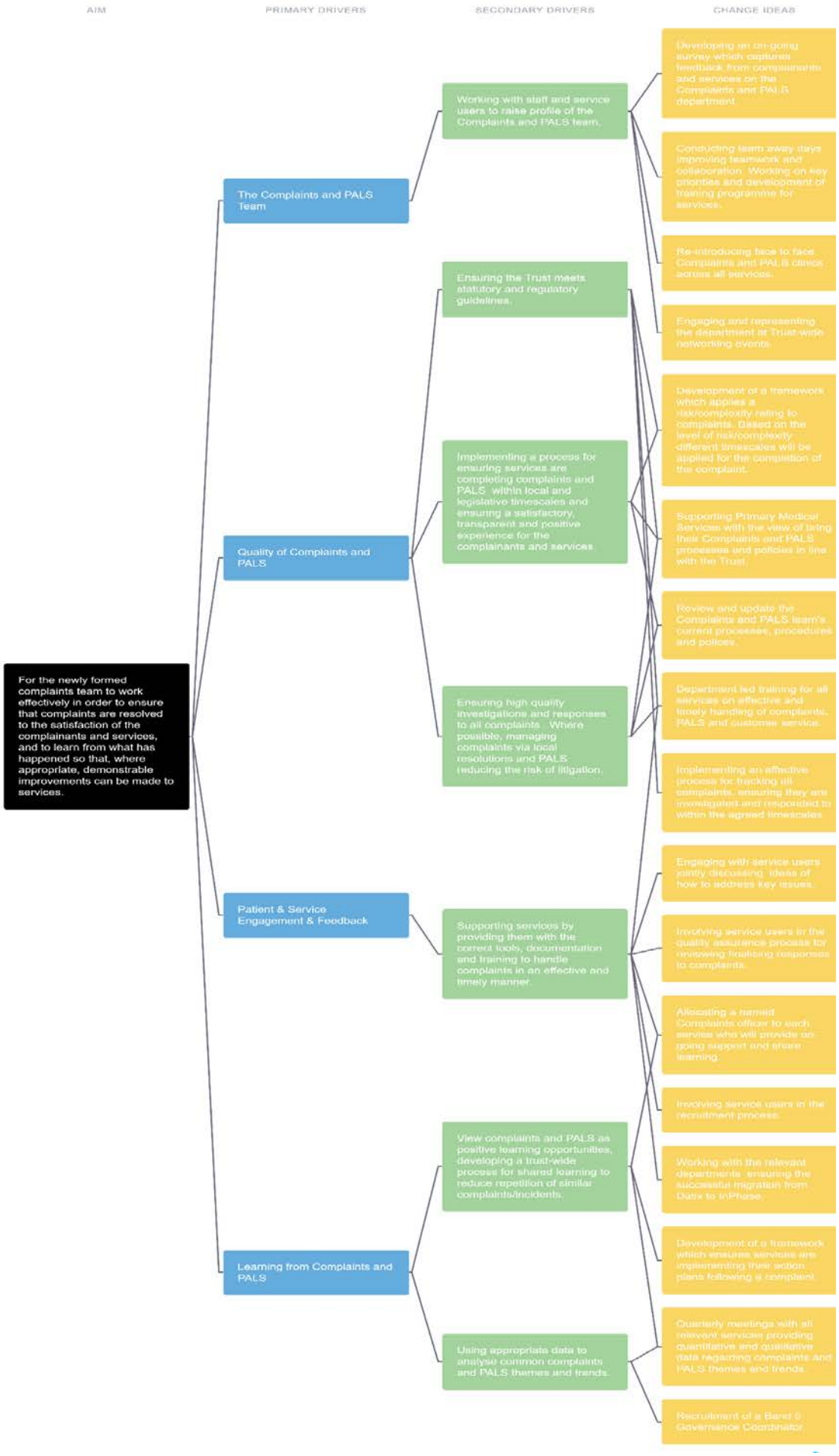
The team are working toward re-introducing both face to face and virtual clinics to enable patients and their families/carers to directly raise PALs issues with staff. There has been a delay in implementing this, this was due to the Trust readjusting the working patterns post-pandemic and also the effect on the team due to inadequate staffing levels, however we are confident staffing levels will be at an adequate from quarter two of this financial year.

3.3.3 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. This continues to be the trend this year and planning is in place to help establish key points of contact in the directorates.

4.0 Work plan for the coming financial year

4.1 Driver Diagram- Key priorities and their links to Trust objectives (see page below)


AIM
PRIMARY DRIVERS
SECONDARY DRIVERS
CHANGE IDEAS
For the newly formed complaints team to work effectively in order to ensure that complaints are resolved to the satisfaction of the complainants and services, and to learn from what has happened so that, where appropriate, demonstrable improvements can be made to services.
The Complaints and PALS Team
Quality of Complaints and PALS
Patient & Service Engagement & Feedback
Learning from Complaints and PALS
Working with staff and service users to raise profile of the Complaints and PALS team.
Ensuring the Trust meets statutory and regulatory guidelines.
Implementing a process for ensuring services are completing complaints and PALS within local and legislative timescales and ensuring a satisfactory, transparent and positive experience for the complainants and services
Ensuring high quality investigations and responses to all complaints. Where possible, managing complaints via local resolutions and PALS reducing the risk of litigation.
Supporting services by providing them with the correct tools, documentation and training to handle complaints in an effective and timely manner.
View complaints and PALS as positive learning opportunities, developing a trust-wide process for shared learning to reduce repetition of similar complaints/incidents.
Using appropriate data to analyse common complaints and PALS themes and trends.
Developing an on-going survey which captures feedback from complainants and services on the Complaints and PALS department
Conducting team away days improving teamwork and collaboration. Working on key priorities and development of training programme for services.
Re-introducing face to face Complaints and PALS clinics across all services.
Engaging and representing the department at Trust-wide networking events.
Development of a framework which applies a risk/complexity rating to complaints. Based on the level of risk/complexity different timescales will be applied for the completion of the complaint.
Supporting Primary Medical Services with the view of bring their Complaints and PALS processes and policies in line with the Trust.
Review and update the Complaints and PALS team's current processes, procedures and polices.
Department led training for all services on effective and timely handling of complaints, PALS and customer service.
Implementing an effective process for tracking all complaints, ensuring they are investigated and responded to within the agreed timescales
Engaging with service users jointly discussing ideas of how to address key issues.
Involving service users in the quality assurance process for reviewing finalising responses to complaints.
Allocating a named Complaints officer to each service who will provide on-going support and share learning.
Involving service users in the recruitment process.
Working with the relevant departments ensuring the successful migration from Datix to InPhase.
Development of a framework which ensures services are implementing their action plans following a complaint
Quarterly meetings with all relevant services providing quantitative and qualitative data regarding complaints and PALS themes and trends.
Recruitment of a Band 6 Governance Coordinator

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

We will be using the new InPhase system to collect the following data:

- Complaints received
- Complaints acknowledged within three working days
- Number of stage 1 complaints
- Number of stage 2 complaints
- Number of PALS inquires
- Number complaints closed within 25 working days/ agreed timeframe
- Number of complaints which have breached the agreed timeframe
- Common themes and trends
- Complaints action plans implementation completed
- Learning implemented by the directorates following outcomes action plans.

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

The complaints team will be providing the data outlined in paragraphs 4.2; monthly to the Quality Assurance department; quarterly to the Patient Safety department; and quarterly to the Risk and Governance department.

The complaints management team will regularly review progress against the work plan, ensuring it continues to be achievable. If we detect key priorities may not be met and/or other priorities have been identified, this will then be reviewed with the corporate senior leadership team to assess how the plan can be adapted to try and achieve these priorities.

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

We will arranging both face to face and virtual meetings with the following stakeholders:

- Service users and/or their representatives
- Past complainants
- The People Participation Group
- Complaints leads across all directorates
- Learning leads across all directorates
- Performance leads across all directorates

4.5 **Resourcing requirements or other risks to implementation.**

There have been recent changes to the leadership of the Complaints & PALS team, as well as retirement of some long standing team members.

A Head of Complaints and PALS Band 8a (1.0 WTE) was appointed to the team on 3rd May 2023. A Manager of Complaints & PALS Band 7 (1WTE) was appointed in November 2022, this role had been vacant since 2019. There are currently three Band 6 (WTE) Complaints & PALS Officers in post, with a 4th one due to start on 31

May 2023. There is a 0.6 WTE PALS and Complaints Band 4 administrative support in place and a Band 5 (1.0 WTE) PALS Officer.

Additional funding has been secured for a substantive Band 5 (1.0 WTE) for the team. In view of the focus on outcomes and evidencing service improvement as a result of learning from complaints, this role will have a responsibility for data reporting and analysis of themes and trends. This role of Complaints & PALS Governance Co-ordinator has been advertised, it is anticipated that the role will be recruited into in the next three months.

The Complaints & PALS team has separated from the risk and governance team, to form a stand-alone service in the last year. A key priority for the team in the next year is to support the team to develop its own identity as a Complaints and PALS department, and raise its profile within the Trust

5.0 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.

5.1 PALS Sample

5.1.1 Patient on ward thought there were cameras in the toilet.

Matron spoke to the service user and explained the reason for the cameras on wards was to protect unwell people.

5.1.2 Unable to get through to the service, phone kept ringing out.

Service assured patient that the phone number in question is answered. They explained that staff could have been away from the phone at the time, speaking with other service users or on another line.

5.1.3 Service user not happy with content of letter following assessment.

The relevant service agreed to send an amended letter to the service user with agreed changes.

5.1.4 Service user wanted an update on referral to the Eating Disorder Service.

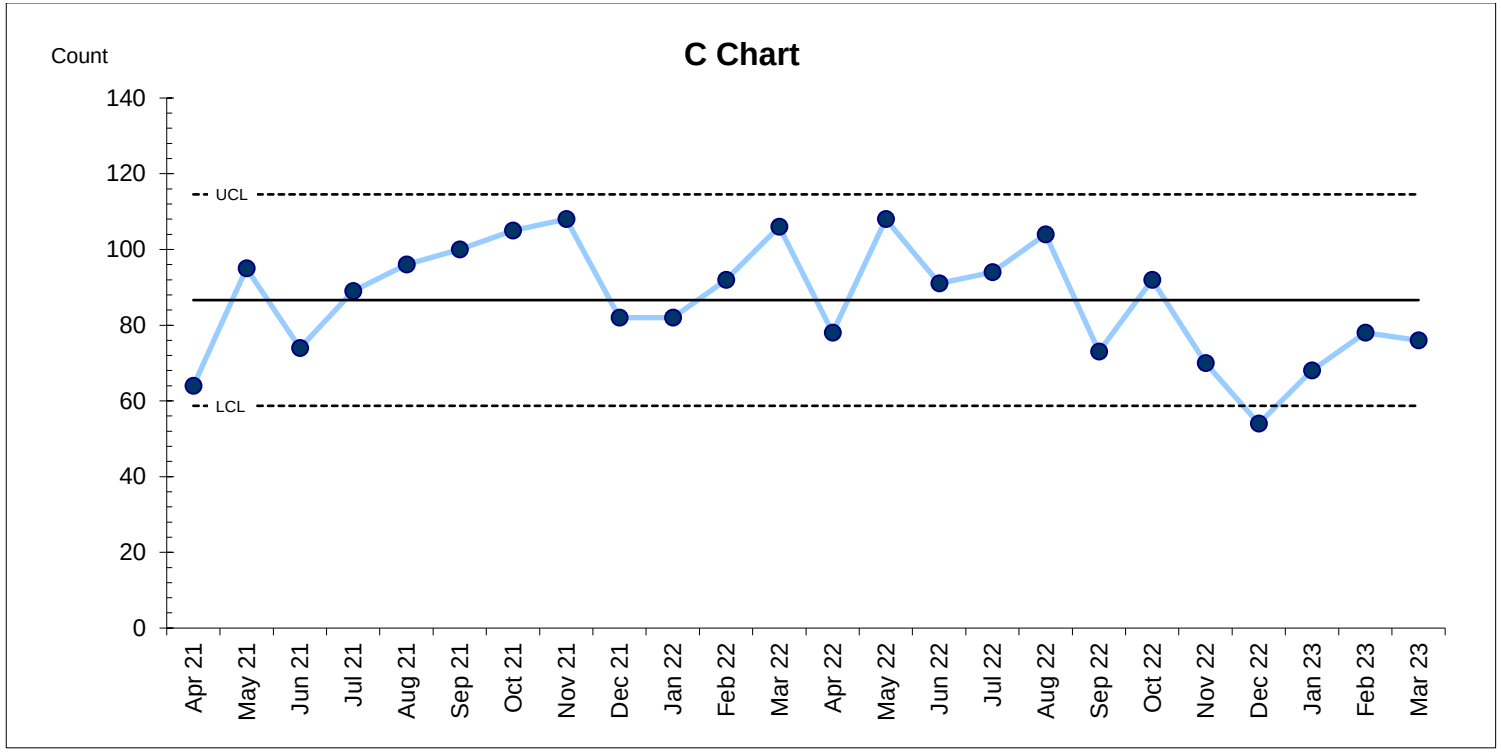
Update was provided, and they were informed that they were on the waiting list.

5.2 **Table 6-** PALS inquiries by Directorate

Directorate	Apr 22	May 22	Jun 22	July22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Bedfordshire MHS	12	20	14	10	16	17	24	12	5	12	10	8
City & Hackney MHS	8	16	12	8	8	14	7	7	10	10	7	15
CHS Combined	18	19	15	17	20	9	13	16	13	9	13	11
Corporate	1	0	1	0	1	0	0	0	0	0	0	0
Forensic Services	5	3	8	7	0	1	0	0	1	1	1	1
Luton MHS	7	6	11	8	5	2	11	6	3	3	7	7
Newham MHS	10	14	6	17	10	7	8	8	7	7	11	12
Specialist & CHN Children's Services	2	4	5	6	10	10	6	6	5	5	5	6
Tower Hamlets MHS	10	15	12	13	16	7	10	11	4	11	10	6
Primary Care	5	11	7	8	18	6	13	4	6	10	14	10
Total	**78**	**108**	**91**	**94**	**104**	**73**	**92**	**70**	**54**	**68**	**78**	**76**

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.

5.3 Chart 6 – PALS Inquiries over time



986

PALS inquiries were logged & handled, an average of 82 inquiries per month

6.0 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 2022/23 the Trust has received **16** new contacts from the PHSO based on complainants expressing dissatisfaction with the Trust's response/outcomes of their complaint. This compares to **3** received in 2021/22. These were all requests for information, no cases were further investigated by the PHSO during this time.

7.0 Compliments

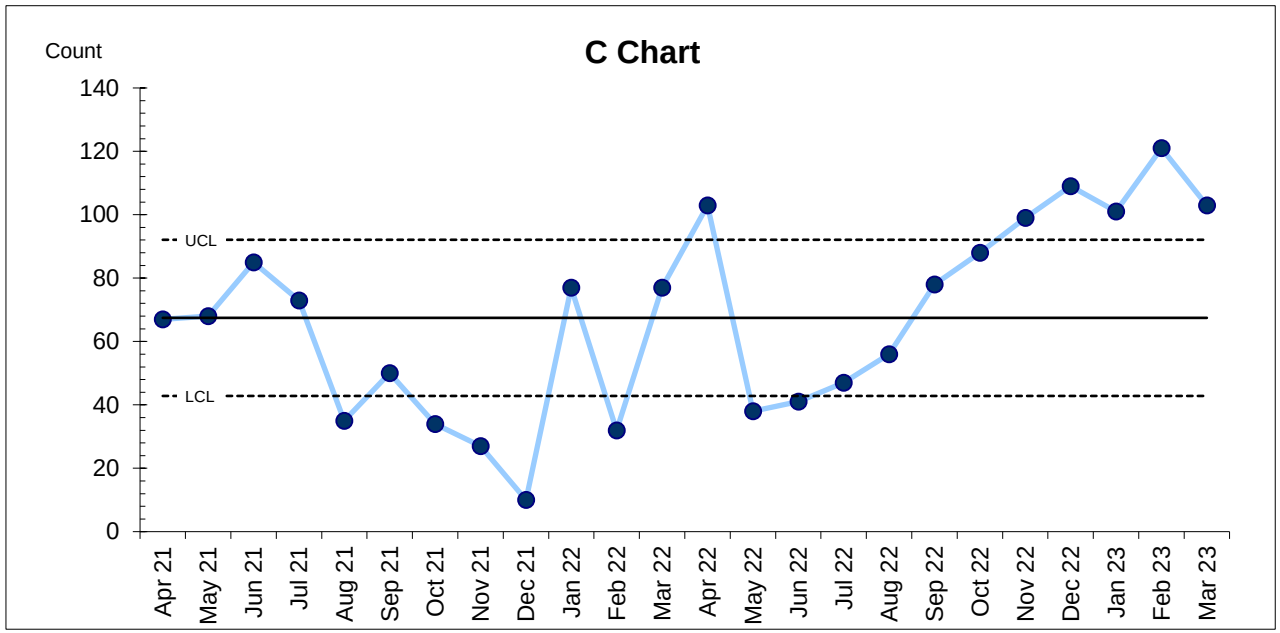
The Trust routinely responds to all reported compliments that are subsequently shared with the relevant teams and publicised in the Trust's weekly news bulletins. The majority praise the care received generally, whilst a high proportion will specifically name staff that have provided excellent service. In addition the complaints team has access to "Care Opinion" where service users and their representatives are encouraged to share their experiences.

Table 7- Reported compliments recorded by Directorate

Directorate	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Bedfordshire MHS	5	8	8	9	8	17	13	11	23	14	18	26
City & Hackney MHS	0	0	0	1	1	0	0	4	1	1	1	0
CHS Combined	23	19	13	12	15	16	21	23	17	14	11	17
Corporate	0	0	1	0	0	0	0	0	0	0	0	0
Forensic Services	3	3	0	0	0	0	0	1	0	2	0	0
Luton MHS	7	0	1	2	0	0	0	4	1	0	1	6
Newham MHS	0	0	2	0	1	0	1	7	0	0	0	0
Specialist & CHN Children's Services	51	0	0	1	1	9	1	14	23	29	26	20
Tower Hamlets MHS	6	3	3	3	4	8	3	18	23	12	21	34
Primary Care	8	5	13	19	26	28	49	17	21	29	43	0
Total	**103**	**38**	**41**	**47**	**56**	**78**	**88**	**99**	**109**	**101**	**121**	**103**

East London
NHS Foundation Trust

Chart 5 Compliments over time



984

Formal compliments were recorded by the Trust in this reporting period. It is recognised that many more informal complaints would have been received by individuals and teams across the organisation where they were not formally recorded.

7.1 Compliments Sample

7.1.1 Corporate Services – Complaints & PALS Service

Thank you for your email. Also for your pleasantness on our call earlier.

7.1.2 Tower Hamlets – Inpatient Services

The staff were very welcoming, kind and warm and they listened to me and my concerns and made me feel safe throughout the visit. They communicated very well and listened to each other and made sure everything was going smoothly.

7.1.3 Community Health Services

Thank you so much for all your support. You went over and above with the care and support you gave us. Thank you so much again and just to let you know you are amazing

7.1.4 Luton Mental Health Services Inpatient Services

During my experience on Jade PICU I was often supported for example when I would deliberately isolate myself and not engage however at these times various team members would ensure that they were there for me and give me options to receive back to my normality of engagement. Sarah Khin would listen greatly to me and in fact result in me coming to better and more positive options.

7.2 Service User Involvement

A service user representative from the People Participation Team provides regular input to the complaints responses by reviewing drafts and providing recommendations. The Complaints Team is also works closely with the People Participation Lead to look at ways the team can encourage further ways to involve input from service users.

Once the PALS Clinics are in place, this will also create a good pathway to involve and get feedback from service users.

8.0 Recommendations/Actions being requested

The Trust Board is asked to receive, discuss and approve this report.

REPORT TO THE QUALITY ASSURANCE COMMITTEE
26 JUNE 2023

Title	Legal Claims annual report – 1st April 2022 to 31st March 2023
Author	Christina Helden, Interim Associate Director of legal Affairs Gregory Smith, Trust Solicitor Pilirani Seyani, Legal Affairs Officer
Accountable Executive Director	Dr David Bridle, Chief Medical Officer

Purpose of the Report:

To provide an overview on claims activity under the Clinical Negligence (CNST) and Liability to Third Party (LTPS) schemes and financial implications.

The report focuses on the period between 1st April 2022 and 31st March 2023.

This report does not consider Employment Tribunals, Court of Protection, Judicial Reviews or 'Ex Gratia' matters.

Summary of Key Issues:

The total number of open claims (72) has remained stable in comparison to 2021/22 (71).

There were 12 new CNST claims and 28 new LTPS claims received between 1st April 2022 and 31st March 2023. This compares with 10 new CNST claims and 23 new LTPS claims in the preceding 12 months (2021/22).

The estimated total value of all claims closed in the 1st April 2022 – 31 March 2023 period is £665,739.75. This compares extremely favourably with the 2021/22 estimated total value of £1,890,859.

The top category of CNST claims is adult deaths, which is consistent with 2021/22.

The top category in LTPS claims is actual physical assault (for comparison, in 2021/22 it was information governance 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.

Committees/Meetings where this item has been considered:

Date	Committee/Meeting

Implications:

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	Appropriate handling of 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 actions 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.

1.0 BACKGROUND

1.1 This report will focus on the claims activity under the Clinical Negligence (CNST) and Liability to Third Party (LTPS) schemes between 1st April 2022 and 31st March 2023.

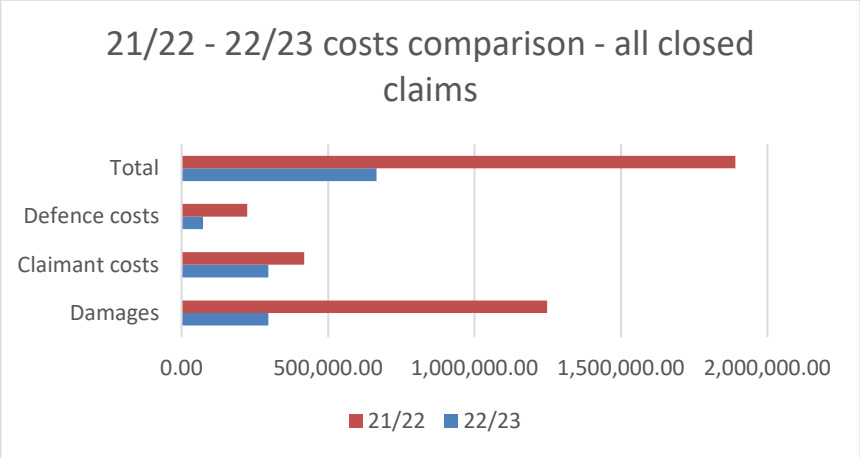
2.0 CNST AND LTPS CLAIMS OVERVIEW

2.1 As noted above, this report focuses on claims activity between 1st April 2022 and 31st March 2023. However, to provide context this section will provide an overview on the number of claims currently open. There are currently 72 open claims across both schemes which divide into 37 CNST and 35 LTPS claims. There were 12 new CNST claims and 28 new LTPS claims received between 1st April 2022 and 31st March 2023. This compares with 10 new CNST claims and 23 new LTPS claims in the preceding 12 months (2021/22), during which time the total number of open claims was 71.

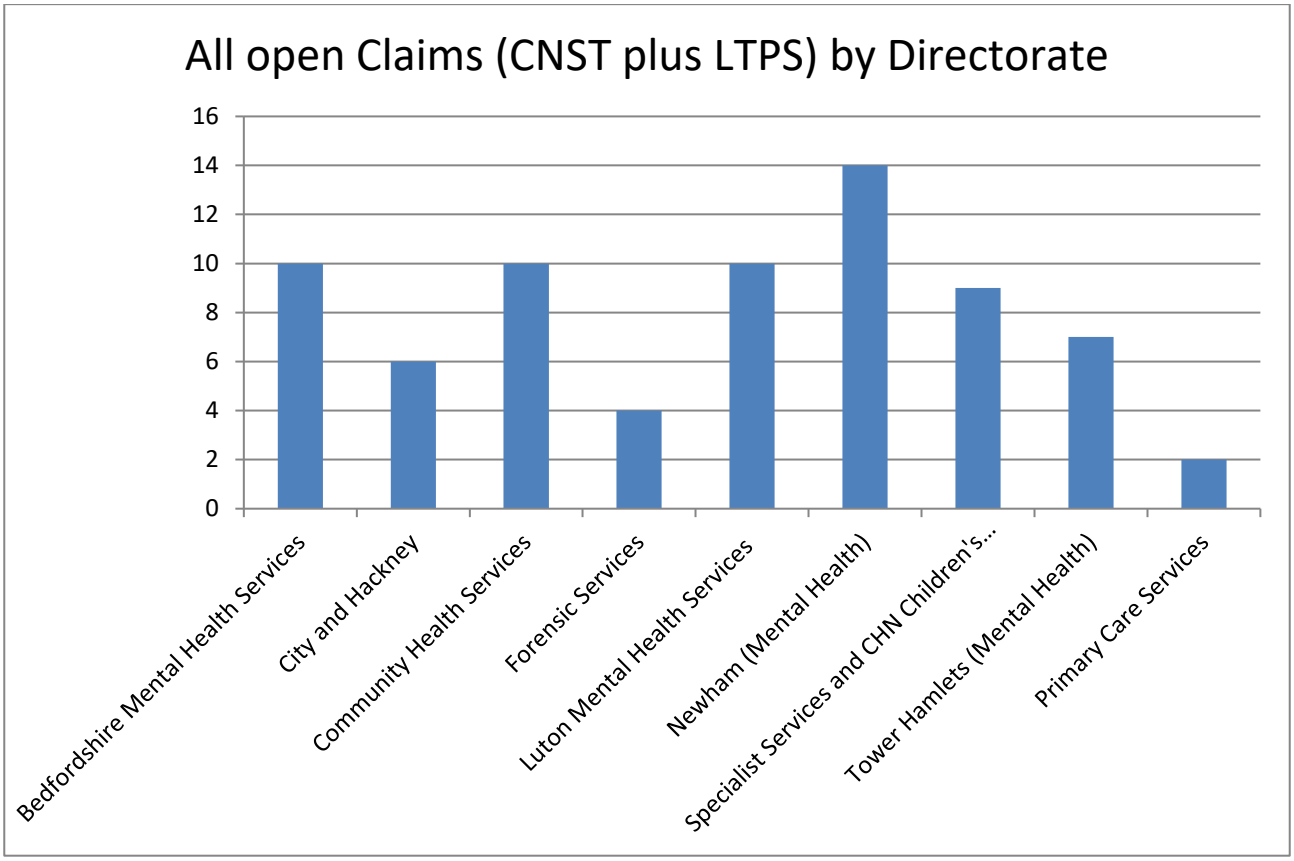
2.2 All claims are categorised on receipt based on a consistent categorisation system for the recording of incidents.

2.3 The estimated total value of all claims closed in the 1st April 2022 – 31 March 2023 period is £665,739.75. This is comprised of estimated damages (£296,594.50), claimant legal fees (£295,748.95) and legal costs incurred in defence of the Trust (£73,396.30). This compares extremely favourably with the 1st April 2021 – 31st March 2022 period, when the estimated total value of the claims closed was £1,890,859 (comprised of £1,248,173 in damages, £419,005 in claimant legal costs and £223,681 in legal costs incurred in defence of the Trust). Significant caution should be used when reviewing these figures as the estimates may change upon final bills being presented. It should also be borne in mind that the actual cost to the Trust is significantly lower due to its membership of the respective NHS Resolution insurance schemes which handle these cases.

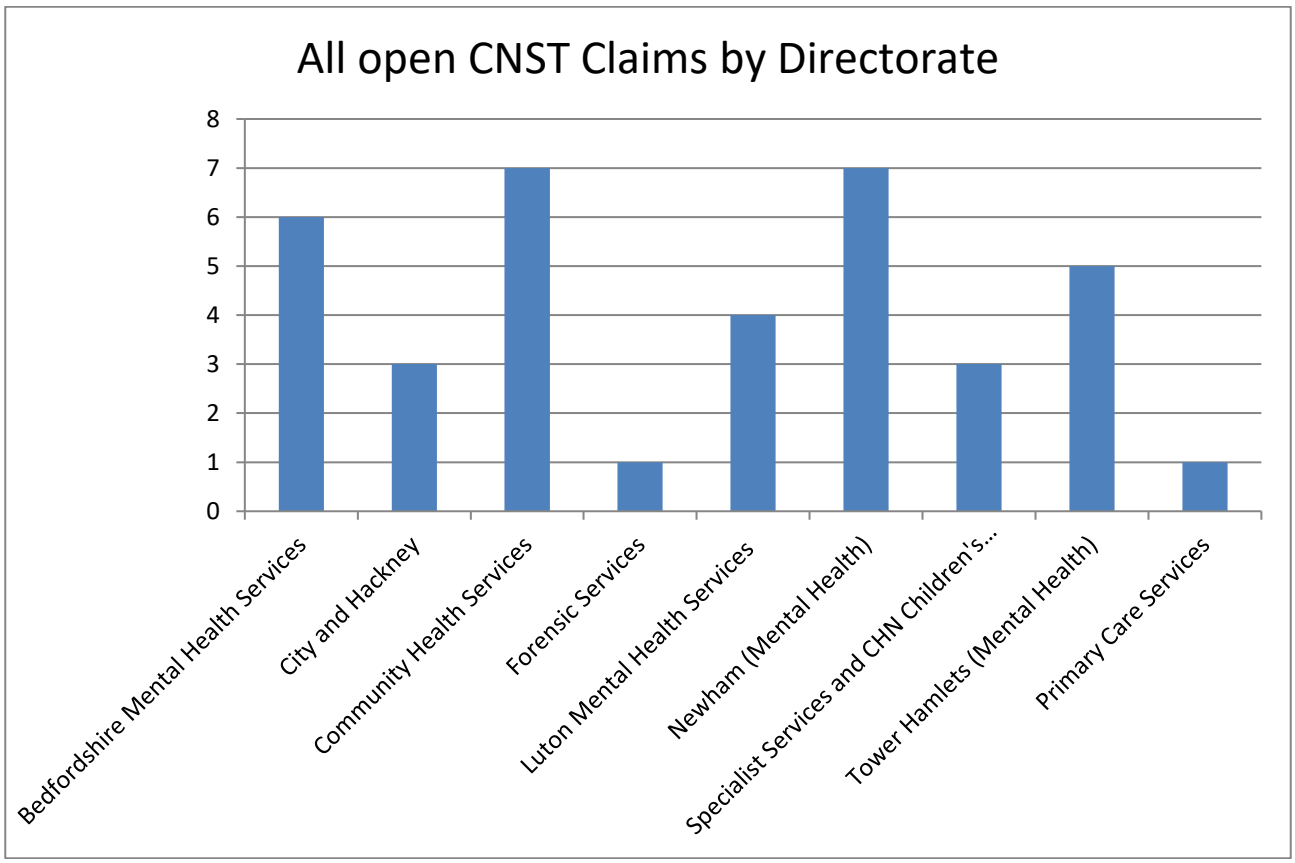
2.4 The graph below shows the year-on-year change from 2021/22 – 2022/23 in terms of the various cost categories.



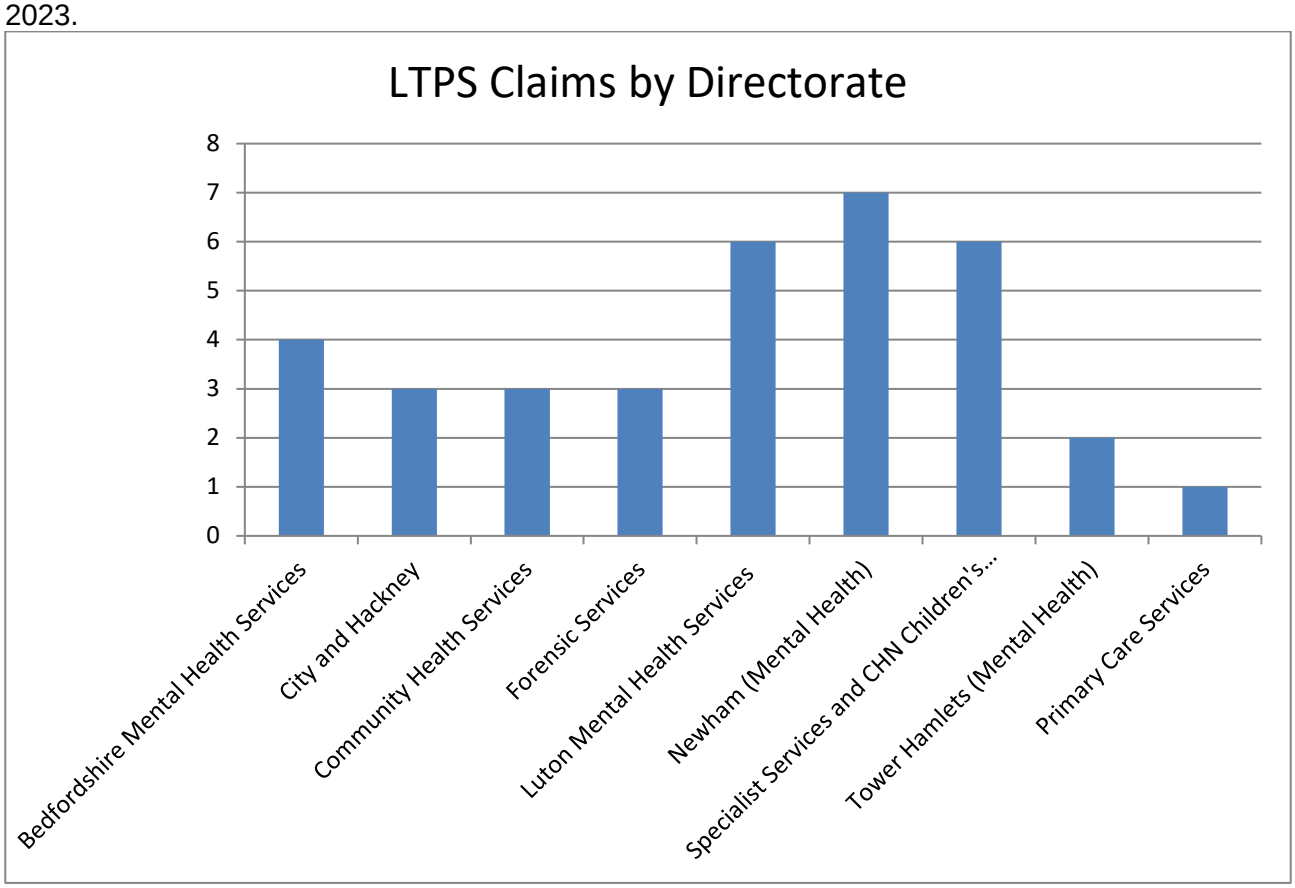
2.5 The graph below shows the total number of currently open claims (CNST plus LTPS), split by Directorate, as at 12th May 2023.



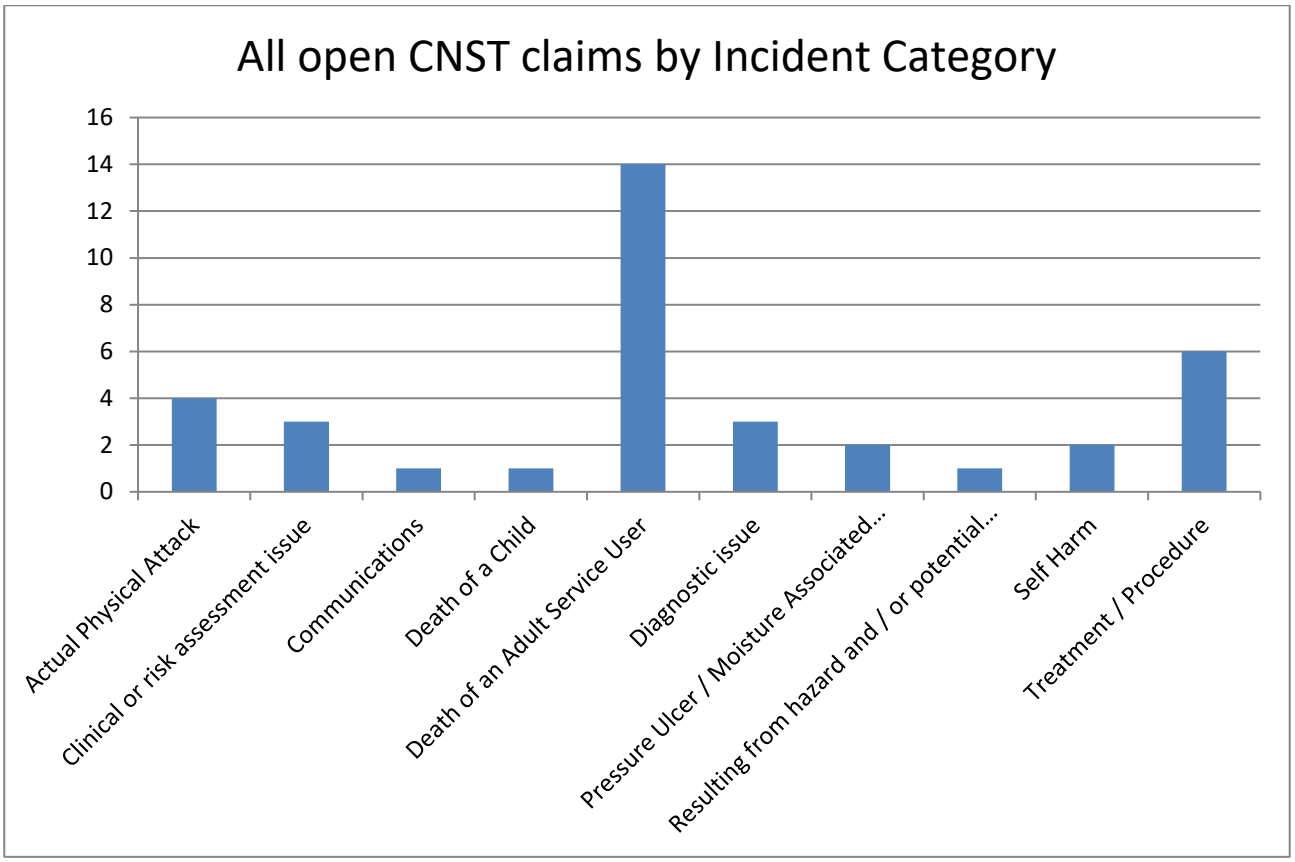
2.6 The graph below shows currently open CNST claims, split by Directorate, as at 12th May 2023.



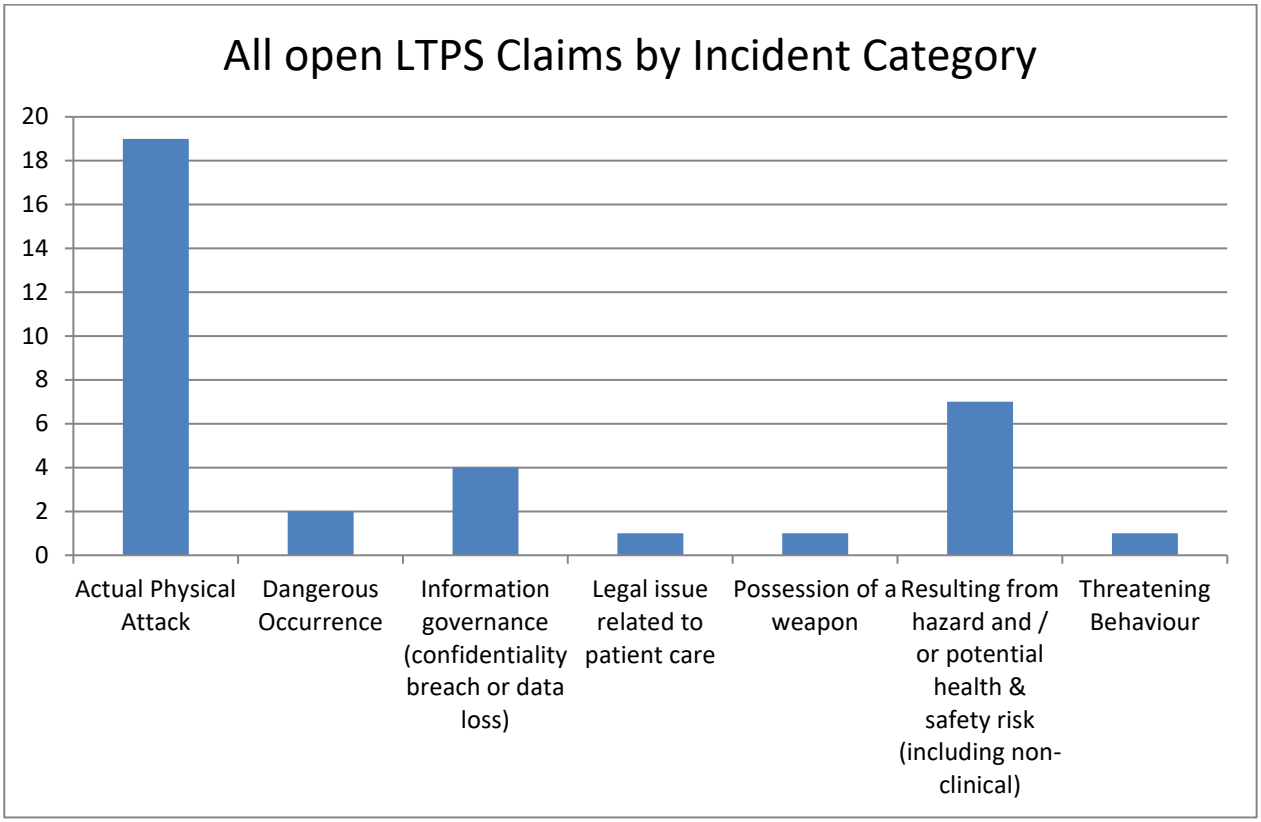
2.7 The graph below shows currently open LTPS claims, split by Directorate, as at 9th May 2023.



2.8 The graph below shows the number of all open CNST Claims categorised by incident category as at 12th May 2023.



2.9 The graph below shows the number of all open LTPS Claims by incident type as of 9 May 2023.

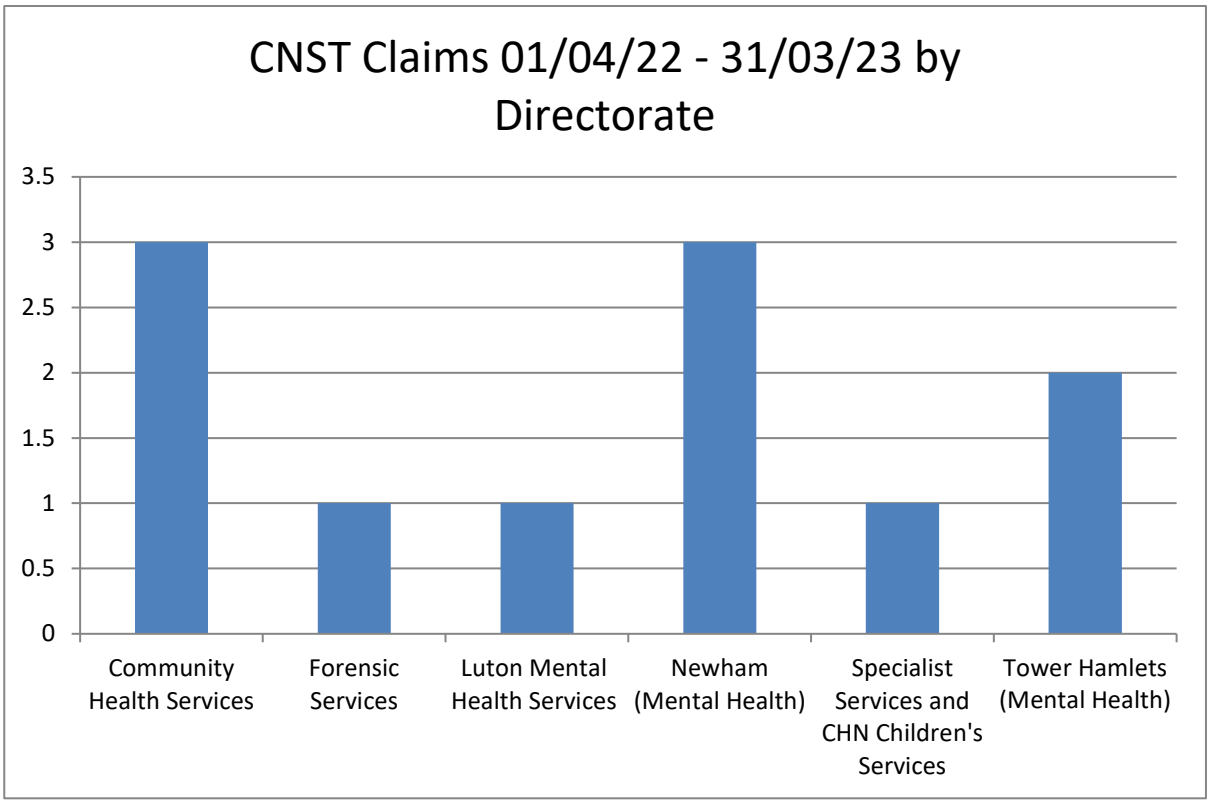


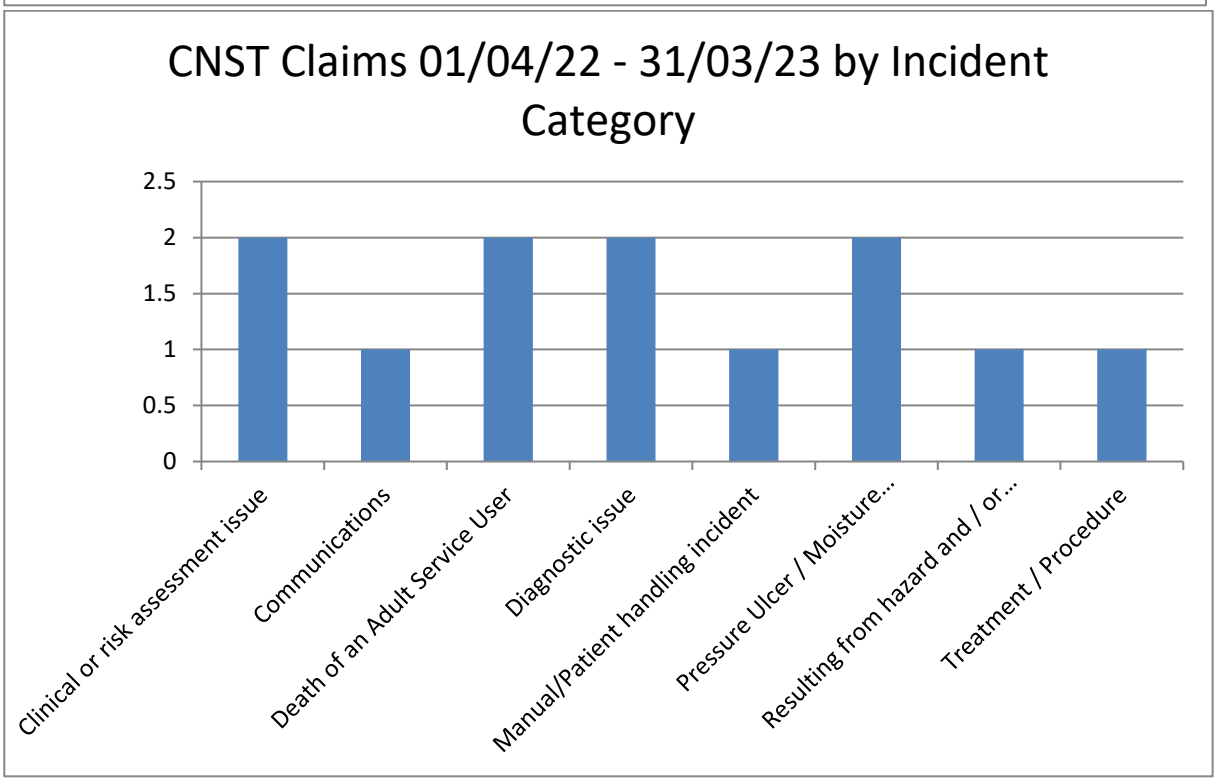
3 CLINICAL NEGLIGENCE (CNST)

3.1 CNST Claims received between 1st April 2022 and 31st March 2023

3.2 Between 1st April 2022 and 31st March 2023, 12 new CNST claims were received.

3.3 The graphs below shows the number of claims received during this period broken down by incident category and Directorate respectively.

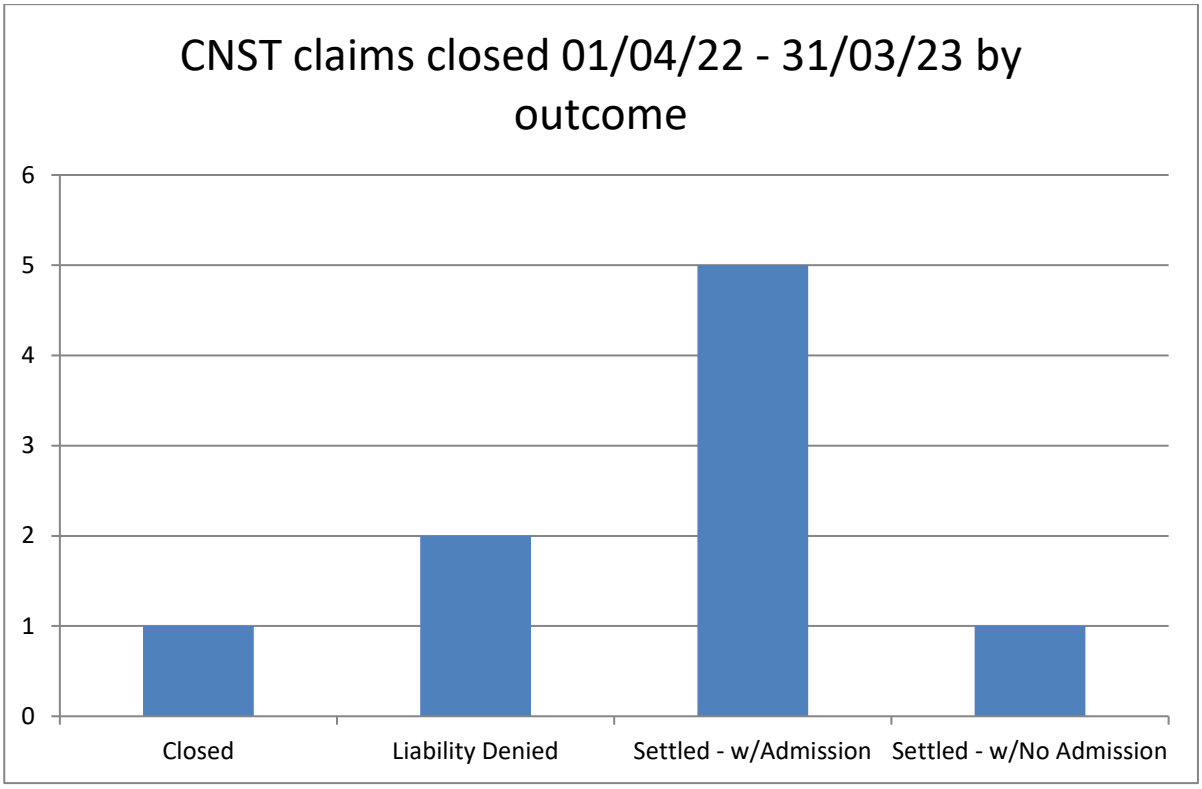


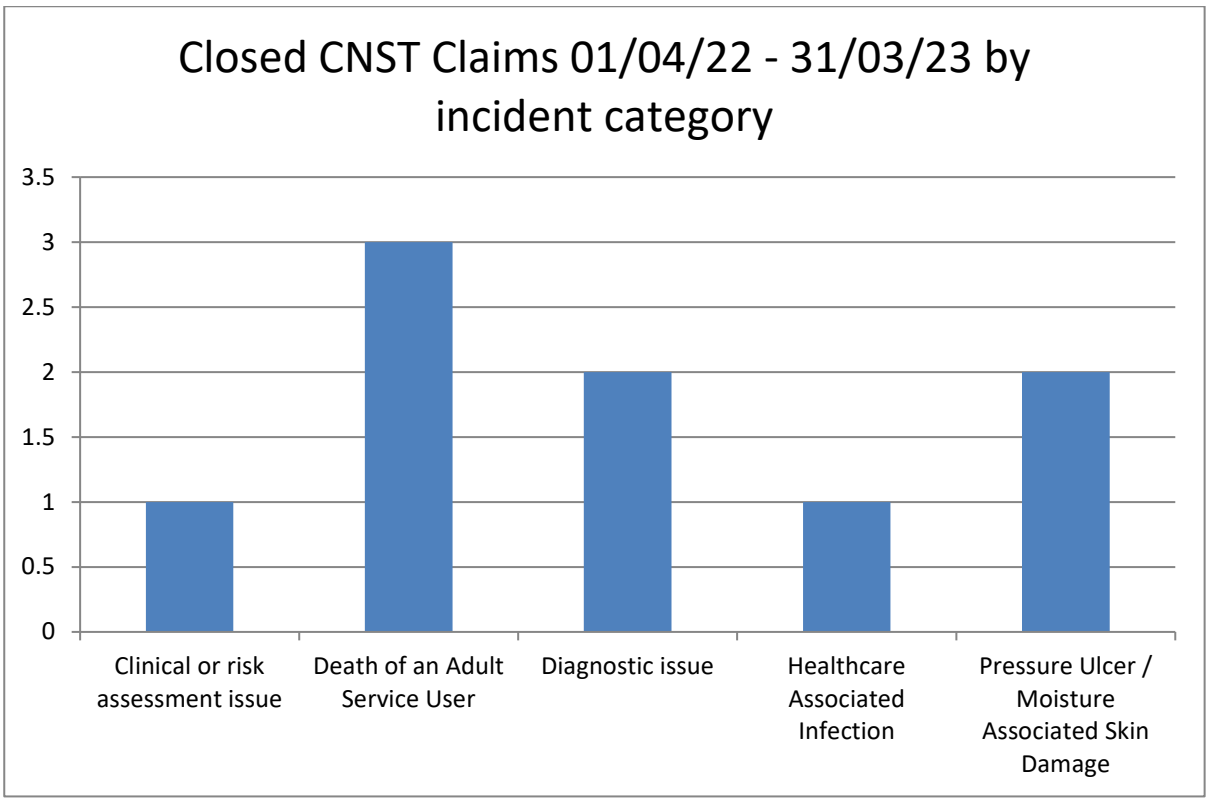


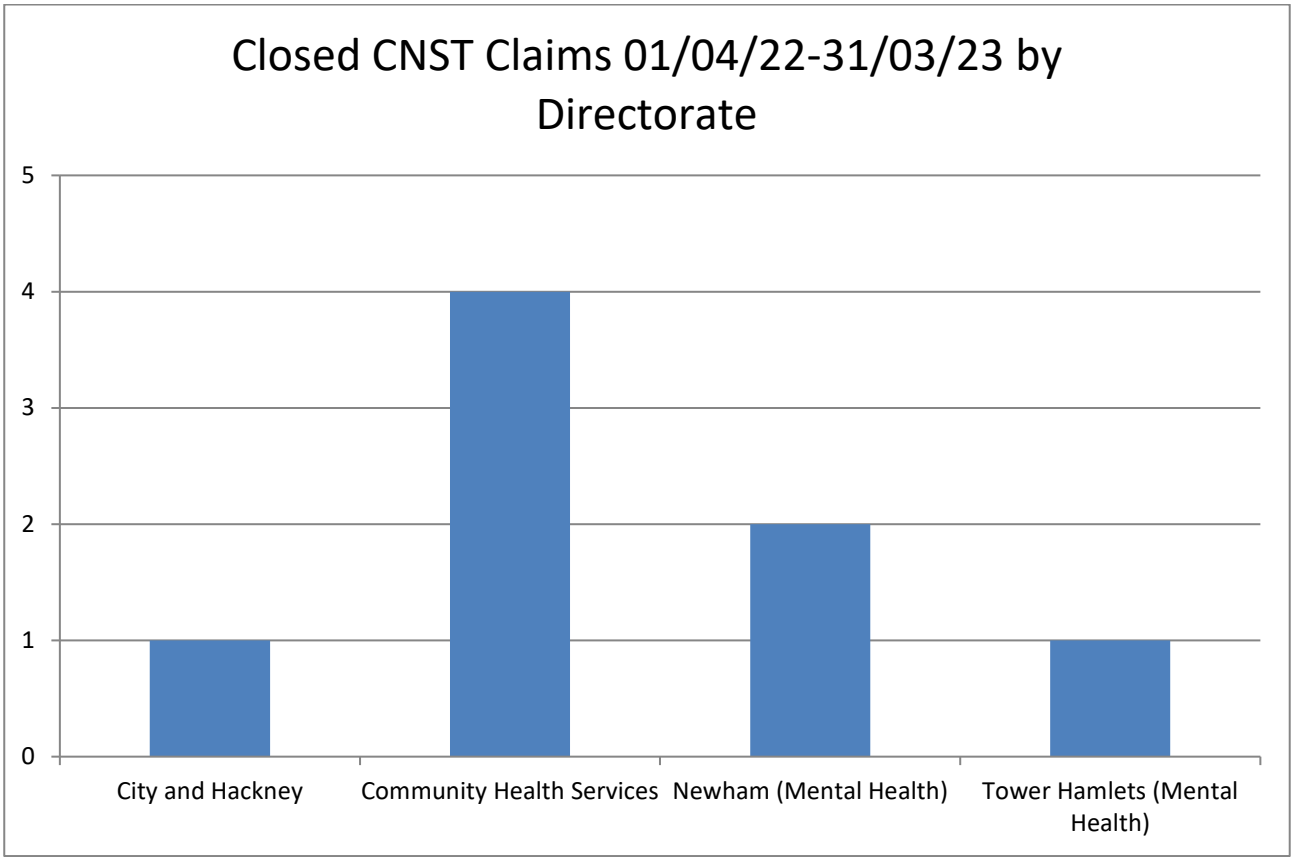
3.4 Outcome of CNST Claims closed between 1st April 2022 and 31st March 2023

3.5 Between 1st April 2022 and 31st March 2023, 9 claims were closed under the CNST scheme.

3.6 The graphs below show number of claims closed during this period broken down by outcome, incident category and Directorate respectively.







Note: One claim could not be assigned to a Directorate due to the paucity of information provided by the Claimant.

3.7 Of the five claims that were settled with admissions of liability during this period, two related to death, two to pressure sores and one in respect of inaccurate diagnosis. The claim that was settled without admission related to a patient developing a healthcare-associated infection (UTI).

3.8 Total value of CNST claims closed between 1st April 2022 and 31st March 2023

3.9 All CNST claims have a 'nil excess'.

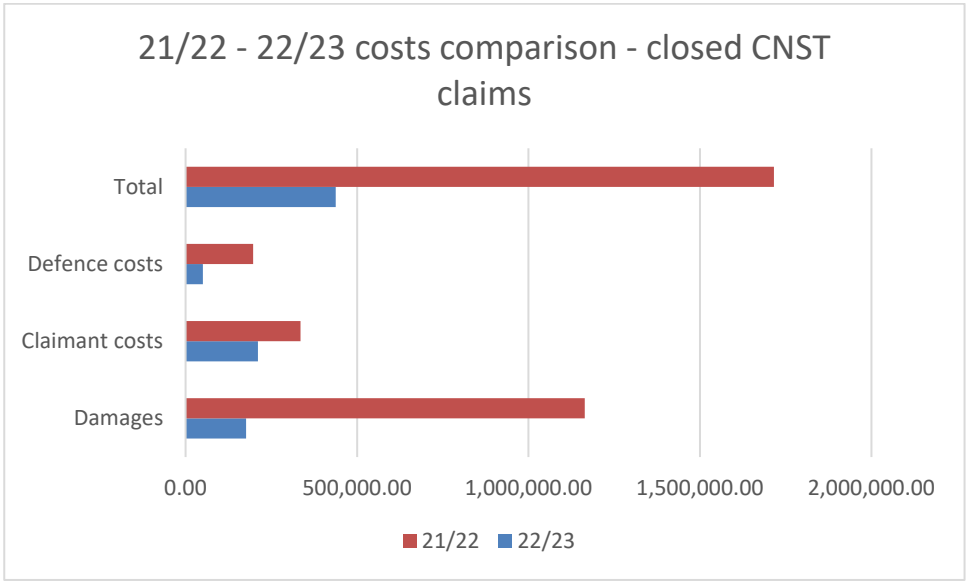
3.10 The number and value of claims each year has an impact on the Trust's contribution to NHSR's CNST scheme the following year. The NHSR site states that *"individual member contribution levels are influenced by a range of factors, including the type of trust, the specialties it provides and the number 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]

3.11 The estimated total value of claims closed between 1st April 2022 and 31st March 2023 is £438,082. This is comprised of:

Damages - £176,500
Claimant's costs - £211,404.80
Defence costs - £50,177.20

[1] https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/

3.12 The below graph shows the year-on-year change from 2021/22 – 2022/23 in terms of the various cost categories.



3.13 Qualitative information regarding CNST claims

3.14 For the purposes of this section the top three categories have been taken from all open claims. This includes new claims received in 22/23. The top three categories of claims are, in descending order: adult deaths (13), treatment/procedure issues (6) and actual physical assault (4). These categories are similar to last year (in descending order- adult deaths, actual physical attacks and diagnostic issues). More details are set out below.

3.15 Adult Deaths

3.16 Of the 13 adult death claims, we have admitted (or intend to admit) liability in five. Liability has been denied in one case; and the remainder are under investigation. Further details about the five cases where an admission of liability has been made (or is planned) are provided below.

3.17 The first case was a human rights claim following a death by asphyxiation on 16.01.20. The Deceased had a complicated diagnosis of Asperger's Syndrome and depression. This, in conjunction with a relationship breakdown and recent attempts at self-harm, should have meant he was recognised as high risk, accepted onto the Crisis Team (but he was not). In addition, the Deceased's risks were such that he should have been urgently assessed, rather than directed back to primary services.

3.18 The second case relates to a fall from a bedroom window on 17.04.20. A friend of the patient's telephoned the crisis line, but the crisis line nurse practitioner failed to explore the nature of the patient's hallucinations. The Coroner found that if the nurse had explored the patient's presentation adequately, he would have discovered this and visited him within four hours. In fact, the nurse did not have sufficient information to allow him to form the view that the patient was not a risk to himself. The nurse gained false reassurance from the fact that the patient had no prior mental health history and from the fact that the ambulance service had visited earlier in the day. He failed to explore any change in presentation since their visit and so did not elicit the information that the patient had suffered a screaming episode after the ambulance service left. He gained false reassurance from the agreement of the patient's flatmate to his plan. The nurse did not call back later, and arranged a visit within 24 hours. Meanwhile, the patient left the window a little over five hours later.

3.19 The third case involved a patient who was known to community mental health services. A few days prior to his death the supported accommodation where he was living expressed concerns about possible deterioration in his mental health. He died during restraint by security guards at a public exhibition centre on 31.07.19. An inquest jury found that various aspects of the care provided by the mental health team was inadequate, including missed opportunities to put him on the Care Programme Approach, discuss him at MDT meetings, involve the Home Treatment Team and have medical reviews. The jury also found that his outpatient reviews were too far apart, that an appointment was too short to properly assess him, that the risk assessments were inadequate and the communication with the supported accommodation was ineffective.

3.20 The fourth case arose from the death of a patient who passed away on an inpatient ward on 01.07.17 after being injected with heroin by another patient. The Trust's SI identified a number of deficiencies in the processes and management of the ward, and immediate measures were taken to restrict its bed capacity as a result of this incident. The lack robust record keeping, documentation or witness accounts were problematic. Other areas of concern included inadequate risk assessments, inadequate observation levels, inadequate communication between staff and lack of searching.

3.21 The fifth case arose arising from the death of a patient on 18.12.18 who overdosed on her husband's medication. The inquest was heard in September 2022. The Coroner came to a narrative conclusion that the patient died as a result of a fatal ingestion of oxycodone and pregabalin. She was living in hazardous conditions and was unable to keep herself safe. Failings on behalf of her familial carer, her mental health team and her social care team contributed to her death. There was a failure to fully assess and manage a clear risk of her ingesting medication that was not prescribed to her. Her death was contributed to by neglect by her husband, the Local Authority and the Trust.

3.22 New CNST High Value Claim

3.23 A notably high value claim has been received in the 01/04/22 – 31/03/23 reporting period, where the estimated damages are £1,500,000 (NB this does not include either claimant or defendant legal costs). The patient had pre-existing spinal issues and mental health issues. During an inpatient stay on a mental health ward, she underwent several rounds of ECT treatment. The claimant is alleging that the mental health team were negligent in providing the ECT treatment in light of the spinal issues. It is alleged that as a result of the treatment she has now suffered paralysis. It should be noted that the index incidents took place in 2017, but the formal legal paperwork was only received in September 2022 to 'open' the claim. This reflects a significant period of extensions being agreed between the parties (which include a local acute Trust) for the purpose of investigations to take place. A joint investigation between both Trusts noted some care and service delivery issues, and concluded that the use of ECT was a potential contributory factor to the injuries alleged. However, based on the records of the ECT treatments where only facial twitching was observed and no gross muscle or body movements documented, this was believed to be unlikely (albeit impossible to rule out).

3.23 Treatment / Procedure Issues

3.24 Of the six currently open claims, we have admitted (or intend to admit) liability in three claims and denied liability in three cases. Further information about the three cases where we have admitted (or intend to admit) liability is provided below.

3.25 The first case relates to community podiatry care in June 2018. The Claimant was referred to podiatry services by his GP and underwent multiple partial nail avulsions. On review the following day, it was noted that the digital glove tourniquets had been used on two of the toes and remained in place contrary to what should have happened. The claimant reported that he had been in extreme pain throughout the night. There was evidence of ischaemic tissue on his right and left second toes and the claimant had to be sent to A&E where he was treated with IV Heparin and analgesia and monitored for revascularisation.

3.26 The second case relates to a nephrology referral which did not take place. The Claimant alleges treatment fell below an acceptable standard on several occasions between June 2017 and April 2019. An expert instructed by the Trust agreed that the Claimant should have been referred for a specialist nephrology opinion and/or secondary care in or after February 2017, June 2017, April 2018, December 2018 and/or April 2019. The claimant is now required to undertake dialysis three times a week and requires a kidney transplant.

3.27 The third case relates to a community patient with a supra-pubic catheter. The Rapid Response team received a call from his daughter on 17 November 2014 where she found his catheter out and on the floor at his home. The rapid response nurse attended his home at approximately 19:45 hours. The old catheter was found on the floor. The patient was catheterised via the urethra. The catheter was draining clear urine, and he did not complain of any pain but the nurse did notice a small amount of blood in the urine as she was leaving the home and advised him to drink lots of fluids. The next day on 18 November 2014, the daughter called to inform the nurses that he had been bleeding and explained that her father was catheterised via the urethra rather than supra-pubic. She was advised to take him to A&E. The Trust's investigation noted that the notes (which the nurse did not read in depth) were unclear about the siting of the catheter, that there was no up-to-date care plan and that communication with the family about the catheter was poor.

3.28 Actual Physical Assault

3.29 Of the four currently open claims, liability has been admitted (or will be admitted) in three, and one is still being investigated. Further information about the three claims where liability has been (or will be) admitted is provided below.

3.30 The first case relates to an incident where a staff member assaulted a patient on 29.07.20. The staff member carried out a single handed restraint in breach of the Trust's Physical Holding Skills Policy, and used physical force beyond the minimum required to manage the situation. The Trust has accepted that this amounted to a civil assault. Separately, the staff member has been convicted of criminal assault.

3.31 The second case relates to an incident where a patient assaulted another patient on 09.04.10. There were failures to conduct any or adequate risk assessment, to put proper care plan in place, to place the patient on general observation, to make significant attempts to investigate and manage the patient's intimidation of the other patient and to take any action when the patient attacked the other patient two days beforehand.

3.32 The final claim relates to an incident where a patient was a victim of an unprovoked physical assault by another patient on the ward on 04.10.16, resulting in injuries (a broken

nose, severe cuts and bruising to the face and a head injury). The perpetrator was admitted immediately following a very serious assault but there was no review of the suitability of the inpatient service in light of their risk. They should have been placed on continuous 'arms length' observations instead of intermittent observations. A risk assessment was not completed regarding the observations, and documentation of the observations was incomplete. Finally, there was no evidence that staff had considered the patient's disclosure of synthetic cannabis use in their formulation.

3.33 Qualitative information regarding closed CNST claims from 01/04/22 – 31/03/23

3.34 We have closed nine cases. Liability was denied in two cases. One was closed due to inaction on the Claimant's part. Liability was admitted in five cases and a settlement was made without admission in one case. Further information about the five cases where liability was admitted is provided below.

3.35 The first case related to a surgical procedure for a broken femur, following which the patient was transferred from an Acute Hospital to an ELFT inpatient service for aftercare with a post surgical sock. It is reported that the patient left the Acute Hospital with no pressure ulcers. It is alleged that the patient's surgical sock was not removed for weeks nor was a thorough and regular review of skin assessments undertaken and as a result a grade 3/4 pressure ulcer developed. The Trust's investigation identified a number of issues with the care provided in circa January 2018. The Care Plan was not complied with. The Claimant was admitted with TED stockings following his surgery, however these were not removed to check for wounds underneath. The Claimant's feet (where the pressure sore developed) did not appear to have been checked at any time prior to noting the pressure sore. There was poor documentation in respect of the skin checks. There were delays in referring the Claimant to a Tissue Viability Nurse once the pressure sore had been identified.

3.36 The second claim related to a patient who died on 13.12.18 while on section on a Trust ward. He had not been observed for a 2 hour period. The claim followed a jury inquest where it was concluded that the patient's death was drug-related, contributed to by neglect.

3.37 The third claim related to the management of a patient's pressure sores in circa December 2013. The care provided to the patient fell sufficiently below the standard to be reasonably expected so as to constitute a breach of duty. The patient had significant pre-existing co-morbidities which increased the risk of developing pressure sores in any event. However, notwithstanding this, it was accepted that the admitted breach of duty led to a worsening of the pressure sores.

3.28 The fourth claim related to the death of an inpatient on 20.03.19 as a result of the natural cause of pulmonary embolism. The Coroner's conclusion was 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 in ELFT's care.

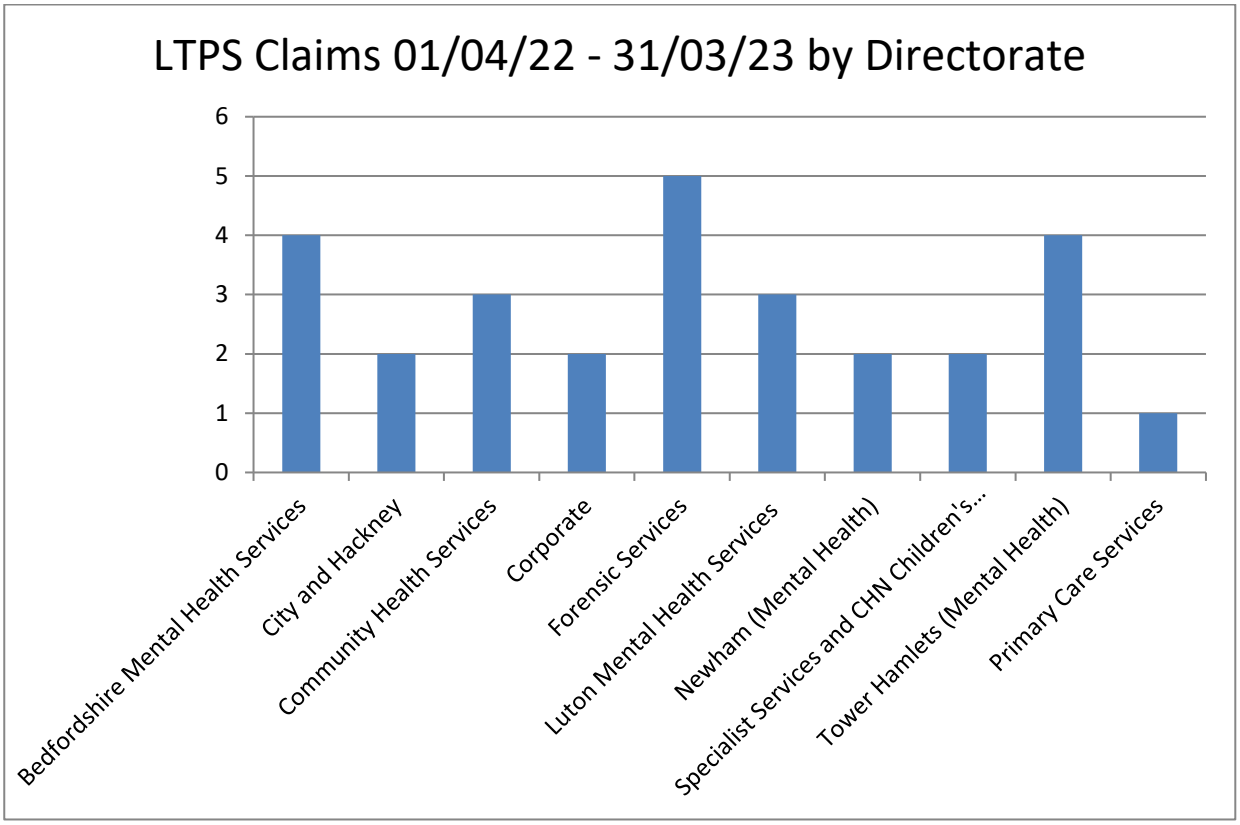
3.37 The fifth claim related to a patient's allegations that two clinicians misdiagnosed her and as a result she was prescribed incorrect medication and detained. This was alleged to have happened between 2018 and 2019. An expert report produced for the Trust concluded that there was a failure to properly assess and monitor thyroid function and to consider its importance as a possible cause of the patient's recurrent psychosis.

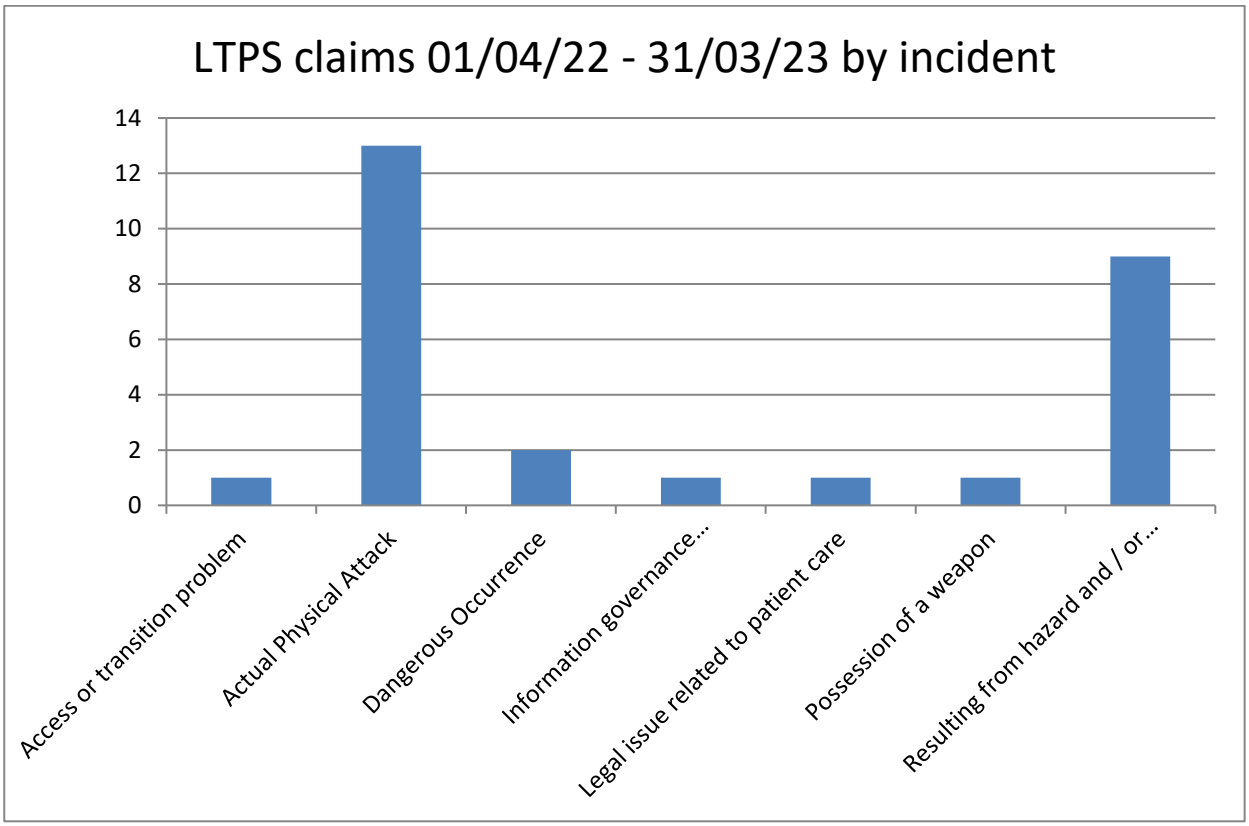
4.0 EMPLOYER LIABILITY AND LIABILITY TO THIRD PARTIES (LTPS) CLAIMS

4.1 LTPS claims received between 1st April 2022 and 31st March 2023.

4.2 Between 1st April 2022 and 31st March 2023, 28 claims were received under the LTPS scheme. This compares to 23 in the previous financial year 2021/22.

4.3 The graphs below show the claims received during this period broken down by type and Directorate respectively.



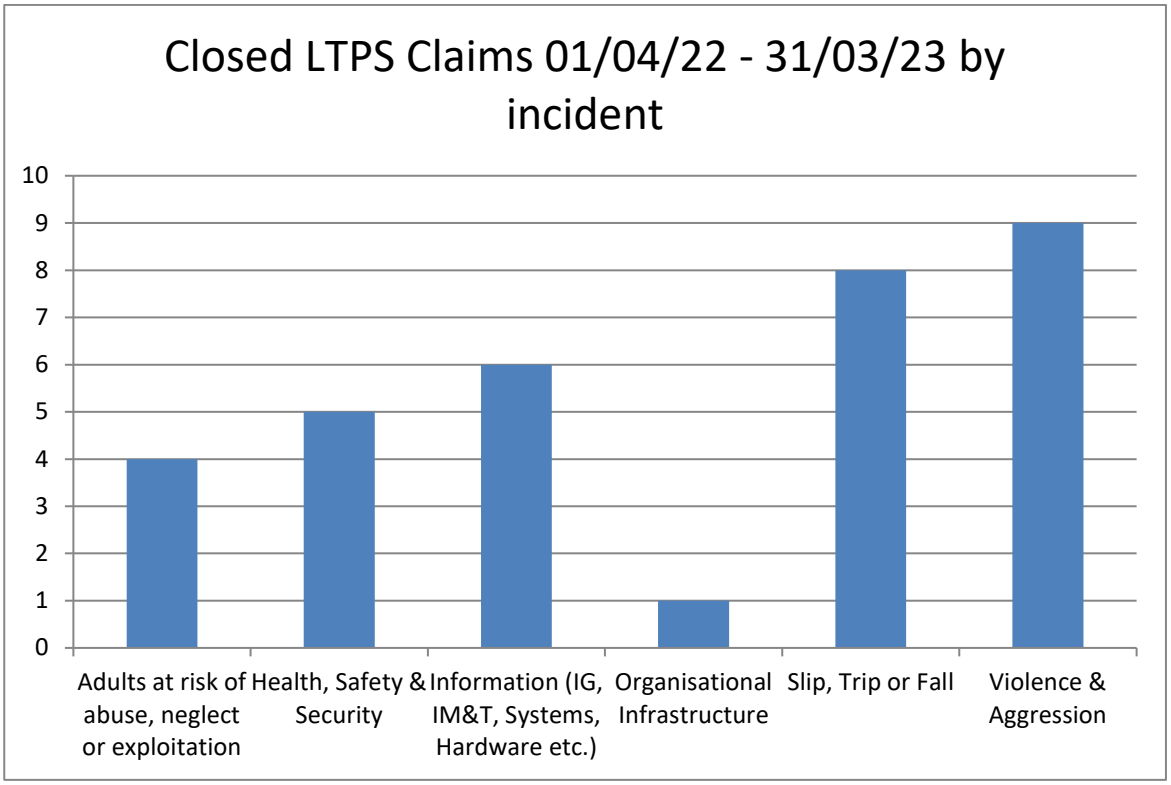


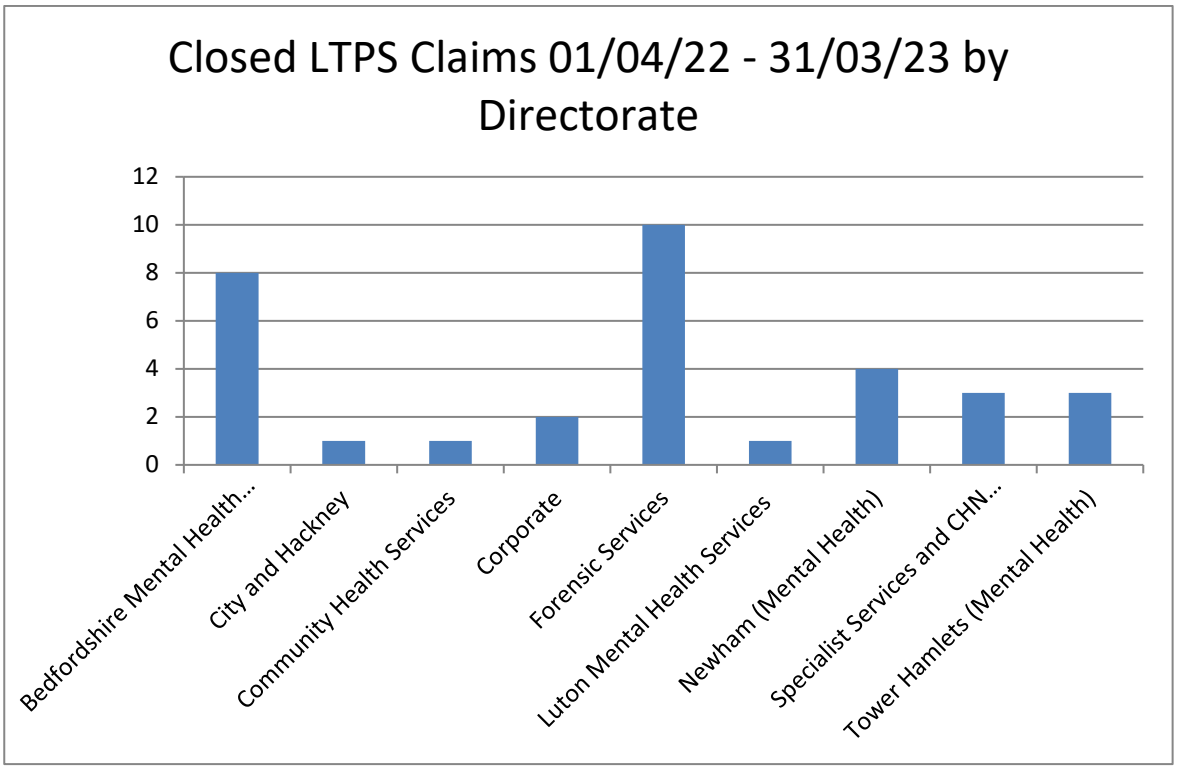
4.4 The highest number of claims received during this period were for actual physical assaults (13 out of 28).

4.5 Outcome of LTPS claims closed between 1st April 2022 and 31st March 2023.

4.6 Between 1st April 2022 and 31st March 2023, 33 claims were closed under the LTPS scheme.

4.7 The graphs below shows the number of claims closed during this period by incident type and Directorate respectively.





4.8 Following the investigation of these cases liability was denied in 14 matters as investigation showed no breach of duty.

4.9 Total value of LTPS claims closed between 1st April 2022 and 31st March 2023.

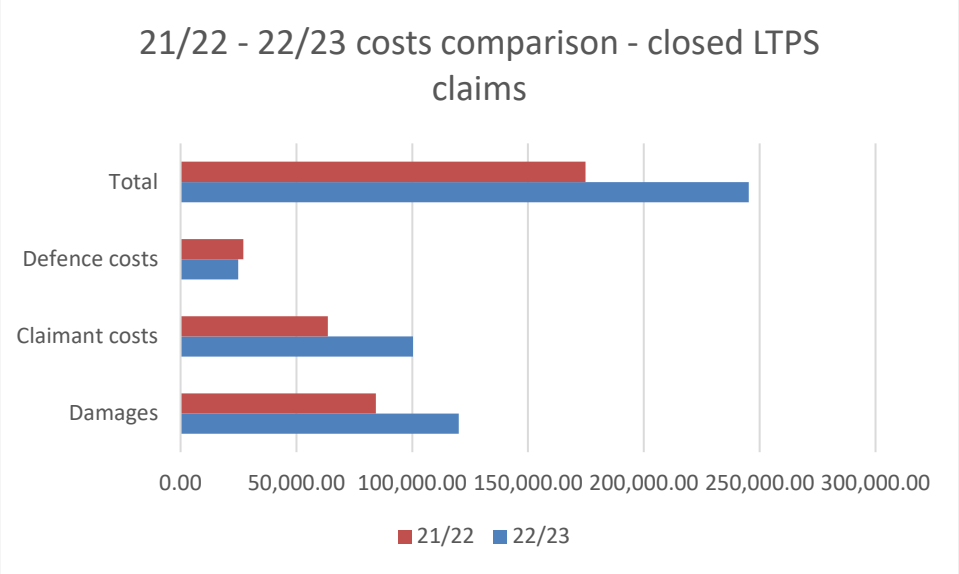
4.10 The Trust pays an Excess on LTPS claims. This is £10,000 for staff claims and £3,000 for other LTPS claims.

4.11 The number and value of claims each year has an impact on the Trust's contribution to NHSR's LTPS scheme the following year.

4.12 The total estimated value of the LTPS claims closed between 1st April 2022 and 31st March 2023 is £245,252.75. This is comprised of:

Damages- £120,094.50
Claimant legal fees - £100,344.15
Defence legal fees - £24,814.10

4.13 The below graph shows the year-on-year change from 2021/22 – 2022/23 in terms of the various cost categories.



4.14 Qualitative information regarding LTPS claims brought against the Trust.

4.15 The top three categories of all 35 open LTPS claims (including those opened between 01/04/22 and 31/03/23) as of 12th May 2023 are, in descending order, actual physical attacks (19), hazards / health and safety issues (7) and information governance issues (4).

4.16 Actual Physical Assault

4.17 Of the 19 open claims, liability has been denied in six, settlements have been made with an admission of liability in six, settlement has been made without an admission of liability in one and the remaining six are still at an early stage. Further information about the six cases where an admission of liability has been made is given below

4.18 The first case related to a student nurse who was assaulted by a patient on 14.01.21. There was a lack of updated risk assessments and care plans. It appeared that the incident

was fairly predictable as several past incidents were triggered by the same event (when the patient was asked to take his depot medication).

4.19 The second case related to a staff member who was attacked by a patient on 14.03.20. Witness evidence suggested the response from staff was inappropriate and inadequate. Staff did not have access to an alarm in reception and this resulted in a delay in calling for help. Furthermore, an environmental risk assessment was not undertaken for the reception area at the material time.

4.20 The third case related to a patient pushing a door violently into a member of staff on 02.05.22. The patient had a propensity for violence and aggression and he was not moved to PICU until after this incident, as no bed was previously available. There were also concerns about how the patient was allowed to 'charge' at the ward entrance/exit door.

4.21 The fourth case related to a member of staff being punched in the face on 09.05.20 by a patient who had been (re)admitted on the same day, having been discharged two days previously. The clinical nurse manager felt that circumstances of his admission (informal) and his level of risk put staff (and other patients) at risk. The consultant noted that if a medical review had taken place as it should, the incident might not have happened.

4.22 The fifth case related to a member of staff who was followed into a kitchen area by a patient and assaulted on 06.01.19. The lock on the kitchen door had been broken for several weeks and was only repaired after the incident. It was not clear that adequate safeguards were in place in the interim while repairs were awaited.

4.23 The sixth case will be reviewed internally as it is suspected to be a duplicate entry.

4.24 Hazards and Health & Safety Issues

4.25 Of the seven currently open claims, liability has been denied in two cases. Two cases were redirected as the Trust is not the appropriate defendant. One case was settled without an admission of liability, and one case has been settled with an admission of liability. Further information about the case which was settled with an admission of liability is provided below.

4.26 The case which was settled with an admission of liability related to a patient who tripped over a bollard outside a Trust building on 05.03.22. The area where the incident occurred comes under the remit of the Trust. Health and Safety inspection of the area should have resulted in the bollards being made visible so that people can see them, especially in the evening. Furthermore, a definitive walkway should have been clearly demarcated from the building to the street to stop people from cutting across the car park and coming near the bollards.

4.27 Information Governance Issues

4.28 Liability has been admitted in all four of the currently open claims. It should be noted however that breach of confidentiality claims attract automatic settlement. Further information about the claims is provided below.

4.29 The first case related to a patient who had explicitly asked that information not be shared with her GP. Despite a clear ‘flag’ on her record, correspondence was sent to the GP on 05.06.18.

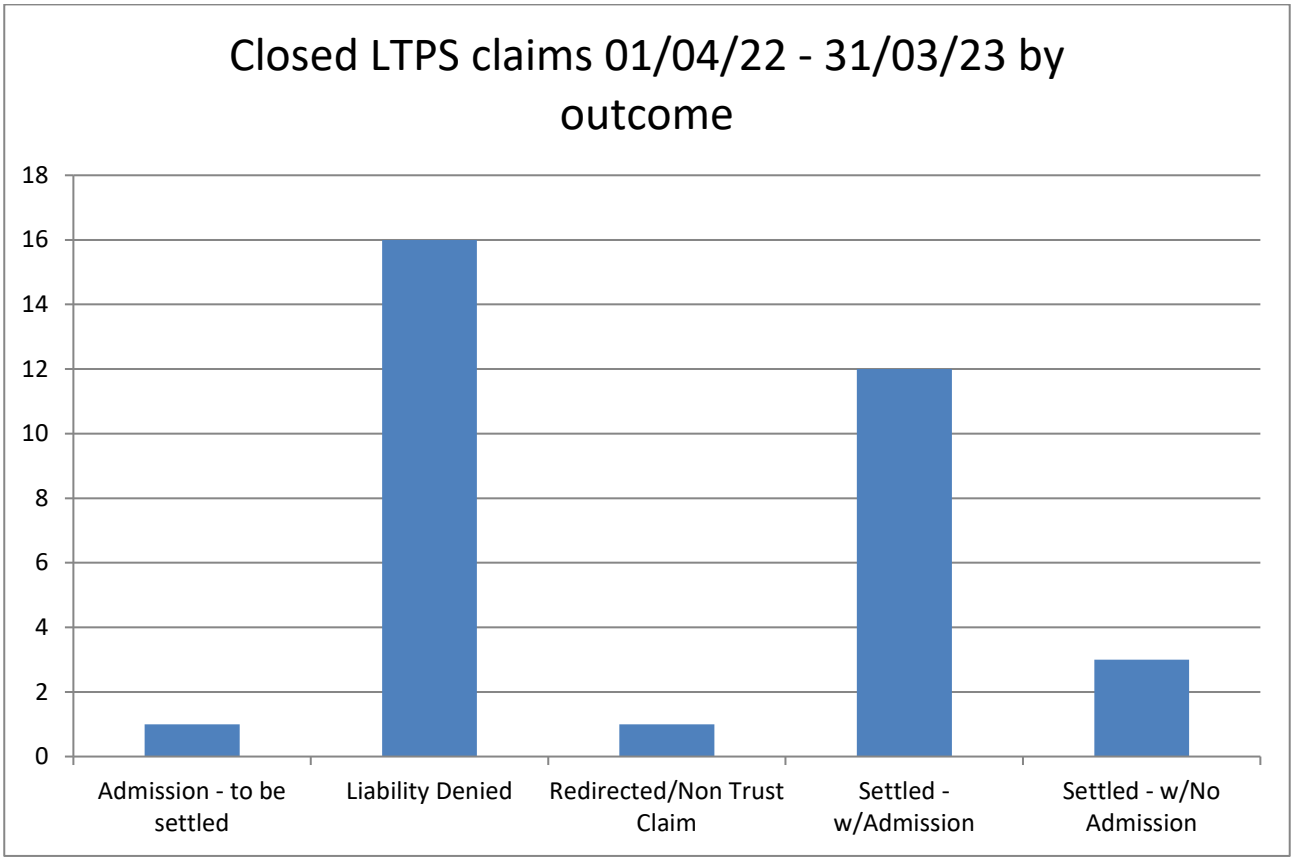
4.30 The second case related to a patient whose daughter was under the care of community mental health services. A potential referrer requested a new referral form and instead of sending

that, an employee of the Trust sent the referrer on 23.09.20 a spreadsheet that contained details of 206 children who had been referred to CAHMS.

4.31 The third and fourth cases related to a patient under the care of young person's mental health services. In May 2015, following an appointment, a member of staff wrote a letter detailing her opinion of a diagnosis she felt the patient's parents might have. This letter was then circulated to different individuals and organisations. Both the patient's mother and father made claims for damages for distress and other losses arising out of the disclosure of the patient's personal data.

4.32 Qualitative information regarding LTPS claims closed between 01/04/22 – 31/03/23

4.33 The below graph shows the outcomes of LTPS claims closed between 01/04/22 – 31/03/23.



4.34 Of the LTPS claims closed in this period for which information is available, liability was denied in 16. 13 cases were settled (or were to be settled) with an admission of liability, and three were settled without an admission of liability. One was redirected as the Trust was not the appropriate defendant. Further information about the cases which featured an admission of liability is provided below.

4.35 The first case related to a patient whose information was sent to his GP without consent on 13.04.21 following an IAPT consultation.

4.36 The second case related to an assault by a patient on a member of staff on 20.04.19. There was no documented written care plan in place, It was not documented in the daily handover that the patient was aggressive and the ward was unable to locate anything in writing that said what the patient liked or disliked and how to handle him.

4.37 The third case related to a member of staff slipping in water in a patient's bedroom on 06.05.19, while retreating from the patient (who was becoming agitated).

4.38 The fourth and fifth cases related to a member of staff accidently sending a spreadsheet containing patient information to a third party on 05.03.21. He immediately called the third party to delete the email. 85 patients were affected.

4.39 The sixth case related to the mother of a patient under the care of community mental health services. A potential referrer requested a new referral form and instead of sending that, an employee of the Trust sent the referrer a spreadsheet on 23.09.20 that contained details of 206 children who had been referred to CAHMS (NB – the patient subsequently brought a claim arising from the same circumstances, which is currently 'open').

4.40 The seventh case related to a member of staff who was sexually assaulted by a patient on 27.04.19. The patient should have been on a higher level of observations or given additional medication to prevent the incident. It was also noted that the handover notes were missing.

4.41 The eighth case related to a member of staff who was sexually assaulted by a patient during a yoga class on 08.03.19. The member of staff received a risk handover for each patient but was not informed that two days prior the patient had grabbed a female nurse's bottom.

4.42 The ninth case related to a member of staff who was assaulted by a patient on 20.02.21. The patient was not being nursed in the correct environment, and the incident could have been prevented had the correct forms of risk management and the management of violence and aggression been followed. It was also noted that no verbal handover regarding risk was given.

4.43 The tenth case related to a member of staff who was assaulted by a patient while transferring them on 17.08.17. The member of staff was alone with the patient, but the patient's level of risk should have merited another member of staff being present.

4.44 The eleventh case related to a patient whose finger was severed above the joint closest to the fingertip by an office door on 11.08.20. Liability was admitted as CCTV showed a staff member closing the door, and the alleged injury was consistent with contemporaneous records. Furthermore there was no separate risk assessment for the door.

4.45 The twelfth case related to a male patient entering a female patient's room on a mixed ward during the night of 28.02.18 and sexually assaulted her. Liability was admitted as the patient was known to be a risk to others and a subsequent plan to admit them to a male ward was not followed. The service was also understaffed.

4.46 The thirteenth case related to a young child who alleged a data breach had taken place in November 2021 and January 2022 after a staff member shared his personal information with his school without his permission.

5.0 Learning from claims

5.1 It is important to note that all the incidents leading to LTPS and CNST claims have been reviewed by the Risk and Governance Team. The level of review is dependent on the seriousness of the incident (in line with NHSE guidance). If the incident resulted in an unexpected death an additional investigation is undertaken by the Coroner's Court as required by statute. There, considerations of whether there is a risk of future death will also be considered by the Coroner. If they have concerns such a risk exists they will issue a Prevention of Future Death (PFD) Report. The Trust has 55 days to respond to a PFD updating the Coroner outlining learning and actions taken. Therefore, significant learning processes have often taken place before an incident becomes a claim.

5.2 It is important to remember the outcome of a claim is only determined several years post incident. Therefore, additional learning is sometimes only apparent after that process has taken place.

5.3 The Legal Affairs Team have identified opportunities for further learning to build upon the processes outlined above. To this end, we have set up the following intitiatives:1) regular ad-hoc meetings with the Associate Directors of Information Governance, Governance and Risk and Estates; 2) the Director of Patient Safety will be attending the end of the weekly Tuesday Legal Affairs Meeting for a brief huddle to discuss learning; 3) either the Interim Associate Director of Legal Affairs or the Trust Solicitor (depending on availability) will attend the Patient Safety Forum to discuss the standing agenda item, 'learning from inquests' though it will be proposed that this is changed to 'learning from inquests, claims and Trust legal proceedings; 4) there are regularly scheduled huddles with the Interim Associate Director of Legal Affairs and the Associate Directors of Governance and Risk, Information Governance and Mental Health Law; and 5) there is an away day with Patient Safety and Governance and risk to discuss best practice incident management from incident to inquest or claim.

5.4 The goal of this work is to develop robust systems for sharing the information learned from claims with the Director of Patient Safety and the Risk and Governance Team to better inform their planning.

6.0 Action being requested

6.1 The Quality Assurance Committee is asked to RECEIVE and DISCUSS the findings of the report.

NHS
East London
NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE
26 JUNE 2023

Title	Medical Education Report
Author	Prof. Frank Röhricht, Medical Director R&I and Medical Education Neetu Klair, Head of Medical Education & Medical Staffing
Accountable Executive Director	David Bridle, Chief Medical Officer

Purpose of the report

The purpose of this report is to highlight key updates of relevance to the board regarding medical education
This report is presented for information/ assurance purposes.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Key messages

This report highlights our key achievements, challenges, quality interventions (internal and externally run) that have taken place in the last year. Progress has been made with the development of physician associates, students from abroad and medical education's contribution to the Academy of Lived Experience.

Whilst significant progress has been made, we are aware of certain challenges addressed by doctors in training and this report highlights how we are working with service leads to reduce these, and highlights key focus areas for the year ahead including additional Physician Associate posts, development of a multi-professional simulation faculty and establishing structured support for international medical graduates.

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) and Cambridge University. Plans to expand the undergraduate teaching in collaboration with internationally operating medical schools are under way.

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 ELFT employs GPs within the GP practices that it runs and in clinical or managerial and leadership roles within community services. Currently this number is about 14 but this is set to grow. Additionally, we work in partnership with the GPs in East London and Bedfordshire.

1.5 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.

1.6 Medical Education’s USP:

2.0 Report Content

2.1 The purpose of this report is to highlight to the committee key updates within medical education for information

3.0 Achievements in the last year

3.1 **First cohort of University of Nicosia international students**: ELFT has successfully supported the first rotation of medical students from the University of Nicosia. Students were clinically supported by a consultant psychiatrist from the Community Integrated Mental Health Service team in the Newham locality. End of placement feedback is positive, with students highlighting placement opportunities and clinical placement support as 'very good'.

3.2 **Physician Associates (PA):** With the support of the Physician Associate Ambassador, we have been able to employ 5 PAs within the Trust across Forensics, Learning Difficulties, Child and Adolescent MH Services (CAMHS) inpatient and Attention deficit hyperactivity disorder (ADHD) service. We are now looking to recruit four additional posts in Memory services, CAMHS Eating Disorders, Child Development Service (CDS). The following has been developed to support placements:

a) 2-day Induction programme and pack
b) Introduction of Inceptorship style programme with protected time for Monthly CPD teaching with simulation sessions, Communication Skills Training and mindfulness sessions
c) Trainer development for supervisors
d) Evaluation of PA programme to promote across the Trust

3.3 **Academy of Lived Experience (ALE)**: utilises the skills and knowledge of our service users and carers to train and develop staff through best practices. ALE aims to support people with lived experience in their educational development through training, support and payment.

3.4 ALE expands on ELFT's innovative work with Medical Education and is working to strengthen partnership collaboration with clinical partners and external organisations and developing work across all services and professional groups in the Trust.

3.5 The Academy of Lived Experience provides an excellent opportunity for service users and carers to develop, and gain skills and confidence for future opportunities like employment and education.

3.6 Through ALE we are aiming to achieve successful outcomes for everyone involved including:

- Enhanced staff/student learning and development
- Improved staff/student/Lived Experience Expert satisfaction and opportunity
- Multiple benefits for service users including confidence building, better recovery prospects, learning new skills, employment opportunities as well as enhanced care.

4.0 Challenges

4.1 **Redistribution of Training posts**: This programme is about addressing health inequalities by reviewing and aligning specialty training placements to the areas of greatest need across England. The aim of this work is to ensure there is a more equitable distribution of training places and therefore more fairly distributed medical workforces across the country. This will have significant impact on ELFT services and the reduction of training opportunities available in ELFT's London service

4.2 The transition of training posts out of London will be phased over the next 5 years, and we have already started to see the reduction of some higher trainee and GP training posts (5 in total) converting to time limited posts with an end date in 3 years' time, with more expected to convert in the coming years.

4.3 By way of mitigating the impact of this, we are working with clinical leads to explore the possible impacts and reviewing job roles within teams to see how they can be managed differently. The additional workforce of Physician Associates can help with this.

4.4 We are however making significant process with trainee expansion of time-limited posts, particularly in Luton and Bedfordshire (10 additional posts over the last 2 years), as well as an additional Psychotherapy Higher trainee post, which is the first of its kind in ELFT.

5.0 Formal Quality Interventions

5.1 Throughout the year, there have been a number of quality interventions facilitated by Health Education England (HEE) who have made visits to meet with trainees in Tower Hamlets, City and Hackney and the Coborn Unit, following the 2022 General Medical Council GMC) National Trainee Survey (NTS) results.

5.2 Feedback from these visits have resulted in significant changes within the localities to improve the experience of doctors in training. Innovations have been made, such as greater educationally focused trainee-trainer meetings which emphasise the learning needs as well as service needs, in-situ Physical Health Multi-Disciplinary Team Simulation Training, monthly safety huddles to ensure safety of all staff visiting wards they are unfamiliar with, and improved access and space for psychotherapy supervision.

5.3 Whilst significant improvements have been made, we are working closely with service leads to regularly review the training experience and work with trainees to further improve the quality of training experience they receive.

6.0 Plan for Coming Year

6.1 **Physician Associates (PA):** Further development of additional Physician Associates across the trust. This workforce can support with holistic patient care and support with pressures faced by the medical workforce.

6.2 **Simulation**: Develop ELFT's definition of Simulation including what we would want this to look like and how we can incorporate it in MDT settings. Whilst initial support for simulation development within MDTs is very positive, we will be working with the Simulation lead and Education leads for other professional staff groups across the trust to develop a multi-disciplinary simulation faculty.

6.3 **Experiential Learning**: Further development and innovative training in collaboration with the Academy of Lived Experience in collaboration with Drama and Arts therapy.

6.4 **Supporting International Medical Graduates (IMG)**: Develop a tailored induction to support the needs of IMG Doctors , which may differ from those who graduated and trained in the UK. Provide training for supervisors on differential attainment training (the unexplained variation in attainment between groups who share a protected characteristic and those who do not share the same characteristic, for example, ethnicity, gender and disability), and safe orientation to the NHS and ELFT.

6.5 **Identifying required Support for Primary & Community Care Medical staff**: The Medical Education team's focus has predominantly been towards those working in the Mental Health services historically (which is where the majority of the medical staff and medical trainees are based in the Trust). However, in the year ahead the needs of the wider medical workforce in the Trust will be reviewed and consideration given as to how this is incorporated within existing medical education functions.

7.0 Action Being Requested

7.1 The Board/Committee is asked to: **RECEIVE** and **NOTE** the report

NHS
East London
NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE
26 June 2023

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, and dovetailing research with QI (Quality Improvement).

Committees/meetings where this item has been considered

Date	Committee/Meeting
15 Jun '23	Research Committee

Key Messages

Over the past year, enrolment into research studies has returned to pre-COVID levels, and ELFT was the highest recruiting community and mental health Trust in the North Thames region. We have increased the number of studies active in the Trust and the number of services who are engaged in research. However, the proportion of our portfolio related to mental versus community healthcare remains disproportionate to the services we provide.

Our most notable achievement this year was the development of an organisational partnership between ELFT and the University of Cambridge (Primary Care Unit) with subsequent execution of an agreement to establish a new hub for health research in Bedfordshire and Luton, aiming to help improve patient care in primary and community healthcare services. Through this collaboration and working with the Cambridge Institute for Healthcare Improvement (THIS) we will strive to better integrate our QI and research work to the mutual benefit of both types of innovation.

Strategic priorities this paper supports

Improved population health outcomes	☒	Research based in the Trust can facilitate the understanding of factors affecting 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 enable 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 for all.
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 three 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, 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 While enrolment of individual participants into research studies has returned to pre-COVID levels, the number of different research studies that were active during 2022/23 remains lower than in the pre-pandemic era. However, increased attention to feasibility assessment of each study, appropriate delegation, and consistent monitoring of progression has meant that we have successfully recruited to all the studies we have set up at ELFT. Our consistent performance on studies has meant that we have been asked to consider other projects from the same teams.

2.2 At the beginning of the year, certain services hesitated to approve any research in their service. However, through discussions with the service leads, careful consideration about the type of studies these services can support, and allocation of adequate resources (CSOs),[1] we managed to get our foot through the door without interfering with their workload. We now have successful engagement from new services and healthcare professionals, e.g. Newham talking therapies, memory clinic, eating disorder, and learning disabilities services. This has also meant that we could provide research opportunities to new patient populations.

2.3 Last year, 76% of the Trust's portfolio of recruiting studies were badged as mental health, an increase from 60% in 2021/22 and disproportionate to the services we provide. An objective for 2023/24 is to begin to redress this imbalance (see 3.1 below).

Fig 1: Areas of Research

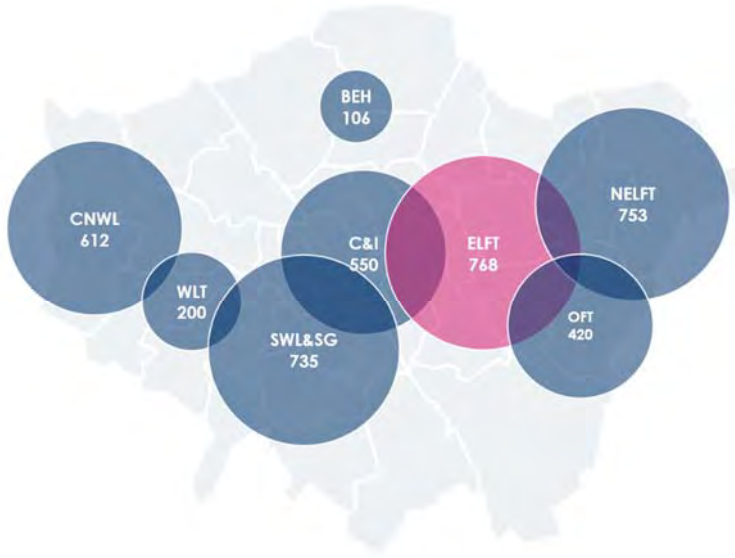
2.4 Prior to COVID, ELFT had been consistently exceeding NIHR recruitment targets and since the disruption, recruitment has increased 65% in 2 years back to pre-pandemic levels. Overall, we enrolled 768 participants into 25 studies from the Department of Health and Social Care's (DHSC) National Institute for Health Research (NIHR)[2]

[1] The CSO team is a group of research assistants, assistant psychologists and - eventually - 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.

[2] 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

research Portfolio.[3] This is 48% above the average of 518 participants recruited at other London-based trusts providing mental health services; indeed ELFT is the highest recruiting mental health trust in London (with the exception of SLAM).[4] The boost in numbers can be attributed to many things, including accurate feasibility assessments, strategic team expansion, and accountability for all studies opened up at ELFT.

Fig 2: London Mental Health Trust Recruitment Comparison[5]



2.5 Hidden in the raw figures of participants enrolled, is the significant proportion of interventional studies active at ELFT during 2022/23 as compared to observational or survey studies. Last year the level of recruitment to interventional studies increased 43% compared to 2021/22 and is 107.5% above our 8-year average.

2.6 In order to compare performance across different NHS organisations, the North Thames local CRN (Clinical Research Network)[6] converts our raw recruitment numbers into 'weighted' recruitment, i.e., enrolling a participant in an interventional study is harder than in an observational study or a survey. They then divide these weighted recruitment figures by the funding allocated to each Trust to derive a value for money KPI (key performance indicator).

---

delivers health and social care research focused on early translational research, clinical research and applied health and social care research.

[3] 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.*

[4] We exclude SLAM from peer group comparisons since it is part of the designated NIHR Biomedical Research Centre for Mental Health which means they should (and do) outperform everyone else in the nation. But they also receive over £100m investment - exponentially more than any other mental health Trust.

[5] Note that SLAM is excluded from the diagram and information above

[6] 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.

2.7 By this measure, for the first time in 2022/23 ELFT had the best value for money score among community and mental health Trusts in the North Thames CRN region, even coming in better value than many of the acute and teaching hospitals.

2.8 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[7] and from studies that fall outside the NIHR's Portfolio. 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 2022/23

3.1 **Partnership with the University of Cambridge:** Our most significant achievement is execution of an agreement to establish a new hub for health research in Bedfordshire and Luton to help improve patient care in primary and community healthcare services. The University of Cambridge and ELFT will together run the research hub, which is the first partnership of its kind for the University.

3.2 The new hub will carry out its research programmes working closely with healthcare staff in primary and community health and social care services in the area, and with the patients and carers of Bedfordshire and Luton. It will also help to bring new academic opportunities to GPs and community healthcare professionals in the area, offering training and support to help them get started on their research journeys.

3.3 The research will address some of the area's most important healthcare problems, such as frailty amongst older people as well as long-term medical conditions, and explore how primary and community healthcare can best address the needs of the local population.

3.4 **Research Grants:** While a number of grants ELFT is managing have been allowed extensions to deal with the disruption of COVID, the vast majority of those currently active will have completed by March 2024.

3.5 Since the previous report on research activity, the Trust has been awarded one new NIHR Programme Grant for Applied Research to develop and trial a highly innovative peer supported group clinic intervention intended to reduce the risk of cardiovascular disease in people with severe mental illness (PEGASUS). PEGASUS is a 5-year programme of research, funded by the NIHR, beginning in October 2023 and continuing until September 2028. The collaboration between City, University of London, Queen Mary, University of London, University of Southampton and King's College London, will deliver the programme in partnership with mental health NHS Trusts in East London, North East London, Birmingham and Solihull, and Nottinghamshire. Professors Steve Gillard and Stanton Newman at City, University of London, jointly lead PEGASUS. Emulating the integrated care systems model, this study is a collaboration of experts in acute, primary, and mental health care, and the study design was developed based upon innovative change ideas from ELFT

[7] 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).

clinicians. Prof Frank Röhricht, Medical Director, is leading for the trust as Principal Investigator (PI).

3.6 **Staff shortage and turnover** has been a persistent issue in R&I teams. This year we strategically expanded our team by asking research assistants (RAs) to be integrated into the CSO team. This meant that we had three extra staff who received and provided support to the rest of the team leading to improved job satisfaction across the board.

3.7 We also adopted several strategies to reduce employee turnover. Firstly, we mainly hired on attitude and ability to recruit into studies. We then streamlined the staff's workload so everyone was responsible for four to five studies, balanced in difficulty. We also created a positive team dynamic with team outings and office days, supported people's career plans, and encouraged a healthy work-life balance. As a result, not only did we reduce staff turnover this year, but also turned in our best performance yet (see 2.4 & 2.7 above). The appointment of a Research Delivery Manager was a very successful addition to the team.

3.8 **Training and development** is imperative. At ELFT the directorates of Medical Education and R&I are functionally aligned (one Medical Director across the two teams), enabling close collaboration with Queen Mary and City University professors. We developed the Research Skills Training Series, fortnightly training with sessions covering how to get a grant, research methodology, and various analysis techniques. These sessions are being recorded and uploaded to the R&I section of the ELFT website to create an enduring resource.

3.9 This year we also collaborated with City University to provide two MSc students with a weeklong work experience with the R&I team. Students learnt about the life cycle of a research project and were encouraged/equipped to undertake their own research project at ELFT. In line with our role as a Marmot Trust, we hope to expand this offering and extend it to local colleges and undergraduate programmes.

3.10 **Public & Patient Involvement:** A project around Advanced Directives was undertaken by PoPuLaR (Patient and Public Led Research) to explore and understand the impact of having an advanced directive in relation to a person's care. Service users lead this project by undergoing training to support developing and interviewing other services users, to get data using qualitative and quantitative research approaches. A survey was sent out to all service users in Trust and from this, one Carer's Focus Group was held and they are currently one to one interview being held to gather qualitative data to feed into the overall research project.

4.0 On the Horizon

4.1 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)[8] similar to the Discovery Project in Tower Hamlets, which is attempting to link primary, acute, mental health care and local authority data.

4.2 We are in the process of integrating two independent lived-experience expert research groups into one team, supported by both ELFT R&I and City, University of London academics in a collaborative structure. This will create career pathway stepping-

[8] Which we hope to replicate in the North East London (NEL) ICS

stones for service users and carers who want to develop skills they can use in research contexts.

4.3 Also in conjunction with City, University of London we have established a Joint Institute of Nursing work stream to increase research literacy, opportunities, and engagement of nursing staff in ELFT. As the largest professional group in the Trust, working across all clinical areas, nurses are an as yet underutilised resource to support delivery of all types of healthcare improvement studies.

5.0 Action being requested

5.1 The Committee is asked to RECEIVE and NOTE the report for information.

East London NHS Foundation Trust

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

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.

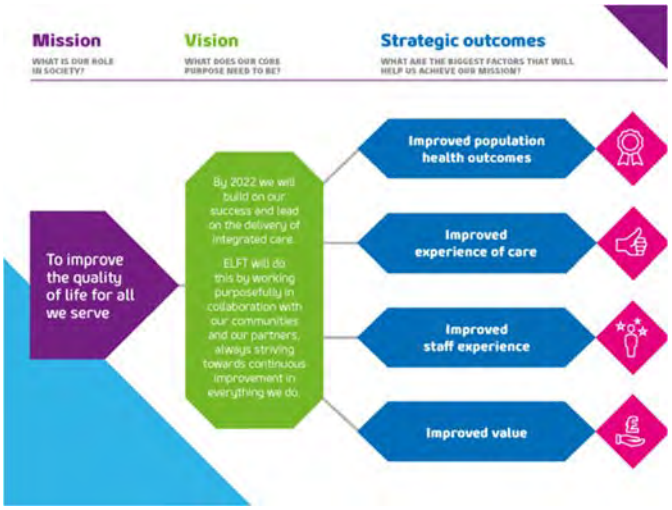
[i] References are listed in Appendix F

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]



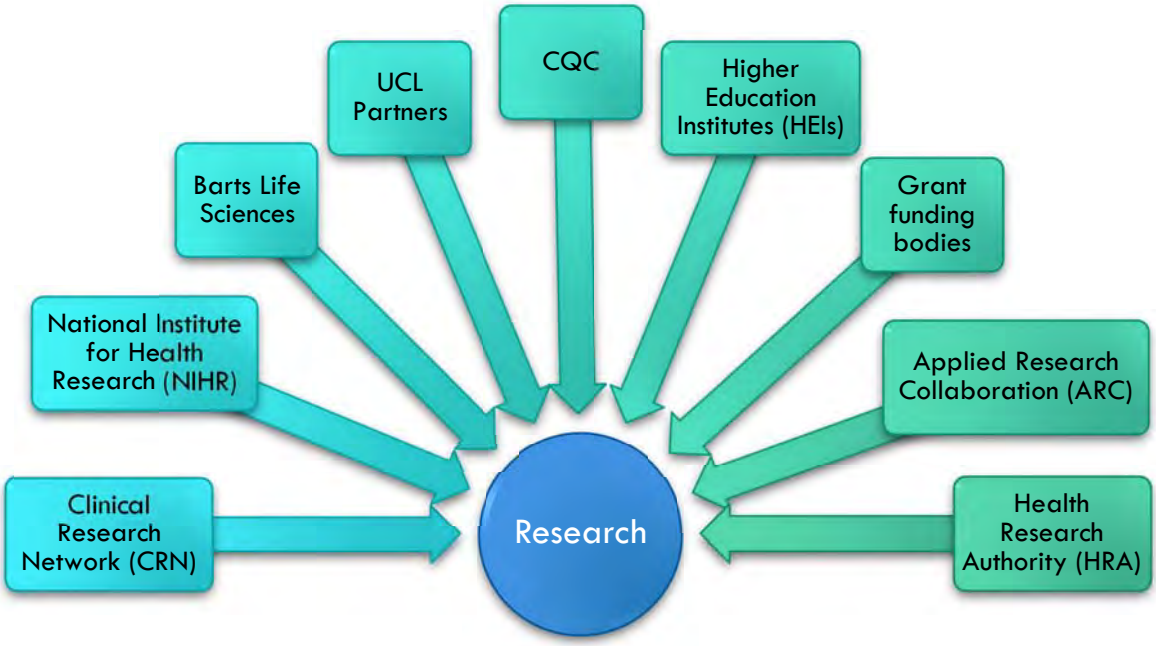
4) Research is now recognised in the NHS constitution[27] and is a key objective in NHS England's long-term plan.[32] The NIHR took this evidence to the Care Quality Commission who recognised its contribution to **improving value** and from 2019 now include questions about research in the "well-led" 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.

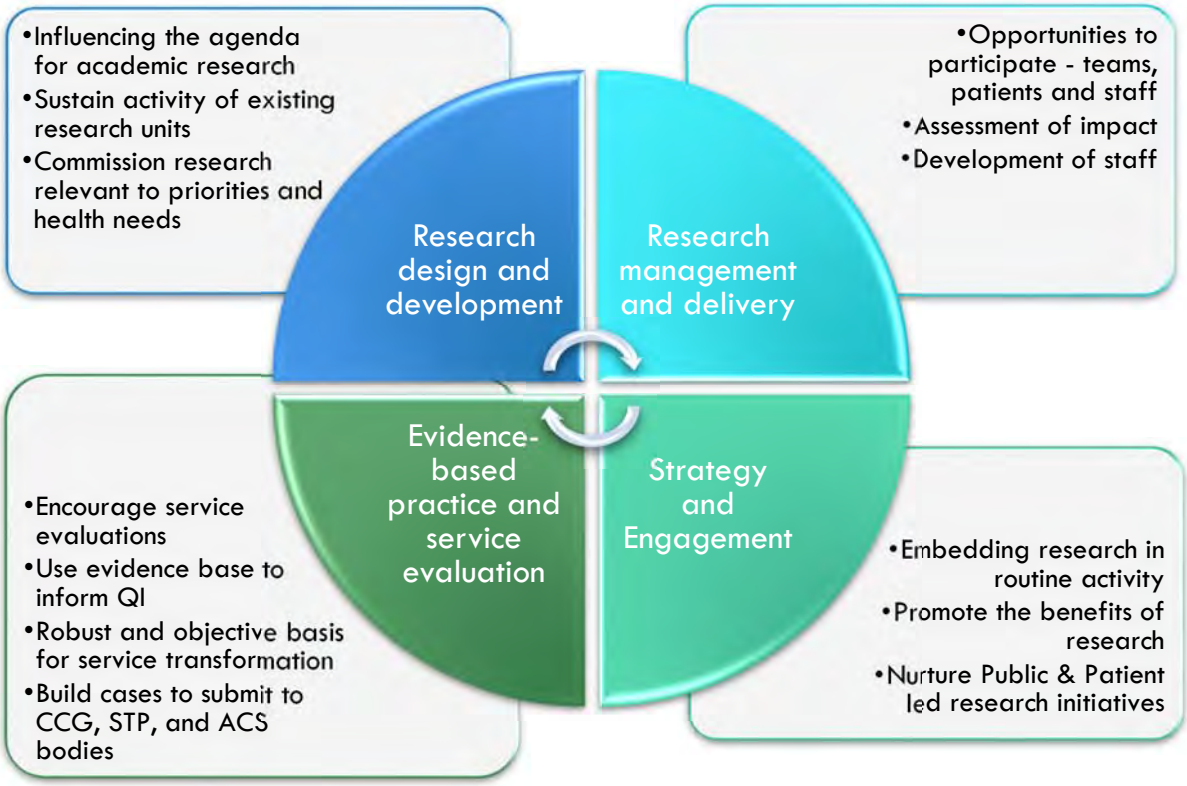
5) Finally, Research directly contributes to improve efficiencies in health economy thus helping to achieve our goal of **improved value.** Our aspiration is to ensure that the populations

[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:

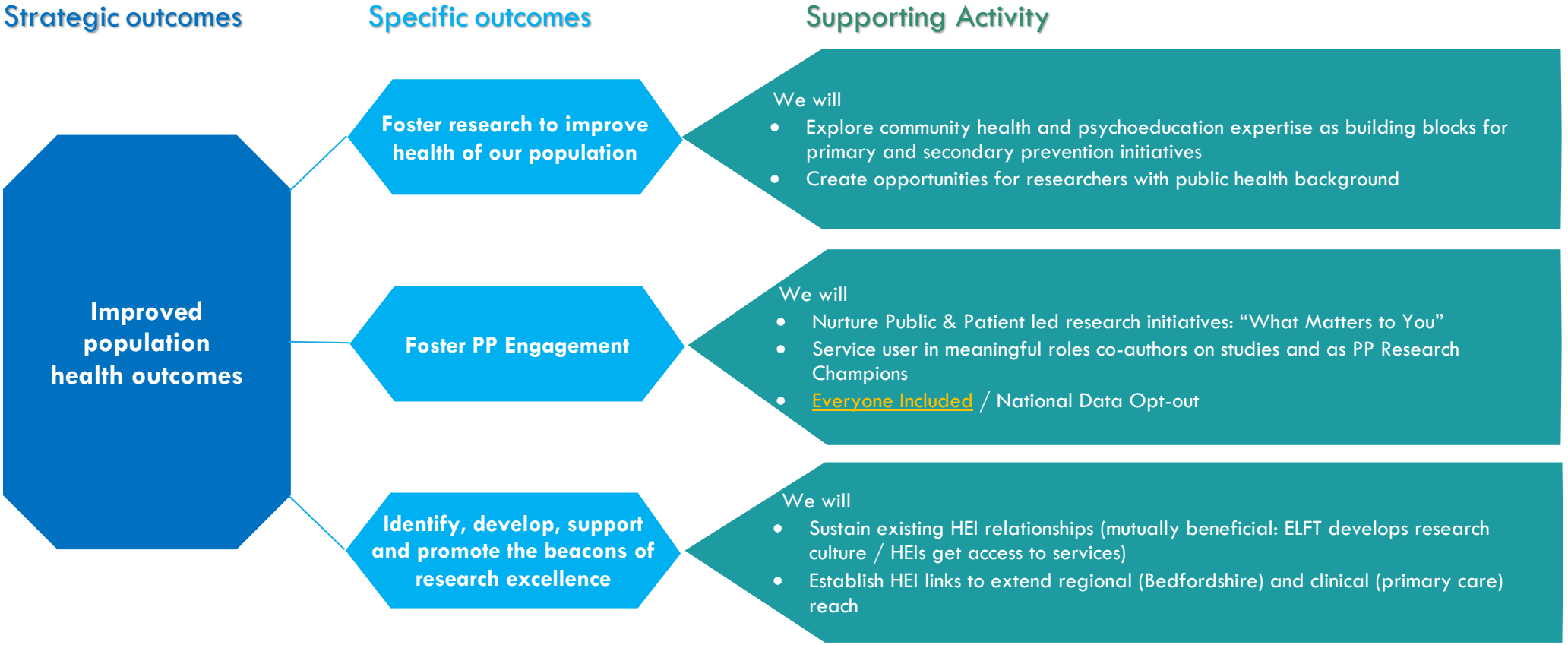
   - TRIALOG: Staff supervision tool mapped onto DIALOG tool developed from a research programme
   - Violence Prevention research grant application grew out of QI projects
   - Research on Medically Unexplained Symptoms has helped identify predictors of success in IAPT
   - Community Transformation would 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.

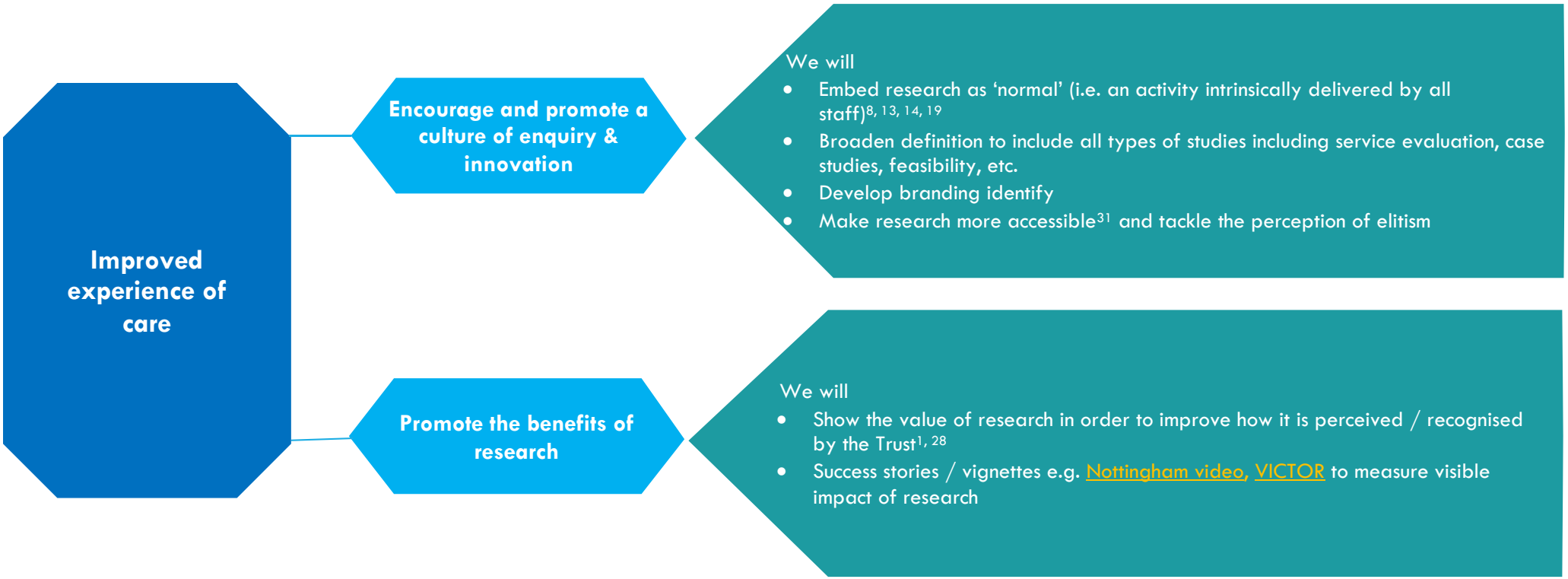
Action Plan: Transformation of Research & Innovation function

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

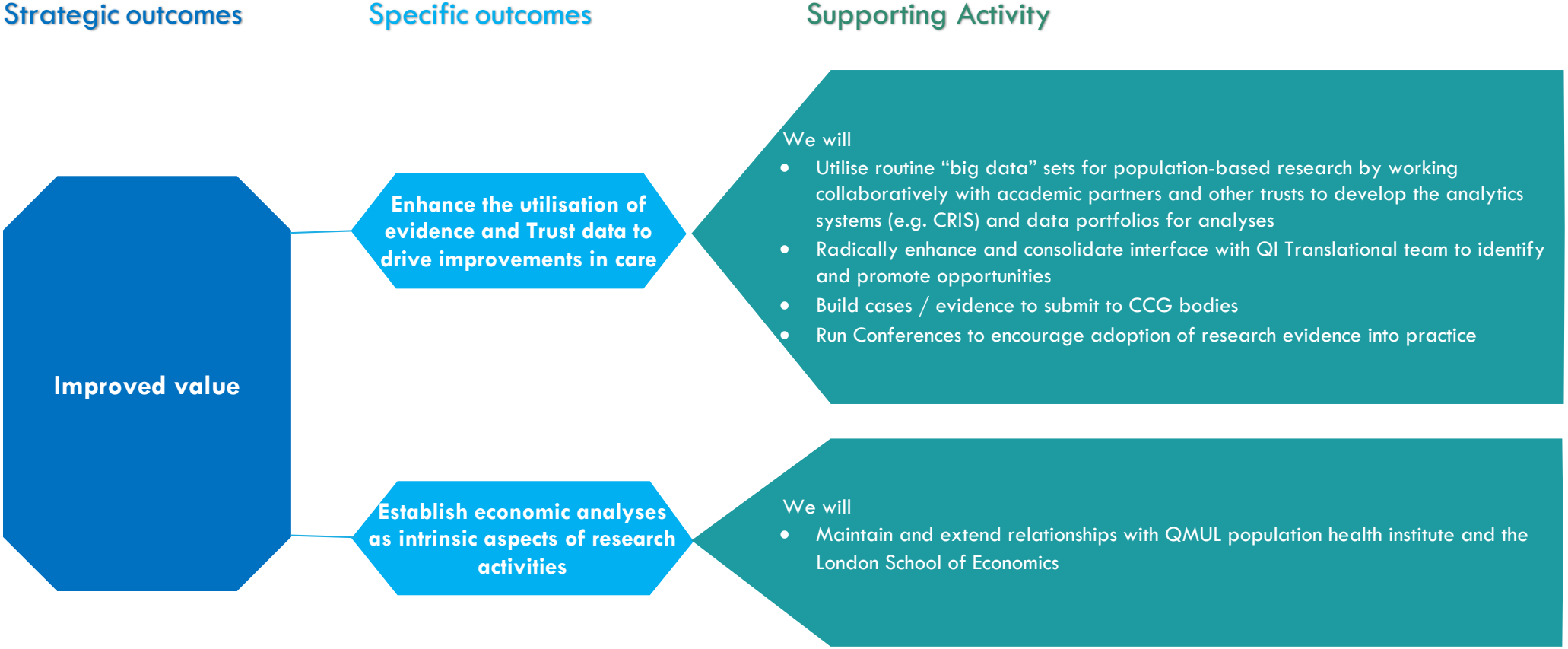


Measured by:

- Increased activity – number of active studies and number of enrolled participants

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.

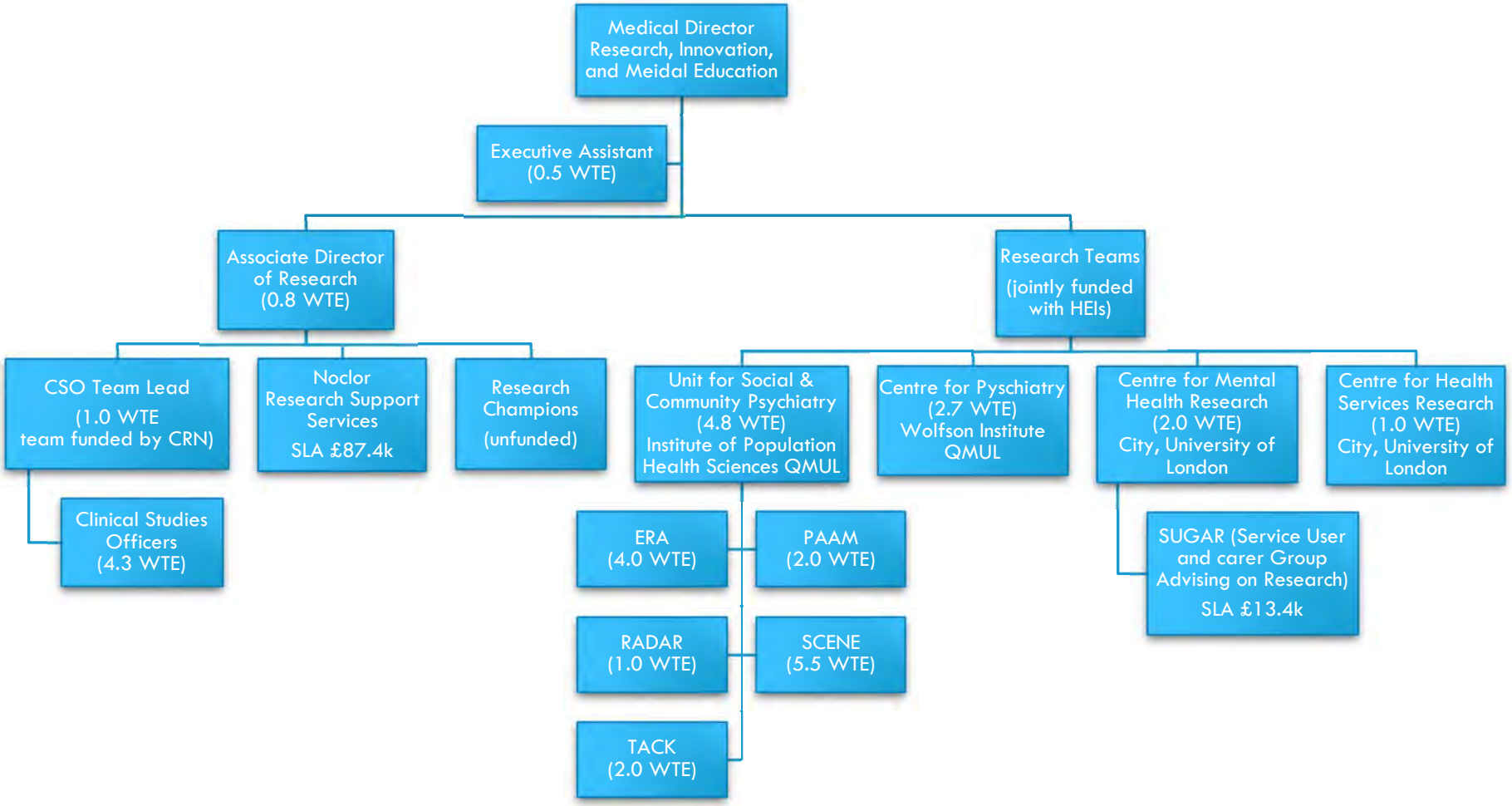
Appendix B: Current structure of Research & Innovation function in ELFT

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

1. Awaisu, A. and N. Alsalimy, *Pharmacists' involvement in and attitudes toward pharmacy practice research: A systematic review of the literature*. Res Social Adm Pharm, 2015. 11(6): p. 725-48.
2. Bacigalupo, R., J. Cooke, and M. Hawley, *Research activity, interest and skills in a health and social care setting, a snapshot of a primary care trust in northern England: Implications for collaboration and capacity*. Primary Health Care Research and Development, 2006. 7(1): p. 68-77.
3. Bateman, H., et al., *Acknowledging the contribution of nurses who support quality care through involvement in research studies*. Quality in Primary Care, 2006. 14(2): p. 71-76.
4. Bhugra et al., 2015, *EPA guidance on the role and responsibilities of psychiatrists*, European Psychiatry, 30(3): pp. 417–422
5. Boaz, A., et al., *Does the engagement of clinicians and organisations in research improve healthcare performance: a three-stage review*. BMJ Open, 2015. 5(12): p. e009415.
6. Burke, Pincus & Pardes, 1986, *The clinician-researcher in psychiatry*, The American Journal of Psychiatry, 143(8): pp. 968–975.
7. Care Quality Commission (2018) CQC *Inspection framework: NHS trusts and foundation trusts: Trust Wide Well Led* (W8)
8. Cooke, J., et al., *On-going collaborative priority-setting for research activity: a method of capacity building to reduce the research-practice translational gap*. Health Res Policy Syst, 2015. 13: p. 25
9. *Delivering research for all: expectations and aspirations for the NHS in England*, Royal College of Physicians (April 2019)
10. Dellis, Skolarikos & Papatsoris, 2014, *Why should I do research? Is it a waste of time?*, Arab Journal of Urology, 12(1): pp. 68–70.
11. Downing A, et al, (2017) *High hospital research participation and improved colorectal cancer survival outcomes: a population-based study*. Gut. 2017 Jan; 66(1):89-96.
12. *Enabling NHS staff to contribute to research*, RAND Europe (2019)
13. Evans, T.W., et al., *Report of a Royal College of Physicians and National Institute for Health Research workshop – developing research capacity to ensure successful study development and delivery*. Clin Med (Lond), 2013. 13(5): p. 431-3.
14. French, C. and C. Stavropoulou, *Specialist nurses' perceptions of inviting patients to participate in clinical research studies: a qualitative descriptive study of barriers and facilitators*. BMC Med Res Methodol, 2016. 16(1): p. 96.
15. Gilbert, A., et al., *Identifying barriers and facilitators to engaging in clinical research within an NHS Therapies Department: results of a listening exercise*. J.Physio 2016. 10 p. 214.
16. Goldstein, Guerra & Regier, 2014, *Targeted research training: developing minority psychiatric investigators,* Academic Psychiatry, 38(2): pp. 191-197.
17. Gorwood, P. 2010, *French university psychiatry and research*, International Journal of Mental Health, 38(4): pp. 77–87.
18. Harrison, J.A., A.M. Brady, and E. Kulinskaya, *The involvement, understanding and attitudes of dietitians towards research and audit*. J Hum Nutr Diet, 2001. 14(4): p. 319-30.
19. Harrison, R.A., *Networking Barriers and opportunities to developing research capacity in primary care trusts: The views of staff attached to a primary care trust*. Primary Health Care Research and Development, 2005. 6(3): p. 185-189.
20. Jonker L, Fisher SJ. *NHS Trusts' clinical research activity and overall CQC performance – Is there a correlation?* Public health, 2018 Apr 1;157:1-6
21. Koelkebeck, Katja et al. *Barriers and facilitators to conducting research by early career psychiatrists: a literature review*, Global Pyschiatry 2019. 2(2)

22. McNicholl, M.P., V. Coates, and K. Dunne, *Driving towards an improved research and development culture*. J Nurs Manag, 2008. 16(3): p. 344-51.

23. Mitchell, K., L. Baillie, and N. Phillips, *Increasing nurse and midwife engagement in research activity*. Nurs Stand, 2015. 29(23): p. 37-42.

24. Moore, J., K. Crozier, and K. Kite, *An action research approach for developing research and innovation in nursing and midwifery practice: building research capacity in one NHS foundation trust*. Nurse Educ Today, 2012. 32(1): p. 39-45.

25. National Institute for Health Research (2019) Research participant experience survey

26. *National Survey of Local Innovation and Research Needs of the NHS*, commissioned by The AHSN Network in partnership with NHS England and the NIHR (April 2019)

27. NHS England. The NHS Constitution for England. NHS, 2015.

28. Rahman, S., et al., *Physician participation in clinical research and trials: issues and approaches*. Adv Med Educ Pract, 2011. 2: p. 85-93.

29. Roberts, R., et al., *Clinical research should be a priority in the NHS - but what do genito-urinary medicine clinic staff think?* Int J STD AIDS, 2015. 26(2): p. 107-12.

30. Silberman et al., 2012, *Recruiting researchers in psychiatry: the influence of residency vs. early motivation,* Academic Psychiatry, 36(2): pp. 85–90.

31. Snooks, H., et al., *What are the highest priorities for research in pre-hospital care? Results of a review and Delphi consultation exercise*. Journal of Emergency Primary Health Care, 2008. 6(4).

32. The NHS Long Term Plan, *Research and innovation to drive future outcomes improvement* (2019)

33. Tinkler, L., et al., *Professional identity and the Clinical Research Nurse: A qualitative study exploring issues having an impact on participant recruitment in research*. Journal of Advanced Nursing, 2018. 74(2): p. 318-328.

34. Van't Hoff, *Why are NHS trusts not doing more research?* **HSJ** (Oct 2019)

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 TRUST BOARD IN PUBLIC
27 July 2023

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.

Key messages

The quality assurance section of the report dives into the six habits and practices of happy, healthy teams that emerged from our work on developing a leadership framework across ELFT. The report describes current progress, oversight mechanisms and future plans across these six practices (supervision, away days, huddles, use of data, people participation and quality improvement). As we work to implement the leadership framework across the organisation, this work will continue to be reported through to the People & Culture subcommittee of the Board.

The quality improvement section of this report provides assurance on delivery of the annual QI plan for the Trust, which supports delivery of the Trust strategy. A second phase of the 'Pursuing Equity' programme will be designed and delivered in 2023-4. The first phase has already seen results in areas such as cervical and breast cancer screening, access to psychological therapies for BAME service users, and increased attendance at BAME groups. Phase two will build on these successes, with an increased focus on systematic application of the QI method, service user involvement and data-driven decision-making on equity issues contained within directorate annual plans.

The Inpatient Quality and Safety programme aims to improve people's experience of inpatient care, through focusing on therapeutic engagement and observations, embedding trauma-informed care and reliable implementation of the safety culture bundle. Teams are currently testing a broad range of change ideas focused on improving therapeutic engagement and the observation process. Bedfordshire and Luton inpatient wards are already seeing an increase in completed observations.

Strategic priorities this paper supports

Improved population health outcomes	☒	Triple aim and large-scale QI programme on pursuing equity
Improved experience of care	☒	QI approach to tackling waits and flow
Improved staff experience	☒	Supporting the development and application of improvement skills in daily work
Improved value	☒	Most quality improvement work enhances value through improving productivity and efficiency, with a minority of work focused on reducing spend or improving environmental sustainability

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

1.1. The quality assurance section of this report follows from last Board's discussion about the work that is being undertaken on leadership and culture at ELFT. Through the series of conversations across the Trust, a set of six habits and practices emerged as being related to well-led, happy and healthy teams (see below):

1.2. These six practices and habits, identified by our staff and service users through the co-design process, show a strong interconnection with the areas of focus set out in the November 2022 quality report to help prevent closed cultures developing at ELFT. Creating ways to listen and involve people with lived experience in understanding and improving quality of care (people participation); involving a range of people in identifying and working through complex quality issues in a systematic way (quality improvement); utilising data to inform decision-making; creating a range of safe spaces that enable people to build meaningful relationships and reflect openly (huddles and check-ins, away days, supervision) all contribute to the creation of a culture that supports safe, high quality, continuously improving care. This report explores the systems and processes in place to support these six habits and practices across ELFT teams, and further work that might be required in order to embed them more reliably.

2. Regular supervision

2.1. All trust staff are expected to receive management supervision. Clinical staff will receive professional/clinical supervision in addition to management supervision. The content and duration of supervision may vary according to the job and the needs of the individual. Within the Trust supervision policy, the Trust has set minimum standards which relate to both management and professional/clinical supervision:

- Managers and clinical/professional supervisors to have been trained in supervision
- Written supervision contracts agreed by both parties, and reviewed on a regular basis – to include expectations, goals, boundaries, rights and responsibilities, methods of recording and confidentiality
- One-to-one management supervision to take place at least monthly
- Clinical/professional supervision to take place at least every eight weeks, which may be in a group setting

2.2. The recording and monitoring of supervision, and assurance that all staff are receiving regular supervision, is carried out locally within directorates. It is evident that there is some variation in the approach to this across directorates. However, all directorates do collate and report on supervision locally at Quality or Management meetings, are aware of areas that require improvement and have appropriate actions in place. Oversight of supervision practice largely focuses on the frequency of meetings, rather than other standards within the policy.

2.3. The Trust has put in place a Project Group, chaired by the Chief Nurse & Deputy CEO, tasked to improve the provision and experience of supervision across all professional groups. The project group has representation from all professional leads, and has developed a programme of work with multiple elements.

2.4. The Trust has developed and tested an innovative approach to managerial supervision based on the DIALOG+ methodology. The TRIALOG tool measures work-related quality of life, enabling the supervision to focus on the areas that will most benefit the supervisee. Measuring work-related quality of life in a structured way also allows the supervisor and supervisee to view data over time, to understand impact and long-term wellbeing of the individual.

2.5. A range of training materials, courses and user guides are being designed which will support staff and new starters. The project group is also working on improving our ability to report in real-time on the provision of supervision. Most of the functionality and resources will be made available through our new e-learning platform, and is aimed to be implemented by the end of 2023. In the meantime, the training and development team are working with directorate performance leads to ensure that supervision data is made available, and reported to the People Plan delivery board.

3. Regular away days

3.1. Away days provide an opportunity for a team to have protected time away from daily work, as a whole team, to reflect, plan, connect and learn. Away days have been an important part of how ELFT operates for over a decade, and there is strong evidence for their effectiveness on staff engagement and team performance. However, there remains variation in the frequency with which teams have away days, and how away days are utilised. All directorates report that their services are expected to have regular aways days. Expectations regarding the format of away days varies across directorates, and between different types of services.

3.2. From conversations across the Trust in exploring this topic, frequency of away days varies from annually to 8-weekly. Typically, in-patient services are expected to have more frequent away days. The objectives and content of away days are largely determined by

the services themselves. Content will be focused on specific needs, and teams will sometimes seek support from the Organisational Development team to address more complex challenges.

3.3. Directorate management teams describe a set of expectations around how away days will be used, and the types of issues they will address. These vary a little between directorates, but common features are:

- Reflective practice and learning (i.e. from incidents, complaints, other feedback)
- Celebration and learning from what is going well
- Forward planning
- Team building and social connection

3.4. The conduct of away days is not monitored centrally or at directorate management level, but at the operational leadership level. Operational leads will often support teams with away days and will monitor that they take place. As part of our implementation plan for the new ELFT leadership framework, we will be working with professional and clinical leads across the Trust to standardise the frequency of away days for different types of services, develop a way to record away days so we can more easily spot teams that are not having reflection time on a regular basis, and creating clearer guidance about how to design and conduct effective away days. This work has already begun for mental health services, led by the directors of nursing and nursing leadership teams within directorates.

4. Huddles and check-ins

4.1. Huddles were first introduced at ELFT in 2012 as part of the safety culture bundle, developed and tested across inpatient wards as one of four interventions to predict and prevent incidents of physical violence. Specific safety huddles continue to be conducted daily in inpatient settings to discuss issues related to flow, safety, staffing and staff wellbeing. Huddles also take part at various levels of the organisation, from ward-level, to unit-wide daily huddles, to a weekly Trustwide directors' safety huddle. This cascading series of huddles, with relevant information flowing upwards, is seen as best practice.

4.2. The widespread shift to virtual working at the start of the pandemic led to the adoption of huddles in many community-based teams that had previously not utilised this approach of bringing the whole team together, for a short, structured conversation aimed at problem-identification, problem-solving and escalation. Most teams now have some form of in-person or virtual 'huddle' or 'check-in' at set frequencies. There is, as would be expected, variation in the frequency and content of huddles, across different types of services. In the last two years, a number of webinars have been provided by the Chief Quality Officer to help teams understand what an effective huddle looks like, and how to utilise huddles, visual display of data, problem-solving and escalation as part of a robust quality control system to manage daily work.

4.3. It is apparent that huddles are more easily undertaken, and most frequently adopted as team practice, within the inpatient environment, where staff are generally together and can convene relatively easily, compared to community-based staff who spend much of their time physically dispersed. Some inpatient safety huddles now also include service users as well as staff.

4.4. There are a number of examples of the routine use of huddles in community settings. For example, in Tower Hamlets community mental health teams and neighbourhood teams, huddles are utilised to review and triage referrals, to review and prioritise the caseload, and to collective decide on the multidisciplinary response. Within crisis pathway teams,

huddles are utilised to check in on staff wellbeing, to review referrals and to allocate new referrals and reviews to the staff on duty. The psychiatric liaison team huddles also focus on staff wellbeing, reviewing ward referrals and allocating cases across the team.

4.5. In community health services, there are daily escalation huddles which serve to:

- provide OPEL status for demand/capacity within each team/ward
- identify any IT issues, travel concerns, information on industrial action that may impact service provision
- Share medical alerts if appropriate
- Discuss complex clinical scenarios

5. Use of Data

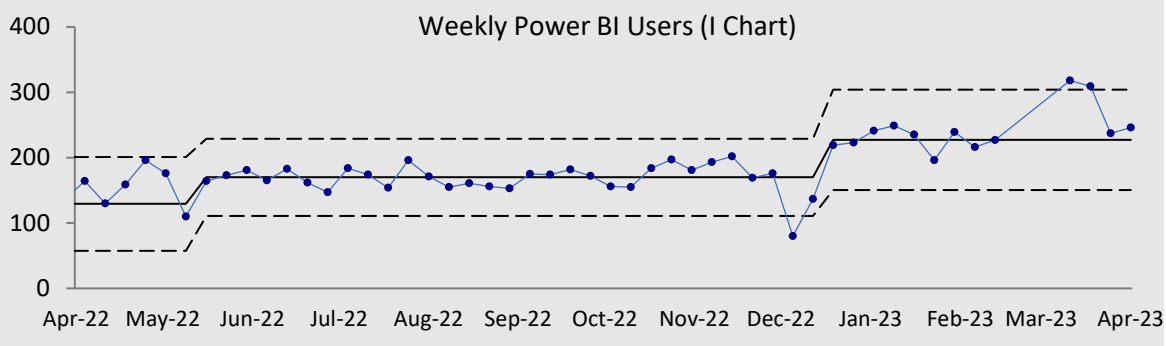
5.1. Over the last ten years, as a result of the introduction of quality improvement across all areas of the organisation, there has been a huge increase in data literacy and the routine use of data to understand variation in order to identify when to (and when not to) intervene.

5.2. At directorate management team level, there is routine use of a range of data to inform and support conversations and actions around quality, either through regularly provided management reports or through bespoke reporting on specific subjects. At team level there remains a lot of variation in both the availability of data, and the use of data to inform decision-making.

5.3. Over the last five years, a new approach to data and analytics has been developed which is aimed at making data more transparent and real-time, integrating data from different sources so that people only have to go to one place to view all their data, and to standardise the way that we view data at ELFT. This has involved the transition to Microsoft PowerBI as our business intelligence platform. Microsoft PowerBI enables all staff to view their data from any device (computer, laptop, tablet, mobile), whether on or off the Trust network.

5.4. The informatics team has been developing apps for each of the core services provided by the trust, the most mature of which is for inpatient mental health services. These apps bring together all data in one place – from our clinical record system, from the incident reporting system, from the service user feedback system, from the workforce system, from our finance system, from our learning and development platform, and many others. Each app is co-designed with clinical staff, developed, tested and refined over time. Workshops are run to help people learn how to navigate and make use of the apps.

5.5. Engagement with the Power BI dashboards is routinely monitored. Over the last year, there has been an increase in weekly PowerBI users from 130 to around 225 (see below). The informatics team have been applying quality improvement to test ideas, with the aim of reaching 400 weekly users, which would represent around 10% of clinical staff.



5.6. Our data and analytics work at ELFT is bringing new insight to teams on areas such as staffing and cost data, which we have just made available to all staff to view in a transparent way. Teams are now able to interrogate their data through equity dimensions. Teams can view their caseloads, and key tasks and clinical information, from their mobile phone. Inpatient teams are starting to utilise digital whiteboards to track inpatient tasks and data. The use of statistical process control within our data and analytics at this scale is a global innovation, attracting interest from healthcare systems across many countries. The development of further innovation, such as an inpatient early warning system based on statistical process control, contributed to our analytics work winning the Florence Nightingale award from the Royal Statistical Society in 2022.

5.7. Whilst our work in this field continues at pace, there remains much variation in both the availability of data across services and data literacy across our staff groups. A big emphasis is on ensuring all our data sources feed into our new, modernised and integrated data warehouse in the cloud, and that our informatics team transition their role towards greater support for our teams to understand and utilise data.

6. People Participation

6.1. Putting the service user at the heart of what we do has long been central to the ethos of ELFT. A well-developed infrastructure for People Participation (PP) has been crucial to delivering high quality, continuously improving care.

6.2. The ongoing strengthening of co-production and involvement in service development, leadership and delivery remains a core element of the Trust strategy. The PP team has grown from three PP Leads in 2008 to more than 140 including PP leads, Peer Support Workers (PSWs), People Participation Workers (PPWs), befrienders and admin support. As a reflection of this growth, and the Trust's commitment to continued effective people participation, the People Participation Directorate was formed in July 2022.

6.3. Each directorate now has a local Working Together Group and a People Participation lead (PPL). In practice, local working together groups are the driving force behind effective people participation, where local priorities are agreed (in line with the strategic objectives set out by the trustwide working together group), actions identified, and implementation monitored. The structure of oversight for activity and impact at local working together groups is through reporting to the trust-wide working together group, and in turn to the People Participation Committee (a sub-committee of the Trust Board, reporting by exception to the Board at each meeting).

6.4. Typically, directorate management teams have oversight of people participation activity in their directorate via their local People Participation lead. PPL's routinely report to the directorate management team, setting out current working together group priorities and progress. An example of such a report, in this case presented to the Leadership Group for Community Health Services in Newham, is set out in the table below.

Priority	Actions	Ownership	Challenges	Timelines	Support Required (internal)	Support required (external)
People Participation	- Improving experience of services users on interview panels	John Kauzeni, Charan Saduera	Getting all managers on board with the process. Payment delays and understanding where the blockers are, managers not having enough time to complete all steps	Sept 2023	All recruiting managers to follow correct process	Corporate PP Team and local PP team to work together to identify payment delay issues
	- Service visits with Health Watch (15 steps for CHS)	Charan Saduera John Kauzeni	Services being under pressure and not being able to accommodate visits	July 2023	All managers to support visits	Healthwatch, Sevice users and Carers
	- Expanding membership of Working Together Group	John Kauzeni	People not able to join due to lack of tech/Wi-Fi, meetings are not accessible enough e.g. lack of sign language facilitators, translation	Dec 2023	All managers	System partners, Voluntary organisations, Community networks
	- Digital inclusion (Chromebook distribution project led by PP Digital Team ELFT)	John Kauzeni	People may not be able to use the device.	Sept 2023	Working Together Groups	Salleem Digital PP Lead Recovery college
	- Including the isolated population (people who have no family/carer input)	Charan Saduera John Kauzeni	Lack of data, lack of engagement from system partners	Jan 2024	DMTs, WTGs	Social care, Local Authority
	- Volunteering programme for CHS	Charan Saduera John Kauzeni	Services unable to identify suitable volunteer opportunities	Dec 2023	All managers	Rajia Khan Volunteer Lead
	- Access Point Audit	John Kauzeni Foujiya Sultana	To gain valuable insights into the quality of customer service in order to improve experience of our patients (access & communication)	Dec 2023	Working Together Group, All managers	N/A
	- Involvement of service users in OT	John Kauzeni	Service users to be involved in recruitment, practices, exams and placements	Dec 2023	Working Together Group	Niall Fitzpatrick - UEL
	- Leavers recording video to share PP experience	John Kauzeni Susanna Rance	Service users and carers to video-record a short clip about the PP experience	Dec- 23	Working Together Group	Taiye – Head of Marketing & Digital Comms

6.5. As indicated above, the Trust tends not to be prescriptive about what form people participation takes, and doesn't monitor activity centrally. However, there are some minimum levels of involvement required, namely that all interview panels include a service user on the interview panel, and that all QI projects involve service users and carers. There is monitoring of service user involvement in QI projects through directorate QI forums, chaired by clinical directors, and by the corporate QI department, with support being provided by improvement advisors and people participation leads where teams cannot demonstrate service user involvement.

6.6. In order to assess and support teams and services to involve people with lived experience, service users have expressed their own expectations around people participation in the design of standards for the Service User Led Accreditation Programme. Standard 2.3 within the accreditation standards states *'the service can demonstrate it includes and invites service users and carers to service management level meetings.'* This standard has been 'met' by 16 teams and 'partially met' by 12 of the services assessed to date. Standard 5.2 states *'the service demonstrates Service User involvement in QI'.* This standard has been met by 31 teams and partially met by a further 23 of the services assessed to date.

7. Quality Improvement

7.1. Quality improvement is now well established at ELFT, with a mature culture and infrastructure in place. The application of quality improvement within a team reinforces a sense of autonomy, enhancing staff experience and instilling a proactive approach to identifying and solving problems, employing creativity and utilising the full diversity of experience and knowledge across the team of staff and service users.

7.2. Over the last decade, an infrastructure has been developed similar to people participation, with approximately 130 improvement coaches across all areas of the Trust. Our QI coaches have full-time roles, but take on the additional responsibility of becoming a QI coach (through a specific development programme) and ring-fence time each week to coach another service with their quality improvement work. Improvement coaches provide first-line support to most quality improvement work across the Trust. ELFT has the largest

such infrastructure of improvement coaches within healthcare globally. Full-time improvement advisors in the corporate QI department provide professional supervision to the QI coaches, provide strategic guidance to our directorate leadership teams, directly coach projects linked to our strategic priorities and deliver our QI teaching programmes. Improvement advisors have access to highly experienced improvers within the corporate department to guide, support and design. This infrastructure is critical to enabling all services at ELFT to be able to apply quality improvement in a robust and meaningful way, in order to achieve results. The corporate Quality Improvement department has not grown in the past 5 years, with recent extensions to the team being funded by our integrated care systems in order to support system-wide improvement work.

7.3. The application of quality improvement within teams is overseen in a number of ways:

- All projects are presented at, approved by and overseen by the local directorate QI forum, chaired by the clinical director (often with a service user co-chair)
- A senior member of the directorate leadership team sponsors every QI project
- All quality improvement projects are allocated an improvement coach, to support and guide the team on a regular basis
- The local directorate QI forum invites projects to present progress, learning and challenges on a regular basis
- Directorate leaders engage with teams to encourage them to apply quality improvement to tackle complex issues that they are grappling with
- Improvement Advisors from the corporate QI department meet monthly with clinical and service directors to discuss projects and teams that are struggling, and to identify solutions and support
- All projects are on the LifeQI digital platform, which includes a project score to gauge progress over time. There is an indicator on LifeQI that flags projects that have not progressed in the last 3 months
- There is monthly reporting to the Chief Quality Officer on directorate maturity with quality improvement, including project progress and service-level engagement with quality improvement

8. Next steps

8.1. As part of the implementation plan for the ELFT leadership framework, the six habits and practices above that we believe are important in enabling happy, healthy teams at ELFT will be developed further. More reliable systems will be developed to enable oversight at multiple levels, so that teams, directorates and the Trust can see the application of these six habits and practices at team level, in order to address variation and provide support proactively. Progress with this work will be reported to the People and Culture subcommittee of the Board.

9.0 Quality Improvement

9.1 This section of the paper serves to provide assurance to the board on the delivery of the annual quality improvement (QI) plan, in support of the Trust strategy.

10.0 Pursuing Equity

10.1 A second phase of the Pursuing Equity programme will take place in 2023-24. The first phase of this program began in June 2022, with 14 teams tackling equity issues related to ethnicity, race, gender, and sexual orientation. Four teams have seen improvement so far in their outcome measure, with the remainder continuing to test changes in pursuit of their

aim. Cauldwell Medical Centre reduced the gap for cervical screening between women aged under and over 50. Bow Ward saw a 15% increase in cervical screening and 16.3% increase in breast cancer screening. Tower Hamlets Early Intervention Service increased access to psychological therapies for BAME service users by 27%. The Community Forensic Service saw an increase in the number of people attending their BAME groups.

10.2 Phase two of the programme in 2023-24 will be informed by lessons from phase one. Teams will access data early on to understand the equity gap and ensure they are tackling the most important issue for service users and staff. Teams will have an increased focus on service user involvement and will be supported to start a QI project from the outset. Recruitment of new teams is underway whilst continuing to support the 14 teams from phase 1.

10.3 New potential projects have been identified based on annual plans across our directorates, on themes that fall into four categories: BAME groups, LGBTQ+ community, Women's Health, and Learning Disabilities. Directorates and teams are currently being supported by improvement advisors to put in place the foundations, with a project team, service users and a project lead, before starting to interrogate data and understand the issue more deeply.

11.0 Inpatient Quality and Safety

11.1 The inpatient quality and safety improvement programme has the goal of improving experience of care, such that anyone in contact with our services feels safe, feels involved in decisions about their care and knows that the staff around them are focused on their recovery and their future goals. This programme is sponsored by the Chief Nurse, Chief Medical Officer and Chief Quality Officer, and connects with the priorities identified by directorates in their annual plans.

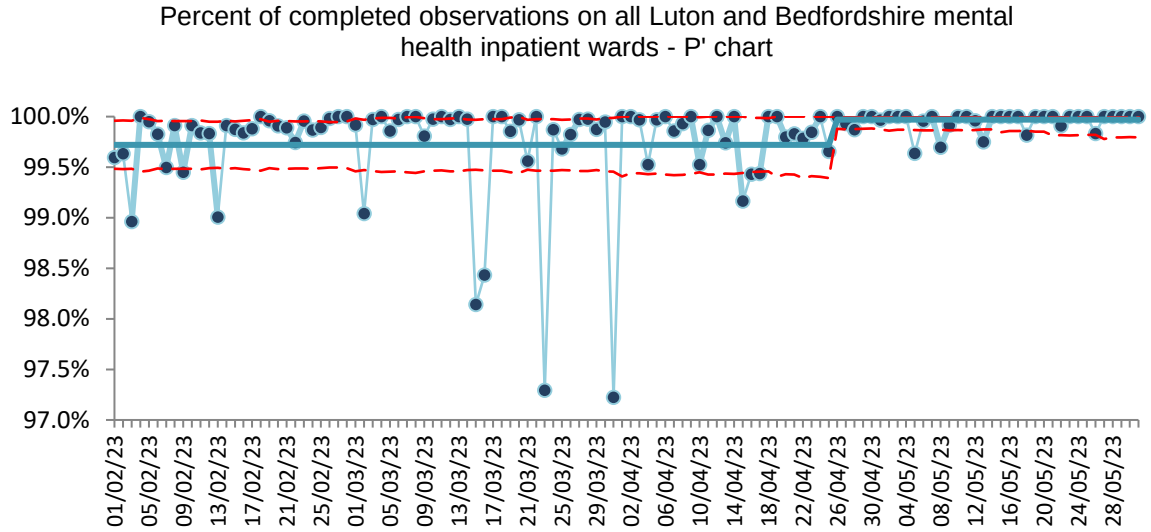
11.2 One component of this programme will be to support the reliable implementation of the safety culture bundle for predicting and preventing violence on mental health inpatient wards. The safety culture bundle was developed at ELFT between 2012 and 2016 and includes four interventions: Safety Cross, Community Meetings, Safety huddles, and the Brøset violence checklist (a dynamic risk assessment tool).

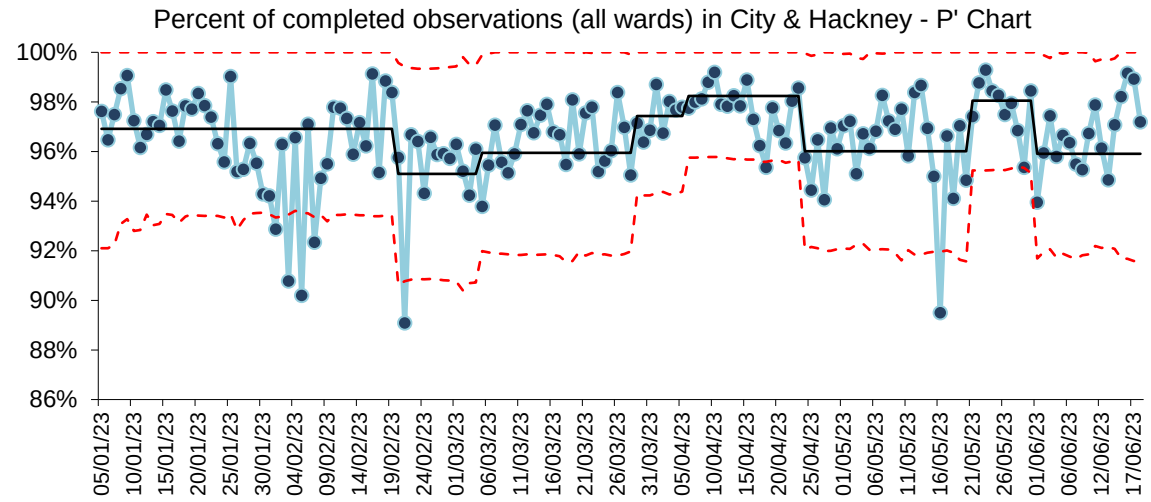
11.3 Another component of this work will be to improve the therapeutic engagement of service users on mental health inpatient wards and improve the completion of observations to assure safety. Teams have already developed change ideas and commenced testing, with further details in the table below.

Theme	Ideas Being Tested
Activities	The ideas are focused on improving the engagement of service users in their care and meaningful activities. Ideas being tested include increasing patient engagement time, involving service users in safety huddles, engaging family members to understand service users' triggers, introducing 'This Is Me' life story work for patients on 1:1 observations, inviting patients' loved ones to the ward to share a meal, and providing individualised structured activity boxes for patients on 1:1 observations.
Staff roles	The ideas are focused on supporting staff in their roles.

	Ideas being tested include redefining the nurse allocation role, introducing zonal nursing, protecting staff time for wellbeing, creating a protected admission/engagement room, implementing a buddy system for new starters, and introducing Life Skills Recovery Worker shifts.
Observations process	The ideas are focused on improving the observation process. Ideas being tested include protected engagement time, introducing reminders, creating a new observation form, using infrared torches, placing observation signs on doors, providing leaflets explaining observations, coloured clipboards for different observations, assigning a key contact on admission, and using high visibility tabards.

11.4 The chart below shows the data that each ward and inpatient unit are starting to collect on completed observations. Below are charts of percentage of observations completed in City & Hackney and Bedfordshire & Luton inpatient wards. In July, this standardised manual data collection will feed into PowerBI dashboards that all staff and teams can view.





11.5 Some teams are testing digital solutions to record interventions in order to reduce the data collection burden and bring data insights to the frontline of service delivery. Planning has started between clinical leads, quality improvement department, informatics department,

and digital to incorporate data collection into the electronic patient record and improve real-time access to data.

12.0 Improving Value

12.1 The QI method is being applied to improve value by making the best use of our resources, making the best use of everyone's time, removing obstacles that delay or hold things up, and adopting systems and processes to make things more efficient and effective for everyone. This is being achieved through individual projects and trust-wide programmes.

12.2 Cauldwell Medical practice has a QI project to increase cervical screening uptake. The project has improved patient experience by increasing the number of patients attending cervical screening appointments by 38%. Multiple QI projects in the flow programme worked to improve productivity and capacity, by testing ideas that reduced non-attendance at appointment. City & Hackney autism service keeps a list of patients who can be contacted at short-notice to fill any last-minute cancellations. All these projects are demonstrably improving productivity and efficiency.

12.3 The Inpatient Quality and Safety work will measure impact through looking at staff sickness absence related to violence, estates costs, response team costs, legal costs, bank costs and medication costs. Support is also being offered to the environmental sustainability programme to apply the QI method. This has included developing a theory of change, a measurement system and control charts for some of the measures.

13.0 Improved Staff Experience

13.1 The approach to quality improvement at ELFT has had a significant impact on the experience of staff, their ability to improve the system they work in, and their autonomy to make changes. The ELFT approach to build improvement capability at scale over the last 9 years was recently published in the British Journal of Healthcare Management.

13.2 Recruitment for the 13th wave of the Improvement Leaders' Programme has commenced, with the programme beginning in October. It is expected that 150-200 staff and service users will take part in the six-month programme, which includes approximately 40 people from partner organisations in our integrated care systems. The 9th cohort of the Improvement Coaching Programme will commence this Autumn. Directorates are being supported to think about the improvement work they need to undertake, the capacity of improvement coaching they need, and to identify a pipeline of people ready to take on this role. Our improvement learning programmes are routinely evaluated through measurement of attendance at training days, project progress scores, pre-and-post skills assessment, and confidence and ability to apply the skills and knowledge to daily work.

14.0 Action Being Requested

14.1 The Board is asked to consider assurance received and any other assurance that may be required.

Performance report

July 2023

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 five key themes (safety; access and responsiveness; effectiveness and outcomes; children and young people; equity). Each theme includes a small number of Trustwide measures, together with 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. 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?

Over the past year, adult community mental health, talking therapies, and East London community health services have experienced the biggest reduction in waiting times. A range of change ideas have contributed to this, including moving from individual to group therapy sessions, and working with GPs and wider partners to increase the proportion of appropriate referrals being received.

The overall number of safety incidents and the percentage of incidents resulting in harm remains stable. Further detail on the large-scale QI programme on inpatient quality and safety is contained within the Board quality report. The percentage of service users achieving recovery in talking therapy services continues to surpass the national target of 50%. Access to Rapid Response in community health services consistently exceeds the national target. Early Intervention Services are starting treatment within two weeks for 74% of service users, with the national target being 62%. Within both inpatient and community settings, outcome data from Dialog continues to show improvement in average scores between initial assessment and subsequent review across all quality-of-life domains.

The equity section of this report describes work underway across the Trust to tackle identified areas of inequity. Early indications suggest a closing of the gap in waiting times between people of different ethnic backgrounds. Talking therapies are testing creative ideas to improve access and outcomes for specific ethnic groups within local communities. The City & Hackney perinatal mental health service is looking to increase preconception referrals for women with serious mental illness through proactive outreach work. The CAMHS Discovery College continues to work closely with children and young people from disadvantaged backgrounds through a combination of face-to-face and online workshops and physical and mental well-being activities. Work is also underway across the Trust to support service users to stop smoking, adopt healthier lifestyles and improve health outcomes.

KEY MESSAGES (continued)

Where are we identifying challenges, and what are we doing about it?

Bed occupancy continues to remain high, at an average of 95%. This can be attributed to multiple factors such as increased levels of acuity and complexity, a rise in formal admissions under the Mental Health Act, delays in discharge due to social care issues, and a rise in admissions of people who are homeless or lack permanent residence. A number of initiatives are underway to improve discharge processes and flow. These include the commissioning of ten additional beds in the private sector to support out-of-area admissions, developing step-down bed capacity in the community, implementation of recommendations from the "Getting It Right First Time" (GIRFT) programme, improving the provision of supported living schemes for service users with complex presentations, and redesigning crisis pathways to enable early intervention, prevent deterioration and reduce crisis admissions.

Over the last 2 months, there has been a 26% increase in the number of complaints. This is attributed to a rise across a small number of mental health services in City & Hackney and Tower Hamlets. This is partially related to changes that now categorise Patient Advice and Liaison Service (PALS) queries as complaints. The main complaint themes relate to assessments, access, appointment cancellations, missing items, staff attitude, and communication. Services have developed plans to address these themes, including training in trauma-informed care, tackling waiting lists, photographing personal items given to staff by service users on our wards, and a weekly complaints huddle in City & Hackney to share learning and provide a focus on tackling the issues being raised.

The percentage of service users who would recommend our services has declined from an average of 90% to 82% in May. This was mainly due to the closure of the vaccination centre, which received high numbers of responses with 100% recommending the service, and also due to reduced responses within Bedfordshire primary care services. Tower Hamlets mental health has also seen a reduction in satisfaction, with themes related to inpatient catering and activities, which are actively being addressed by the service.

In the past two months, there has been a rise in the overall waiting list throughout the Trust. Out of the 48 services where waiting times are being monitored, 18 have seen an increase. These teams are receiving support to develop and test innovative ideas to address demand upstream, increase capacity and remove waste in the pathway. Specialised services, particularly adult Attention Deficit Hyperactivity Disorder (ADHD) and Autism, are currently collaborating with partners across the system, including the ICB and primary care, to address the increase in demand. These teams are taking a system approach to tackling waiting times by focusing on coproduction, understanding community-based assets, agreeing and redefining the service offer, and redesigning the service model. These teams are receiving extra support from the commercial department, performance teams, and ICB commissioning colleagues to better understand demand and capacity, and to develop sustainable system-wide solutions.

Executive Summary

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

Improved service user experience	☒	The performance reports supports assurance around delivery of all four strategic priorities. The Board performance dashboard includes population health, service user 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	☒	

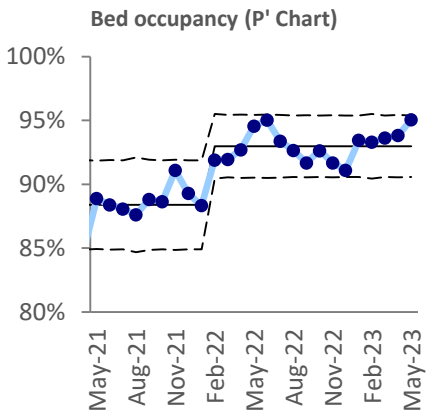
Committees/meetings where this item has been considered

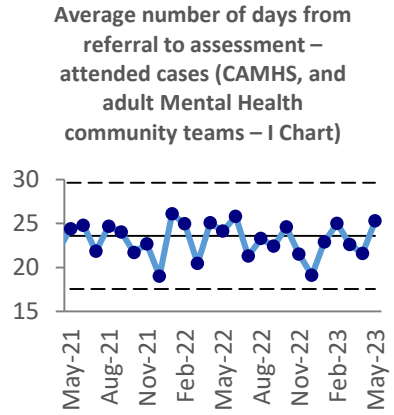
Date	Committee and assurance coverage
Various	Various sections of this report are submitted to the Service Delivery Board, Finance Business and Investment Committee and other Trust committees. Some of the performance information is submitted to commissioners and national systems.

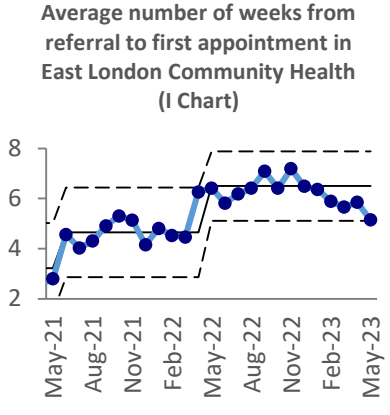
Implications

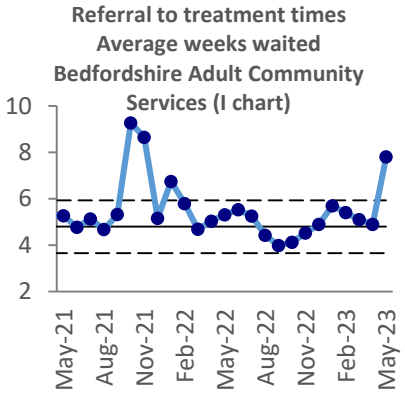
Impact	Update/detail
Equality Analysis	Some of the metrics in this report are designed to improve equalities by ensuring access to services and good outcomes. Analysis of the experience of different groups is undertaken as part of the Trust's inequalities work stream and population health task and finish group.
Risk and Assurance	This report covers performance for the period to the end of May 2023 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.

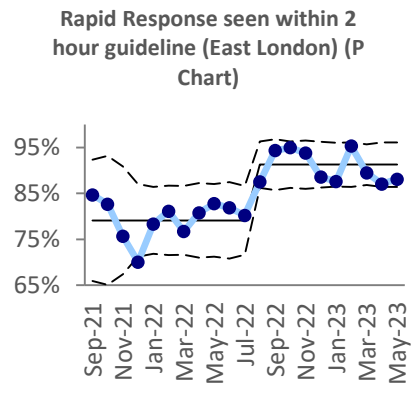
Access and Responsiveness

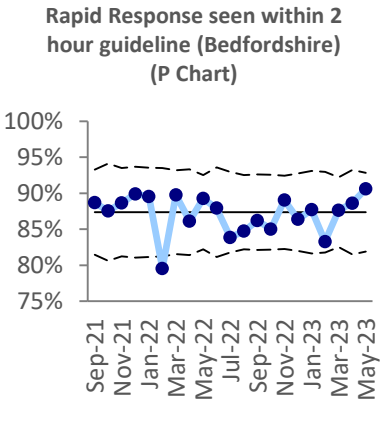












Inpatient bed occupancy across most services continues to remain high, with an average of 95% in May. The themes highlighted in the previous report continue to persist, related to social care delays, limited specialist placements available for service users with complex needs, out-of-area admissions to ELFT wards, increased admissions of homeless individuals or those without permanent residence, and individuals on remand awaiting court proceedings. Although crisis line services in City and Hackney and Bedfordshire experienced an increase in calls during past two months, overall crisis call activity remains stable.

In order to manage admissions and length of stay as effectively as possible, all services hold daily huddles and regular bed meetings to ensure timely discharge. Services are focusing on preventing admissions through strengthening admission avoidance pathways, such as crisis line, crisis cafes and home treatment services. In partnership with NELFT, the system has commissioned ten additional inpatient beds across North East London to help both Trusts manage inpatient capacity more effectively. The new capacity is being utilised for admissions from outside the area, with the aim of supporting local residents to access services close to home. All teams have started to implement the Clinically Ready For Discharge (CRFD) protocol which supports services to identify delays to discharge much earlier and plan ahead with local authority partners. Services have also established review panels to help reduce delays related to service users with the most complex needs, and inpatient flow coordinators are in place to help teams coordinate discharge plans in a timely manner.

In Newham, services are testing the use of six step-down beds in the community and are in the process of expanding crisis house beds to help improve flow. These initiatives offer intermediate care for service users no longer requiring acute hospital services and specialised support for those facing mental health crises, reducing unnecessary hospital admissions and optimising acute inpatient capacity. An additional medical role is being created to offer dedicated support in the management of service users with complex needs, diagnosed with severe mental illness, and originating from outside our catchment area. A comprehensive analysis is being conducted on a case series of service users with multiple crisis presentations to try to identify any factors that might be amenable to earlier intervention.

In City and Hackney, the mental health Urgent Care Assessment Team is collaborating with Homerton Hospital on a pilot project that will redirect mental health presentations at A&E to the Crisis Hub, which is co-located on the same site. This is similar to crisis services in Newham and Tower Hamlets, enabling individuals facing

mild to moderate mental health challenges to receive prompt assessments and support from specialised community teams, and also alleviating pressure on A&E and inpatient services. Following a consultation period, staff were assigned to the service in May, and testing of the new care model has begun with the aim of having the service fully operational by September 2023.

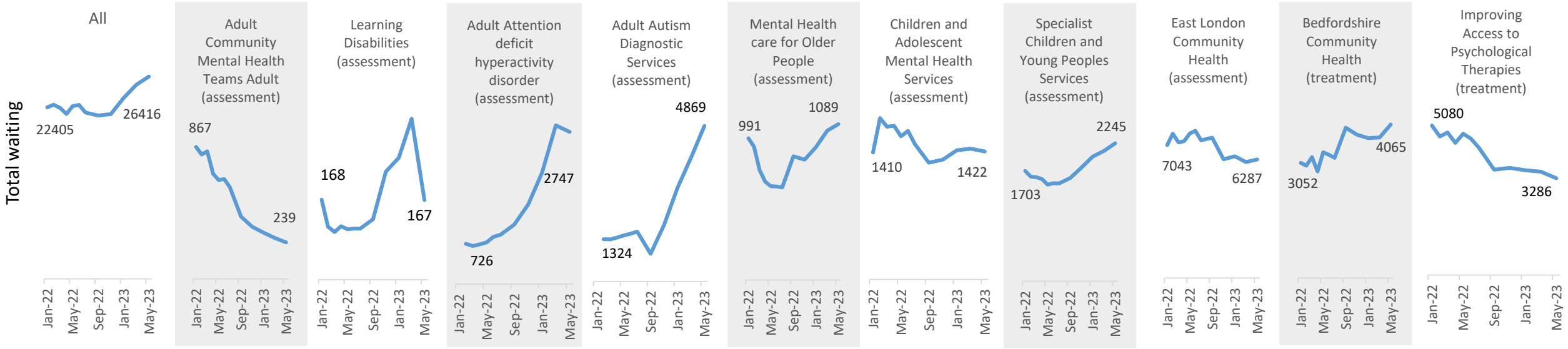
A review is underway in Tower Hamlets to improve the quality of crisis services. The primary goal is to provide adequate support and care to service users, enabling them to avoid relying on emergency departments as their initial point of contact. To enhance assessments, there is an increased presence of senior staff in emergency departments. Teams review service users with a length of stay over 28 days through daily huddles and weekly bed meetings. Hospital discharge funds are being utilised to support service users to return to the community as soon as they are clinically ready, through tackling potential delays in awaiting a home clean or social care package. Additional staffing has been allocated to the Home Treatment team to facilitate early discharge and reduce admissions by proactively supporting service users at home. A dedicated discharge coordinator is collaborating with service users who have no fixed abode or who live out-of-area. Additional weekend shifts are being offered to help complete Activities of Daily Living and Care Act assessments, enabling faster decision-making for accommodation and care packages. Improvements to the funding panel processes have been implemented, enabling teams to make out-of-panel decisions and facilitate prompt discharges. Collaboration with ICB colleagues is ongoing to review and improve the borough's supported living schemes, particularly for individuals with complex service needs who frequently have long lengths of stay due to a lack of appropriate accommodation.

An Urgent and Emergency Care mental health group has been formed in Bedfordshire and Luton, involving various stakeholders to tackle challenges related to flow and demand across Bedfordshire, Luton, and Milton Keynes. One of the priorities for this group is to implement the recommendations of the Getting It Right First Time (GIRFT) programme, which aims to enhance quality and outcomes by identifying variation, promoting evidence-based practices, and optimising resources across the system. A stakeholder event is being organised in the summer with service users and system partners to identify ways to strengthen community-based offers for admission avoidance and crisis management. A dedicated discharge hub has been established, supported by additional funding, to enhance flow across all inpatient wards. This hub includes a discharge coordinator who works closely with service users, carers, and key partners to ensure smooth transitions and timely discharges from inpatient services.

The waiting times for rapid response in community health services remain consistent, with 91% of assessments in East London and 88% in Bedfordshire completed within two hours, surpassing the national target of 70%. Collaboration with acute providers, ambulance services, and NHS 111 is underway to establish efficient pathways that ensure that service users are seen by the most appropriate team and at the right time to help improve flow across the system.

In Bedfordshire, a successful initiative with the Ambulance Service and Fire Brigade has resulted in the implementation of a nurse-led falls service. Preliminary findings highlight that this service has reduced ambulance conveyance for falls-related calls by 55%. Additionally, an advice line has been developed to assist GPs and other referrers to find solutions in the community in order to avoid sending service users to A&E. These innovations in the urgent care pathway have gained national recognition, as demonstrated by NHSE East of England region receiving the HSJ 2023 Digital Innovations award on behalf of all providers involved. This recognition specifically acknowledges the successful implementation of the Ambulance Stack system, which optimises flow across the system and ensures that service users are directed to the most appropriate care setting and team for their needs.

Access and Responsiveness



Of the 48 teams where waiting times are being closely monitored, 18 are seeing an increase in their waiting list. The narrative below includes a deep dive into these teams to understand why the waits are increasing and the plans that are in place to support improvement.

Autism and adult ADHD services across the Trust are experiencing the greatest increase in waiting times across the Trust. The main challenges are around increasing demand, believed to be related to an increasing awareness and recognition of these conditions, which has contributed to a substantial increase in referrals. In Luton & Bedfordshire, conversations are underway with ICB colleagues to explore the opportunities to design a single neurodevelopment service. The corporate performance team has undertaken a wider review of national best practices to support the next phase of this work. In East London, a Triple Aim ADHD project is co-led by ELFT and the ICB. During the latest project meeting, various innovative ideas were discussed to enhance service capacity. These ideas include implementing group-based psychoeducation, utilising computer-aided self-help resources to support service users while they remain on the waiting list, establishing full-time nurse prescriber roles to assist with medication reviews, thereby releasing medical capacity to offer more assessments. This project will be supported to understand the population, their needs around ADHD, and potential collaborations to tackle increasing demand.

Across adult Autism services, a workshop is currently being planned with Autism leads and stakeholders across the Trust focusing on five core themes: meeting demand upstream, reviewing the current service model, exploring the digital offer, tackling recruitment challenges, and linking with wider teams around transitions between CAMHS Autism and Adult Autism Services. The workshop is planned for July and will be an opportunity to generate new ideas to tackle the complex challenges services face and prioritise the most high impact change ideas for testing over the next few months.

Access and Responsiveness

Within the City & Hackney Autism service, the admin team maintain a standby list of service users who can attend appointments at short notice to help fully utilise the capacity that is available. The teams are currently finalising the new referral form to enhance the front-end screening process, by ensuring that a Band 7 nurse reviews the referrals before they are accepted. Learning from this process will be shared at the Autism workshop. The Tower Hamlets Autism team continues to have a high caseload of people with a diagnosis of autism who are receiving follow-up care. The team expect to be fully resourced from August. The team's QI project is ongoing, with the next phase of the work looking at equity measures to understand how waiting times vary depending on ethnicity.

Through the ADHD and Autism programmes of work in place, it has been recognised that a system-level approach is required to manage the demand and waiting lists in a sustainable way. Teams have come together to share their main challenges and have acknowledged the need to explore opportunities to improve the quality of referrals, rethink roles and responsibilities, manage the risks of those on long waiting lists, and ensure that solutions are effective and meet the needs of the local population. Teams have recognised the importance of building stronger networks with stakeholders and signposting to alternative services to ensure that service users are 'waiting well' and not deteriorating further while waiting for an appointment. Initial ideas for change include improving screening form efficiency, auto-filling screening forms to lighten the workload of administrative staff, and removing inefficiencies in the referral process.

Dementia services across the Trust are starting to see an increase in assessment waiting time, due to an increase in the number of referrals. The Newham Memory Service has developed inclusion and exclusion criteria with the aim of reducing inappropriate referrals by 10%. The team has partnered with referrers including GPs and neighbourhood teams to improve the quality of referral information, in order to reduce re-work. The team is now working to ensure that roles and responsibilities are well defined, with screening and triage protocols embedded consistently. Bedfordshire Memory services are adopting a similar approach, reviewing the team skill mix and identifying ways to maximise existing capacity. The team is developing referral criteria in collaboration with GPs, which will help to support information-sharing and reduce duplication of time and effort for duty workers in the screening and assessment process.

Specialist Psychotherapy Services (SPS) in City & Hackney are experiencing longer waiting times for assessments, which is mainly due to staff recruitment challenges. A quality improvement project is underway, with the aim being to complete 95% of assessments within 11 weeks and improve the quality and experience of care. The next phase of the project is focused on improving treatment waiting times. Proposed changes include group-based information and enrolment sessions to improve information sharing and ensure that service users have access to appropriate resources ahead of commencing treatment. In Newham Psychological Therapies Service (PTS), the number of service users waiting over 11 weeks for assessment continues to grow, due to an increase in referrals that exceeds the team's capacity. The team is exploring short-term options to increase capacity, including offering bank shifts for staff to do assessments, and strengthening the psychological therapy offer within the blended PCN teams.

IAPT services in Tower Hamlets and Bedfordshire continue to prioritise group therapy sessions to reduce waiting lists. In Tower Hamlets, interventions delivered in a group format are taken up by around 15% of service users. The team has conducted an evaluation that shows that group therapy interventions have similar outcomes to individual therapy and are more cost-effective. To increase uptake, the service is reviewing the content of the group programmes by improving the language offer available

and co-facilitating the sessions with service users. The team in Bedfordshire is exploring changes to the pathway so that service users waiting for high-intensity individual therapies would be able to access support through group courses, delivered primarily online. This would give service users an introduction to the tools and approaches used in Cognitive Behavioural Therapy before they start treatment. Overall, access to talking therapies, highlighted in Appendix 1, remains steady, and services have plans in place to meet the increase in access that is expected within the Long Term Plan.

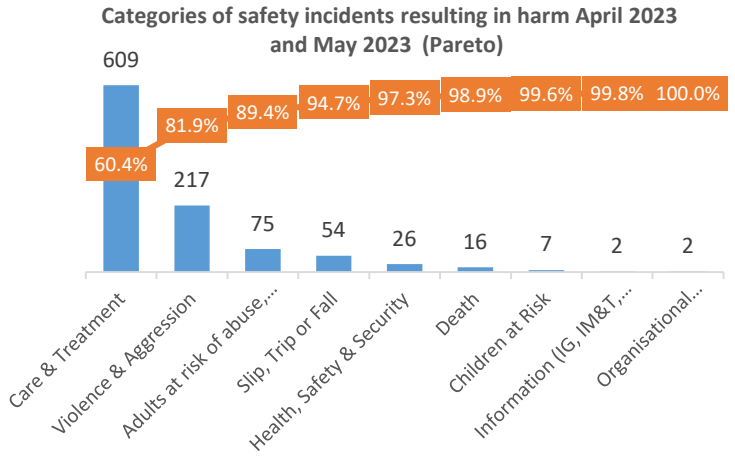
The waiting times for MSK services in East London have been reducing since August 2022. This is attributable to a number of initiatives, developed, tested and implemented by the service as part of their recovery plan. The service is now writing to service users who have been waiting the longest to ask if they still require support from the service, which has led to a number of people being able to leave the waiting list. The service has reviewed its referral criteria, and is exploring alternative approaches to manage care home activity and handle low-risk cases. This includes utilising telehealth and digital methods to remotely support care homes and other referrers.

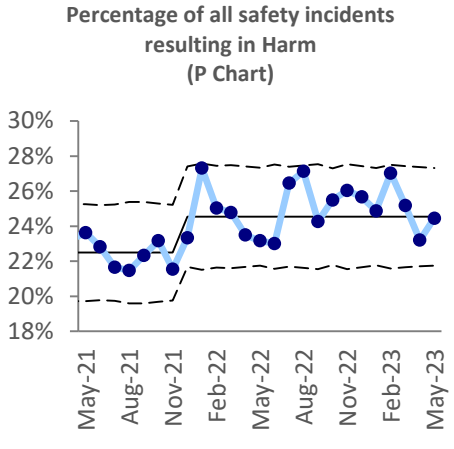
The increase in referral to treatment times in Bedfordshire community health services is driven largely by the podiatry service. In order to minimise impact on individual service users due to worsening of symptoms, the service has developed an urgent priority pathway. This involves telephone triage and assessment, providing appropriate advice or arranging face-to-face appointments where necessary. The service maintains a focus on prioritising service users with the highest risk, such as those experiencing ulceration or sepsis, in accordance with the newly updated access criteria. Efforts to decrease the waiting list are still in progress, with daily monitoring of service users awaiting appointments, and a focus on recruiting to vacant posts.

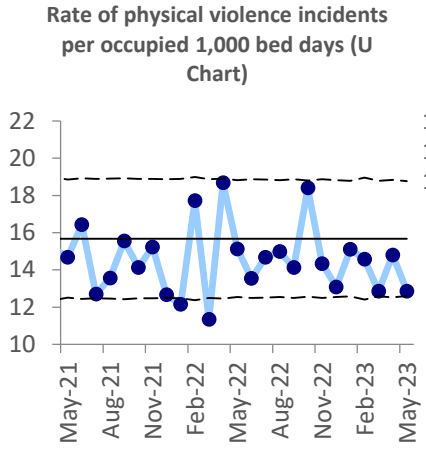
Across perinatal services, 74% of service users were seen within 28 days, with the target being 80%. This represents a decrease from previous months, and is due to an increase in referrals across most services that is outstripping routine capacity, particularly in Bedfordshire and Luton. The service has now managed to recruit four additional staff members, including a consultant and psychologist, which will add critical capacity. The service is currently undergoing a comprehensive review, alongside a quality improvement project aimed at enhancing both access and the overall quality of care provided.

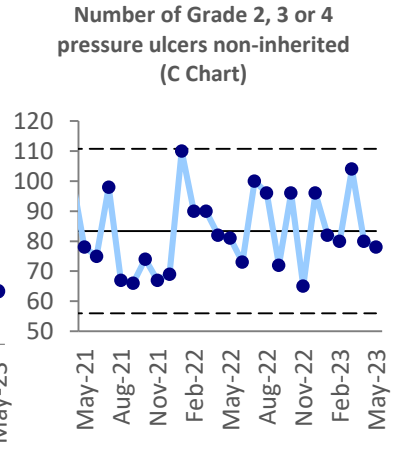
Early Intervention Services continue to exceed the national target of 62% of service users commencing treatment within 2 weeks of referral, achieving 74% in May.

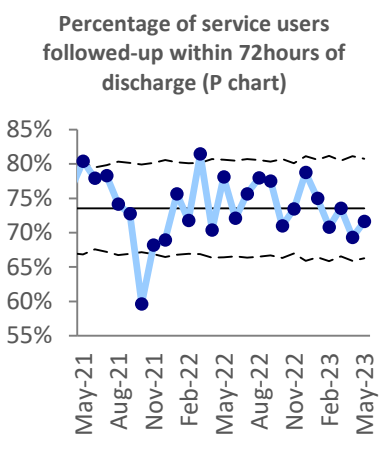
Safety











The overall number of safety incidents and the percentage of incidents resulting in harm remains stable. Most reported incidents are categorised as low harm or no harm in terms of severity. The Pareto chart above shows the main categories of reported incidents during April and May. 82% of reported safety incidents were associated with care and treatment or violence and aggression. The most common themes within the care and treatment category were pressure ulcers or moisture-associated skin damage, self-harm incidents, and complications or unexpected deterioration.

The rate of physical violence in inpatient settings is showing early signs of a potential reduction, with the rate for the last seven months being below the average. Teams continue to highlight the beneficial influence of the "Safety Culture Bundle" in promoting a proactive and positive safety culture. This bundle of four interventions was created as part of the violence reduction quality improvement programme. The board quality report has more narrative on the current inpatient quality and safety improvement programme. The rate of restraints increased in May (see appendix 1, page 24). This is primarily attributable to an increase on the CAMHS PICU ward in Newham, where 58% of the incidents related to 2 services users with complex needs and challenging behaviour, including self-harm. Services have emphasised that these service users are currently experiencing acute illness, and it is expected that the incidents will decrease once their condition stabilises. Alongside work to embed the safety culture bundle reliably, every staff member on the CAMHS wards is undergoing de-escalation training to improve their ability to defuse and handle difficult situations on the wards. This will support teams to prioritise the well-being of individuals, facilitate effective communication, and maintain a safe environment for both the individual and the staff involved.

Across Community Health Services, the aggregate number of pressure ulcers continues to remain stable. In Newham, low harm pressure ulcers remains stable but moderate harm pressure ulcers increased from 5 in April to 9 in May. Most of these were acquired in one locality, where staff training and awareness sessions have been delivered to support improvement. While pressure ulcers in Tower Hamlets remain stable, there was a notable decrease in the number of moderate harm cases in May, dropping from 24 cases to 14. There was a slight increase in moderate pressure ulcers in Bedfordshire during the same month, although the total number has decreased. The improvement reflects the positive influence of staff and service user training, as well as the collaborative development of educational materials. These initiatives encourage service users to actively participate in adhering to recommendations and prevent the worsening of pressure ulcer conditions. During the May root cause analysis

panel meeting, several important areas were identified for further work, including the need for better escalation processes when service users are discharged without the necessary equipment or experience delays in receiving the equipment. Ideas to improve documentation were also considered, leading to the decision to implement more uniform and standardised training throughout the Trust.

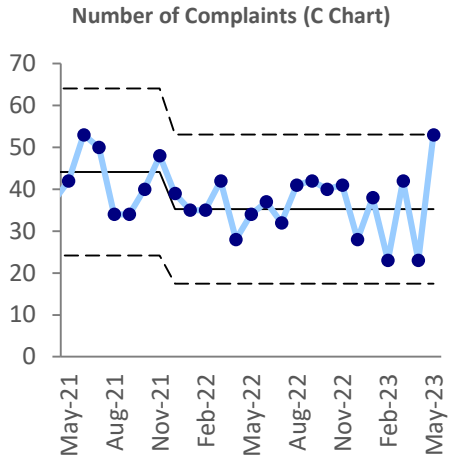
The percentage of service users followed up within 72 hours of discharge from mental health inpatient care is currently at 72%. In May, City & Hackney achieved a small improvement to 66%, with an additional 4% being followed up within 7 days of discharge. City & Hackney is working in close collaboration with the Community Recovery teams and has introduced a daily process for its Flexible Assertive Community Treatment team to distribute caseloads for clinicians to follow-up. Further work is underway to improve efficiency of the process and enhance service user safety by sharing responsibilities among the team. On Brett Ward, 90% of discharges were followed-up within 72 hours. The knowledge gained from Brett ward's approach, which involves verifying contact information with service users before they are discharged, and assigning a designated staff member for daily follow-ups, is being shared with other teams. During the May directorate management team meeting, a task and finish group was agreed to be formed to explore additional improvement ideas over next few months.

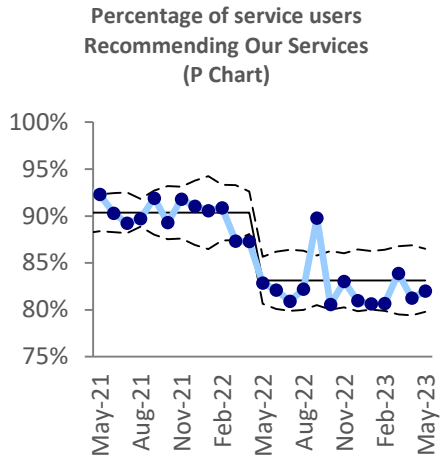
Performance in Newham has dropped slightly to 72%, with a further 18% being contacted within 7 days of being discharged. Efforts are underway for wards and community teams to delve into the underlying causes of breaches. Notably, there has been a rise in service users travelling abroad after discharge, as well as an increase in service users from outside our catchment areas, which can pose challenges for follow-up. Furthermore, some service users lack suitable means to facilitate a follow-up, such as a mobile phone number of a permanent address. To tackle these issues, potential solutions are being explored, such as organising follow-up within community hubs. Ongoing work aims to improve pre-discharge discussions with service users, ensuring they are adequately prepared to be contacted.

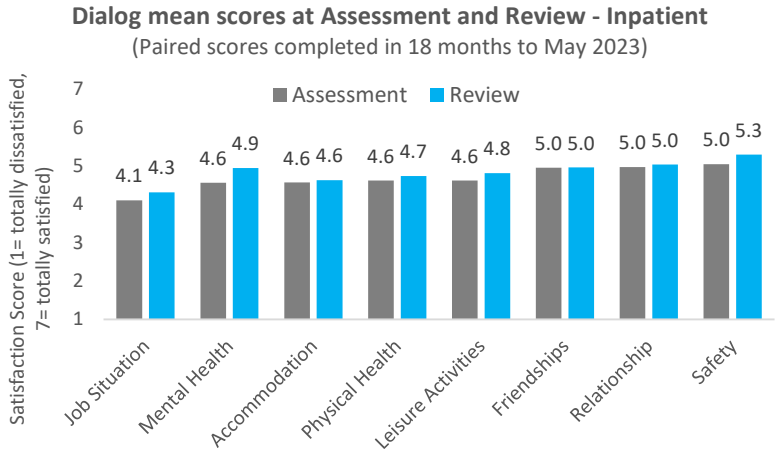
Tower Hamlets dropped slightly to 73% in May, with a further 8% being followed up within 7 days of being discharged. The performance team provide weekly league tables and send daily reminders. The 72-hour follow-ups are now being discussed during ward huddles. In some cases, breaches occur when multiple contact attempts have been made but have proven unsuccessful. As part of pre-discharge planning, contact details and follow-up arrangement are established and agreed with the service user. For more vulnerable groups, contact details are being obtained through family, carers and residential staff. Luton achieved 79% in April and most of the breaches were due to incorrect recording on RiO. Work is underway to ensure that all follow-up contacts are recorded correctly by staff. Bedfordshire has seen a drop in performance to 66% in May. This has been attributed to patient choice and multiple attempts by staff to contact service users. Training and awareness sessions are being held to ensure staff confirm follow-up plans with service users to reduce the number of avoidable breaches.

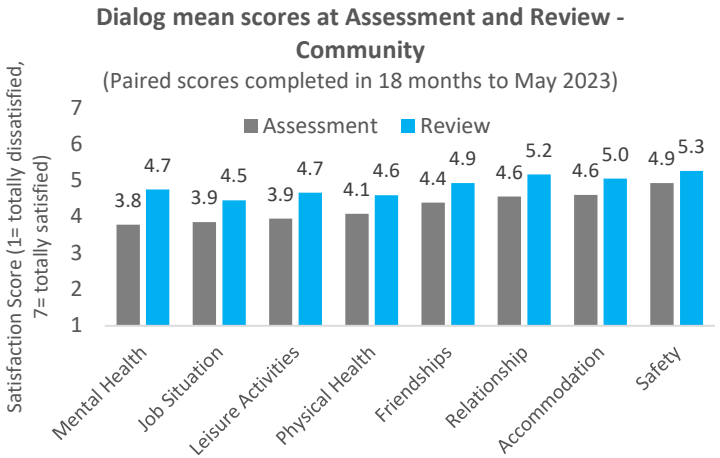
As part of the Trust's efforts to enhance patient safety, the Trust has introduced a Patient Safety Culture survey for inpatient services. All inpatient staff are invited to contribute and subsequently engage in a collective reflection session on the team's results, agreeing actions to strengthen safety culture. Over the coming year, the process will be adapted and improved, extending across all inpatient services.

Experience and Outcomes









Although the overall number of complaints remains stable, there was a notable rise in May. This increase was predominantly observed in a small number of mental health services in City & Hackney and Tower Hamlets. Complaint numbers have risen in both boroughs, partly due to changes that now categorise certain Patient Advice and Liaison Service (PALs) queries more accurately as complaints. This adjustment helps ensure that all relevant concerns are appropriately recognised and addressed. The main complaints themes related to assessments, access, appointment cancellations, missing items, staff attitude, and communication. Services have plans in place to address these concerns, for example, trauma-informed care training is being adopted by services to enhance the experience and quality of care. Services are addressing waiting lists as highlighted earlier in this report. Inpatient services are photographing items given to staff to reduce complaints about missing items. An East London mental health newsletter is being developed to share learning from complaints and serious incidents. In City and Hackney, services are testing a weekly complaint huddle, inspired by the experience from Newham, where this helped reduce the number of complaints. The complaints department is also in the process of introducing a new complaints management system, which will offer better insights into themes as well as demonstrating the learning and impact teams are having in resolving issues. As part of this work, the department is reviewing internal monitoring processes for acting on complaints to ensure that they are not only completed but also evaluated for effectiveness.

The percentage of service users who would recommend our services has experienced a decline, decreasing from an average of 91% to 83%. This can be attributed to a gradual decrease in survey responses, particularly in services with historically higher satisfaction, such as the mass vaccination centre that ceased operations in March. The overall number of teams collecting feedback from service users has continued to grow, which is encouraging. Primary care services in Bedfordshire have also contributed to the reduction in survey responses and satisfaction, thought to be due to survey fatigue following an extensive marketing campaign last year to improve the volume of feedback. The main themes of dissatisfaction in primary care relate to waiting times for appointments, delays in answering calls, staff attitude and communication. Teams are offering more face-to-face contacts, introducing a new telephony service to reduce phone waits, and providing customer service training to staff. Tower Hamlets mental health has seen a reduction in positive responses from service users over the past four months, from 80% to 73%. The vast majority of responses came from inpatient

services, and the main themes of dissatisfaction related to a buzzer not functioning on one ward, lack of variety with the snack menu, and activities on the ward. The buzzer has been fixed and a new catering provider has been procured, with meetings in place to co-design the menu with service users. A new occupational therapist has been recruited and will start in the next few months to improve the availability of activities on the wards.

The Dialog outcome charts continue to show improvement in average scores between initial assessment and subsequent review, for both inpatient and community-based services, across all quality-of-life domains. The dissatisfaction domains differ between the two settings. In inpatient services, the three areas where services users scored the lowest related to employment, mental health, and leisure activities. In community services, lowest scores related to employment, mental health, and accommodation. These findings are based on paired scores from 5555 outpatient and 1797 inpatient records, up from 2136 and 401 respectively, a year ago. The community mental health transformation programme continues to advance, focusing on improving access and providing a more holistic set of support to improve quality of life goals.

To support service users into employment, service users are being offered support from Individual Placement Support (IPS), which is a team embedded within community mental health providing evidence-based support to help people return to employment or retain their jobs by giving advice and liaising with employers. The overall number of service users in employment is increasing, as is the percentage of service users receiving support from employment services through Individual Placement Support (IPS), which has risen from 16% in March to 20% in May. This is a key long-term-plan indicator, and all services are seeing a gradual increase in referrals, with more service users returning to meaningful employment. The trust-wide employment steering group is well established and continues to support services by developing a gold standard framework for our employment services and resources to support service users to enter back into employment.

In the Bedfordshire Path to Recovery (P2R) service, the percentage of service users reporting improved quality of life and successful completion of addiction treatment remains stable. However, there has been an increase in drug misuse cases and waiting times due to complex referrals and wider socio-economic factors related to the cost of living crisis.

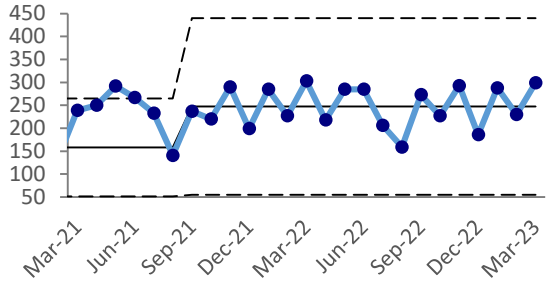
The percentage of service users achieving recovery in talking therapy services continues to surpass the national target of 50%. However, services continued to observe fluctuations in the service user experience questionnaire (PEQ) over the past few months. Tower Hamlets and Bedfordshire scores have both decreased while Newham has improved. Services have been paying close attention to the feedback from these surveys and have not discovered any specific themes.

The Trust has expanded its efforts to support service users in quitting smoking or transitioning to vaping, emphasising a harm reduction approach. This initiative has led to an increase in referrals and the uptake of services, resulting in a reduction of serious incidents related to tobacco across inpatient services. By providing dedicated support and resources, teams are empowering individuals to make positive changes and promoting healthier lifestyle choices to improve the overall health and well-being of the population.

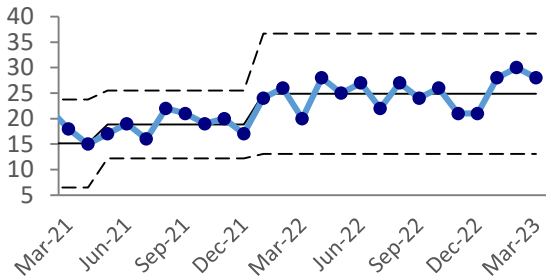
The proportion of perinatal service users who have completed outcome measures has increased to 50%, exceeding the national target of 40%.

Children and Young People

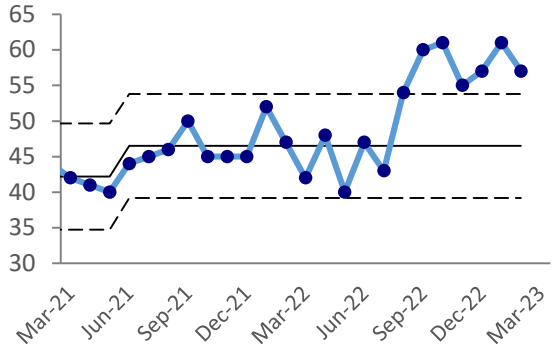
Number of service users presenting in crisis to our crisis pathway
(I Chart)



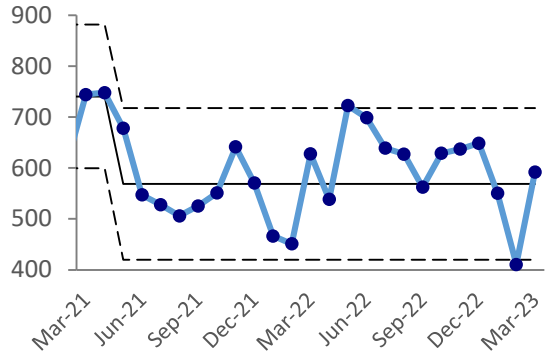
Average Assessment Waiting Time for Children and Young people aged 0-18
(I Chart)



Average Treatment Waiting Time (Days) for Children and Young people aged 0-18
(I Chart)



Tier 4 Occupied Bed days East London excluding leave
(I chart)



Although referrals continue to remain high, CAMHS crisis presentations have stabilized. In City & Hackney, the waiting list for assessment has decreased from 144 to 87. In Newham, the waiting lists for assessment remain stable at 420 although the treatment waiting list has increased from 270 to 307 in the past three months. In Bedfordshire, waiting times have also seen a reduction in the past three months, from 374 to 312 for assessment, and from 287 to 272 for treatment. The waiting list for assessment in Tower Hamlets has decreased in the past three months from 273 to 206, and treatment waiting list has decreased from 240 to 171. All CAMHS teams are meeting their Long Term Plan access targets for urgent and routine referrals to the Eating Disorder service.

CAMHS teams across the Trust continue to prioritise staff recruitment, and group therapy sessions to manage demand more effectively. City & Hackney recently opened a Saturday clinic focusing on ADHD and medication to increase available capacity, and this has largely led to the reduction in number of young people waiting for assessment. The admin team have managed to recruit someone on a full-time basis to focus on reviewing waiting lists and prioritising the longest waiters.

Group interventions have been a successful approach across Bedfordshire CAMHS and this is now being tested in different services. In Newham CAMHS, the Neuro-Developmental Team (NDT) and Emotional and Behavioural (E&B) team have been identified as having the longest waiting lists. The E&B team continues to use the allocation spreadsheet and the service is now focusing on implementing group therapy sessions. Four additional group therapy sessions launched in mid-June and it is hoped that in July, the team will start observing a reduction in their overall waiting lists. The team have managed to successfully recruit a group of care coordinators to help support these sessions. Two of the new sessions will focus on social skills, one is focused on anxiety and the other specialises in obsessive-compulsive disorder (OCD). Training on non-violent resistance has commenced and twenty people have attended so far. The team is currently training additional clinicians to help lead this group. A recent away day with the team focused on promoting group therapy sessions as the main solution to tackle waiting times.

Children and Young People

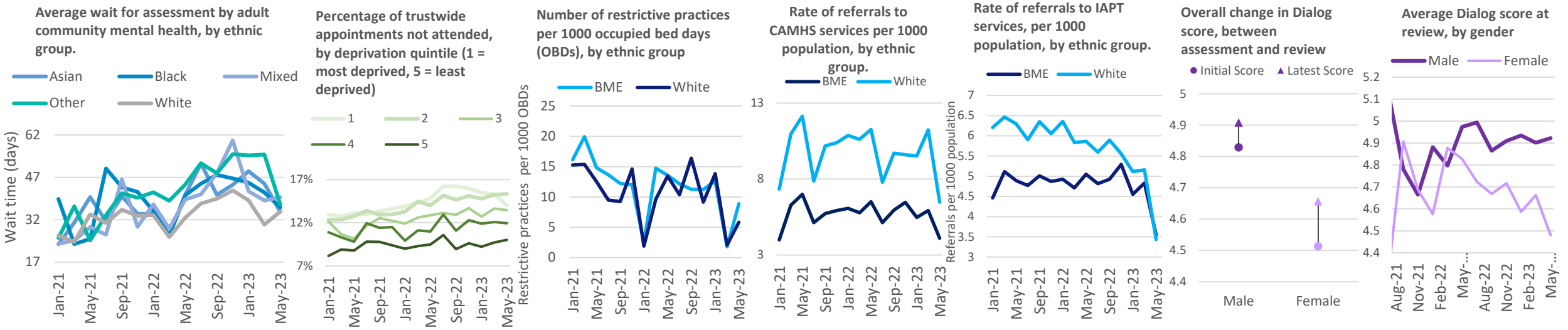
A CAMHS people participation strategy across East London is currently in the process of being developed. A focus group has been established to understand how the experience of waiting could be improved to ensure service users are "waiting well". Suggestions from this focus group will be presented back to senior leads to discuss appropriate change ideas and ensure that ideas being tested help to improve patient experience and manage the safety of children and young people.

Within our eating disorder services, we have now separated out the Intensive Home Treatment eating disorder team in our reporting, to improve the visibility of true waits and data accuracy. The newly established community eating disorders neighbourhood team has identified a disparity in the number of referrals to the service across the three London boroughs, with Newham having the lowest numbers. To improve access for Newham residents, a QI project has been established to engage St Ann's Hospital, talking therapies and the community team, with the aim of increasing access by 100% by December 2023.

The Children's Autistic spectrum disorder service in Newham continues to face increasing demand and lengthening waiting lists. It was recently found that Newham primary schools have the highest proportion of Autism and Profound Multiple Learning Disabilities in England. The current capacity in SCYPS services is 52% below what is needed to manage the level of referrals. Longer term plans include integrating ASD and CAMHS colleagues to create a single referral and screening process for autism and ADHD. Integration with CAMHS would also help to facilitate a holistic approach, considering the impact of adversity and trauma, in the formulation of a neurodivergent child.

SCYPS quality and experience indicators remain consistently high, with 100% of parents and service users satisfied. As shown in the population health indicators, over half of children with neuro-disabilities are receiving prompt annual reviews. Satisfaction levels are believed to be related to regular team reviews and the work to streamline pathways in the neuro-disability clinic and motor neurone clinic.

Equity and Equality



This section focuses on a range of equity and equality measures through a gender, ethnicity and deprivation lens in order to better understand disparities and the initiatives underway to provide more equitable care. Equity measures have also been added to each of the populations in the full system performance dashboard (see Appendix 1).

The average waiting times for assessment across adult and older adult community mental health services chart is showing a closing of the gap between BAME (Black, Asian, and Minority Ethnic) and White groups over the past few months. Among the various ethnicities, individuals with mixed or 'other' backgrounds, who previously experienced longer waiting times to be assessed, have observed the largest reduction. As highlighted in the March report, a number of initiatives are underway to support improve access and flow across community services. This includes effective waiting list management, prioritising vulnerable groups, and integrating mental health care and support into Primary Care Networks (PCN). Collaborations with Voluntary Community and Social Enterprises (VCSE) organisations and system partners have led to the development of new resources and pathways. For example, new roles have been established, such as peer support workers and community connectors, who are bridging the gap between mental health services and disadvantaged communities. Furthermore, the implementation of the Patient and Carers Race Equalities Framework (PCREF) is underway across the Trust to improve the quality of care for service users from disadvantaged communities.

The percentage of service users not attending appointments continues to be higher amongst services users from more deprived communities. A number of initiatives to tackle this have been introduced, which include introducing different consultation options, such as virtual appointments. Services are offering more flexible scheduling options, including appointments on weekends, and at different locations such as community hubs, outreach clinics and crisis cafes. Written communication is offered in multiple languages, and home visits are provided for individuals with more complex requirements. The community mental health transformation program is actively focused on addressing inequities, including issues related to missed appointments in socioeconomically disadvantaged areas.

Equity and Equality

The restrictive practice chart suggests that the ongoing initiatives focused on enhancing safety culture and fostering open dialogue regarding restrictive practices may be yielding favourable outcomes. While the rate of restrictive practices is greater amongst BAME groups, over the past 12 months we are seeing reduction for both White and BAME groups. Inpatient services across the Trust note variations in the use of prone restraints, rapid tranquilisation, and seclusion at times of high occupancy and complexity, and teams continue to utilise daily safety huddles and MDT review of care plans to manage this. Our goal is to eliminate prone restraint, due to the potential strain on the respiratory system and the heightened risk to physical health. All instances of prone restraint are reported, regardless of their duration.

The “Let's Talk” project group is working to enhance the quality of community mental health services for BAME individuals in East London. The group is implementing suggestions put forward by service users, which encompass enhancing staff cultural awareness, promoting accountability, improving accessibility, and fostering a comprehensive understanding of needs. In Newham, a mental health event was organised in collaboration with HealTogether, a Somali organisation. A third-sector organisation called BADU, which offers support to families, schools and local systems, has been successfully recruited to conduct cultural awareness sessions. Service users are actively engaged in offering consultation to services through the Together Café initiative. Through several workshops held with voluntary, community and faith organisations, it was found that these organisations find it challenging to refer people to mental health services as they aren't a statutory service, the pathways can sometimes lack clarity and, in their view, their professional judgement on a resident's mental health isn't trusted. As a result, the project group is looking to review existing clinical pathways, helping to make sure they are user-friendly and use appropriate language. Similar engagement is taking place in Tower Hamlets, with numerous community organisations facilitating cultural awareness sessions.

City & Hackney have developed a Black men's group, running bi-weekly to provide a space for emancipation circles, which are groups to help heal and end trauma caused by anti-Black racism. The community pharmacy team have introduced medication side effect workshops for the community organisation 'IRIE Minds'. A feedback session has been held to reflect on the workshops, which were found to be useful and to have encouraged the planning of further outreach work. Trainee psychologists are running focus groups with staff to look at the outcomes of previous cultural awareness sessions and identify gaps for further improvement work. The City & Hackney perinatal service is looking to increase preconception referrals for women with serious mental illness. Proactive outreach is being completed in early intervention services as well as the coproduction of multilingual information leaflets with GPs, to better educate service users about the service. This is believed to have had a positive impact on referrals to the service. The service is in the process of creating a self-referral process to help reduce stigma and improve access.

In recent months, services have highlighted that there has been a small reduction in referrals to talking therapy services, which has been attributed to seasonal fluctuation, additional bank holidays, and religious observances like Passover, Easter, and Ramadan. Talking therapies services are actively addressing inequalities by implementing targeted strategies to improve access and outcomes for specific underserved populations within their respective communities. Bedfordshire talking therapies continue to target Asian men over 40, offering multilingual information and partnering with local faith organisations. Newham focuses on Black males aged 18-25, utilising community outreach, promotional merchandise, and increased social media presence. Tower Hamlets aims to improve outcomes for Bangladeshi service users by offering services at accessible locations and enhancing staff training for a culturally competent service. Additionally, talking therapies have been successful in being able to recruit a population health fellow to work across North East London with a focus on inequalities in access and outcomes. Our data is showing an improvement in the equity indicator, with a higher percentage of service users from Black and Minority Ethnic (BAME) communities accessing talking therapies (see page 23, appendix 1).

Equity and Equality

Reverend Lloyd Denny, a respected community leader in Luton, conducted a review of health inequalities in Bedfordshire, Luton, and Milton Keynes (BLMK) post-pandemic. The findings of this review are informing the evolving strategy on health equity in the region. The literature review that supported the work highlighted that the communities experiencing the greatest health inequalities across BLMK include Gypsy, Roma, Traveller, LGBTIQ, people living in deprived areas from ethnic minority backgrounds, people living in deprived areas with both physical and learning disabilities, as well as migrants and homeless people. The evidence gathered outlined areas for focus including communication barriers, NHS culture, community and faith interventions. Numerous initiatives are currently underway which our mental health and community services are engaged in with Integrated Care System partners, including developing community hubs, incentives for pregnant smokers, and the implementation of the 10 year BLMK mental health strategy.

The Bedfordshire CAMHS Discovery College continues to work closely with children and young people from disadvantaged backgrounds through a combination of face-to-face workshops, online workshops and physical and mental wellbeing activities. The breakdown of overall attendance shows 44 attendees from the Discovery College, 283 attendees from schools, 221 attendees in multi-sport sessions specifically designed for English for Speakers of Other Languages (ESOL) learners at Dunstable College, 53 attendees in Safe Space sessions, and 66 attendees at other projects, including the Careers Fair, Mock Interviews, and Evergreen Inpatient Unit. In total, 667 young people between the ages of 13 and 18 were reached. Qualitative feedback was collected during the Spring Term from eight schools situated in the Bedford, Luton, and Dunstable areas. Each school received three sessions, with valuable positive insights and perspectives on how the service was received by teachers and students. The next phase of this work will seek to build on the service user feedback, and focus on increasing awareness through social media campaigns, increasing the variety of programmes and activities on offer, and improving access by working more closely with diverse communities and organisations, particularly those that are hard to reach.

Across Learning Disabilities services in East London, services have recently conducted a comprehensive health needs assessment, specifically focusing on adults with a learning disability. The assessment has yielded valuable insights and identified areas of focus related to inequalities, particularly pertaining to ethnicity and other protected characteristics. Based on the findings, 19 recommendations have been formulated to address these disparities and enhance the provision of services for this vulnerable population. These recommendations encompass areas such as enhancing access, diminishing stigma, addressing loneliness and social isolation, promoting integrated care within the system and among care providers. A workshop is being organised with service users to prioritise the recommendations and develop a roadmap for implementing targeted interventions, promoting equitable access to healthcare, and ensuring that the diverse needs of individuals with learning disabilities are appropriately addressed and supported. The outputs from the workshop will include a project plan outlining key milestones for the upcoming year. A similar programme of work is also currently under way for young people using CAMHS services with learning disabilities and autism.

Appendices

Appendix 1 – System performance dashboard

Appendix 2 – Regulatory compliance against the system oversight framework

Appendix 3 – Prevention of future deaths reports issued in the last two months

Appendix 1: System Performance dashboard - overview

Special cause variation (↑ ↓) and when it's of potential concern (↑ ↓)

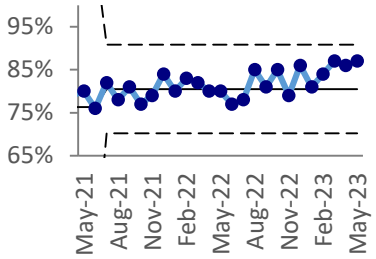
		Average	
People with substance misuse problems			
Service users reporting improvements in quality of life on discharge in Bedfordshire	Population Health	81%	
Service users in employment on discharge in Bedfordshire	Population Health	42.1%	
Percentage of successful completions not re-presenting to service in Bedfordshire	Quality	39.3%	↑
Waiting times to treatment - average days wait in Bedfordshire	Quality	5.9	
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	1.3%	
Successful completions in Bedfordshire, by ethnic group	Quality		
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	25.0	
Average Treatment Waiting Time (days) for children and young people aged 0-18	Population Health	57.8	↑
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	6109	↑
Admissions to adult facilities for services users under 18 years old (monthly)	Quality	1.4	
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	82%	
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	
Referrals, by ethnic group, per 1000 population	Quality		
Dementia			
Average wait (in weeks) from referral to diagnosis -18 week target	Quality	14.3	
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%	
Percentage of service users seen from minority groups	Quality		
Children with complex health needs			
Percentage with complex neuro disability receiving a clinical review within past 12 months	Population Health	60.2%	↑
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	72.5	
Children receiving ASD diagnosis within 2 or less appointments	Value	75.5%	
Percentage of service users referred from minority ethnic groups	Quality		
People receiving end of life care			
Service users on End of Life Pathway (end of month)	Population Health	1,614	↓
Service Users referred to Continuing Healthcare as a fast track in month	Population Health	40.8%	
Percentage of service users with Care Plan in place (advanced) in East London	Quality	86.1%	
Percentage of service users with Care Plan in place (advanced) in Bedfordshire	Quality	99.6%	↑
Percentage of service users who died in their preferred place of death	Value	73.8%	
Percentage access from minority communities (East London)	Quality		
People who are frail or who have multiple long term conditions			
Percentage of service users who have recorded a positive experience	Quality	92.4%	
Rapid Response seen within 2 hour guideline (East London)	Quality	93.8%	↑
Number of Grade 2, 3 or 4 pressure ulcers (monthly)	Quality	83.3	
Promoting independent living - discharged within 6 wks. Bedfordshire	Quality	92.3%	↑
Percentage of inappropriate referrals into Intermediate Care - Bedfordshire	Value	6.2%	↓
Percentage of referrals re-referred within 30 days, by ethnic group	Quality		

		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	39.8%	↑
Percentage of positive comments to PEQ	Quality/Experience	91.5%	↓
Average wait times to assessment (in weeks)	Quality/Experience	1.11	↑
Average wait times to treatment (in weeks) from assessment	Quality/Experience	7.68	
Number of people accessing IAPT services (in month)	Value	2649	
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	50.0%	
Occupied bed days used in month by service with Learning Disability (Monthly)	Quality	270	
Number of specialist out of area inpatient placements (Monthly)	Value	3	
Referrals by ethnicity, per 10 000 population	Quality		
People with Severe Mental Illness			
Percentage of service users receiving Individual Placement Support – IPS	Population Health	15.5%	↑
Percentage of service users in employment	Population Health	6.8%	↑
Service users receiving NICE concordant care within 2 wks of referral (EIS services – face to face)	Population Health	76.3%	
Percentage of service users in settled accommodation	Population Health	44.9%	
Percentage of service users followed-up within 72hours of discharge	Quality	74.7%	
Percentage of Service user service users with paired outcome measures showing improvement.	Quality	33.0%	
Psychological Therapy Service average wait times to (in weeks) to 1st assessment in East London	Quality	6.3	↑
Psychological Therapy Service average wait times to (in weeks) to treatment in East London	Quality	16.4	↑
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	93.0%	
Percentage of service users with SMI receiving a full physical health check	Quality		
Woman who are pregnant or new mothers			
Number of woman 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	81%	↓
Percentage of service usersundertaking 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	Quality	15.2	
Average weeks waited for face to face appointment with the Diabetes Service	Quality	7.1	
Average weeks waited for initial appointment with the MSK and Physiotherapy teams	Quality	7.6	↓
Average weeks waited for initial appointment with the Continence Service	Quality	7.8	
Average weeks waited for initial appointment, by ethnic group	Quality		
Stable Long Term Conditions (Bedfordshire)			
Adult Continence Referral to treatment times average weeks waited	Quality	9.9	
Podiatry Referral to treatment times average weeks waited	Quality	8.6	↑
Occupational Therapy Referral to treatment times average weeks waited	Quality	2.5	
Physio Referral to treatment times average weeks waited	Quality	3.4	
Adult Speech and Language Therapy Referral to treatment times average weeks waited	Quality	5.4	
Wheelchairs Referral to treatment times average weeks waited	Quality	15.1	
Average weeks waited for initial appointment, by ethnic group	Quality		

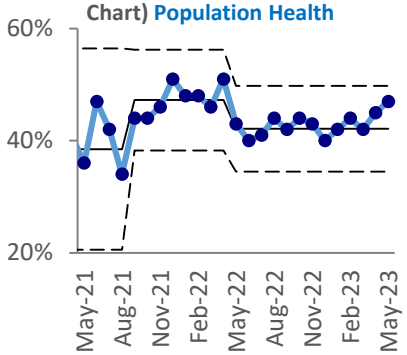
Appendix 1: System Performance dashboard Long Term Plan ( ) Special cause variation ( ) and when it's of potential concern ( )

People with substance misuse problems

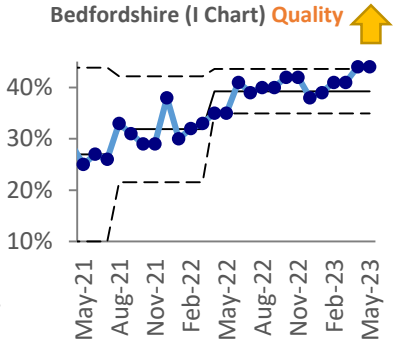
Reporting improvements in quality of life on discharge in Bedfordshire (I Chart)
Population Health



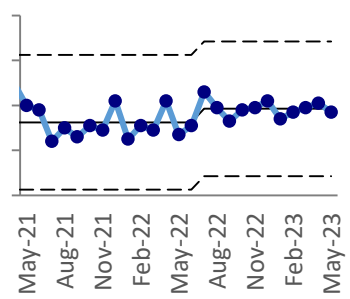
Service users in employment on discharge in Bedfordshire (I Chart) Population Health



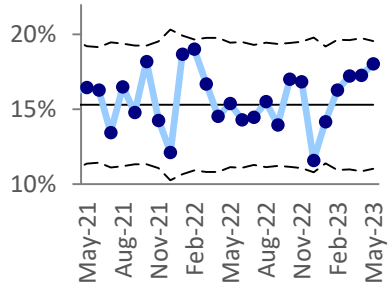
Successful completions not re-presenting to service in Bedfordshire (I Chart) Quality



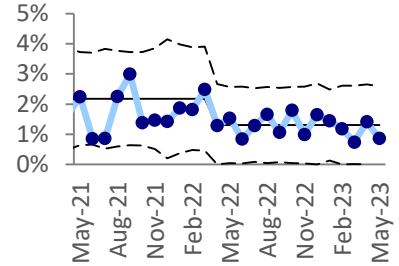
Average waiting time (days) to treatment in Bedfordshire (I Chart) Quality



Service users with drug problems across Mental Health services (P Chart) Quality

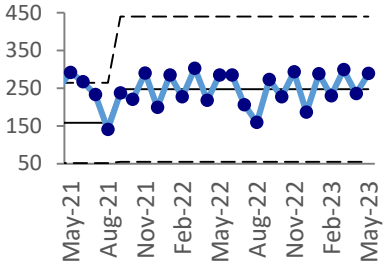


Service users with Alcohol problems across Mental Health services (P Chart) Quality

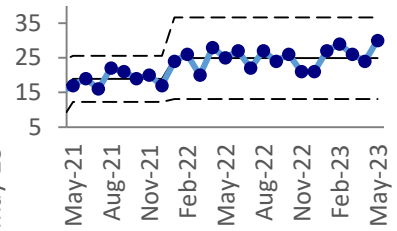


Children with complex mental health needs

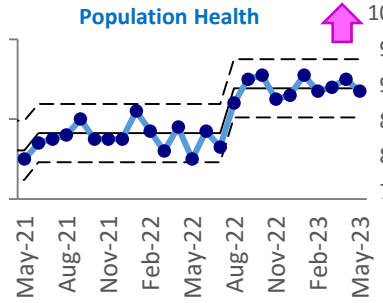
Number of service users presenting in crisis to our crisis pathway (I Chart)
Population Health



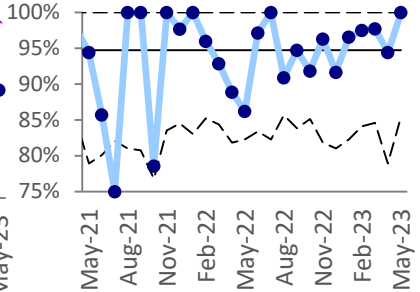
Average Assessment Waiting Time for Children and Young people aged 0-18 (I Chart)
Population Health



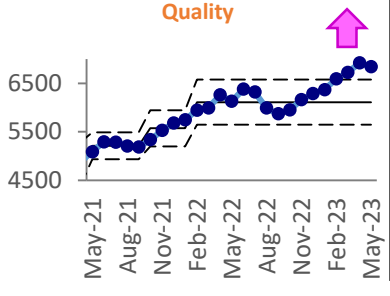
Average Treatment Waiting Time (Days) for Children and Young people aged 0-18 (I Chart)
Population Health



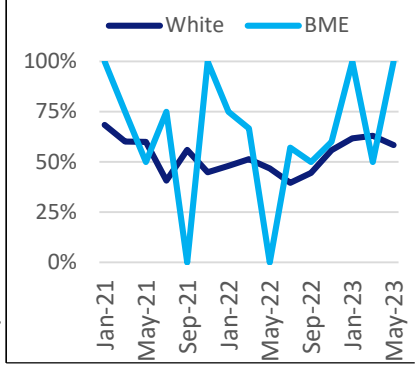
Carers and service users recommending our Community services (P chart)
Population Health



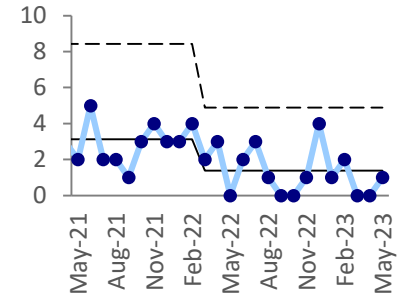
Children and young people aged 0-18 who have received one or more contacts with mental health services (I Chart)
Quality



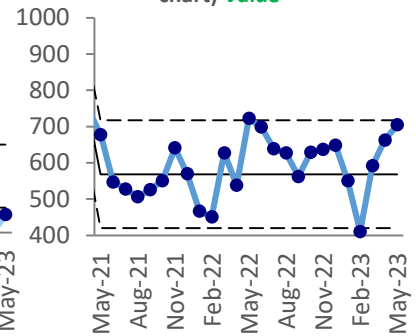
Successful completions in Bedfordshire, by ethnic group



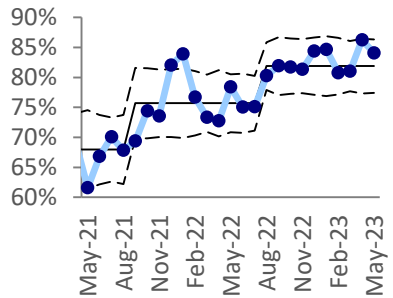
Admissions to adult facilities for services users under 18 years old (C Chart) Quality



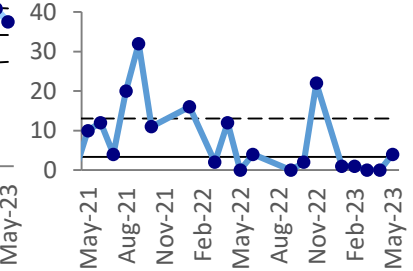
Tier 4 Occupied Bed days East London excluding leave (I chart) Value



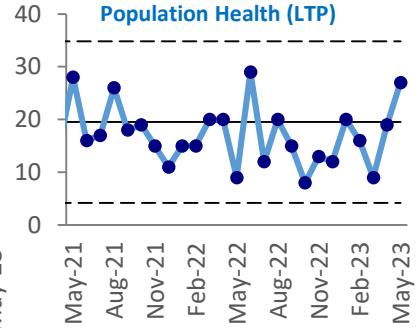
Percentage of service users has paired Outcome Measures at discharge (P chart) Quality



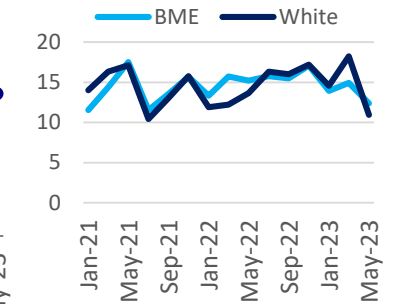
Average waiting time (days) for urgent referrals to CYP Eating Disorders services (I Chart)
Population Health (LTP)



Average waiting time (days) for routine referrals to CYP Eating Disorders services (I Chart)
Population Health (LTP)



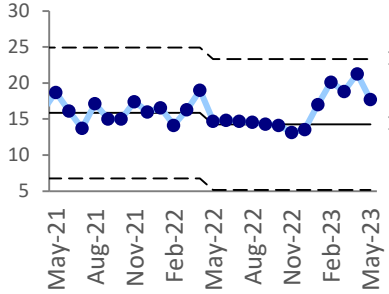
Referrals, by ethnic group, per 1000 population
Quality



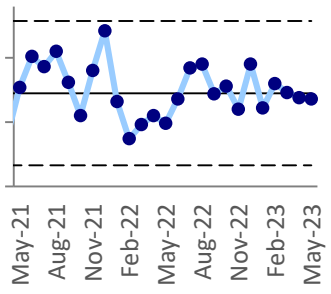
Appendix 1: System Performance dashboard Long Term Plan ( ) Special cause variation ( ) and when it's of potential concern ( )

People with dementia

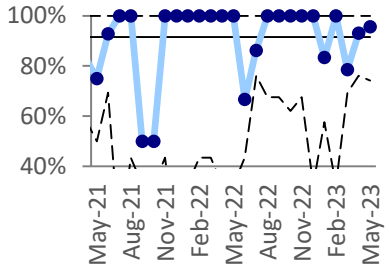
Average wait (in weeks) from referral to diagnosis (I chart) Quality



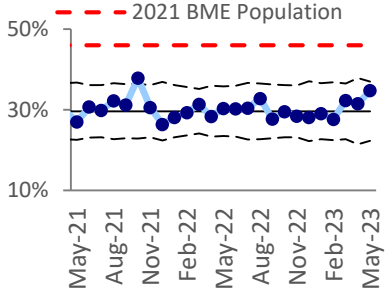
Average waiting time (in days) from referral to assessment (I chart) Population Health



Percentage satisfaction with service, service users and carers (I chart) Quality

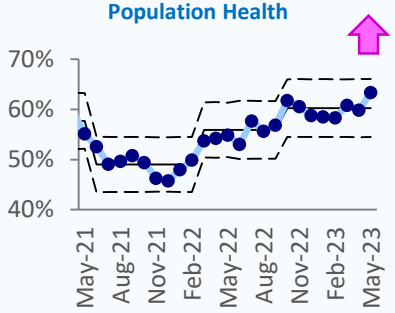


Percentage of service users seen by dementia services from minority communities (P chart) Quality

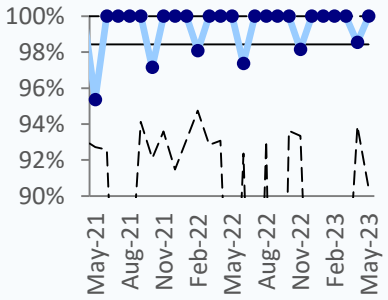


Children with complex health needs

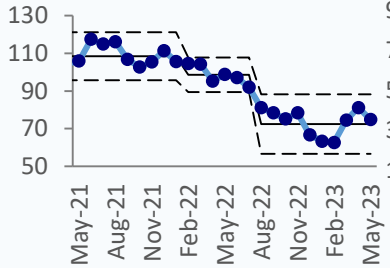
Complex neuro disability receiving a clinical review within past 12 m (P Chart) Population Health



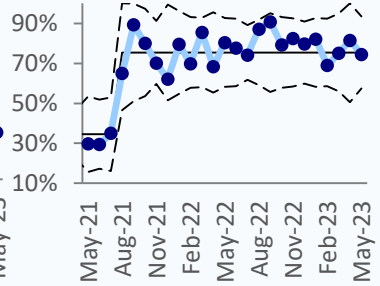
Percentage of service users and parents satisfied with services (P Chart) Quality



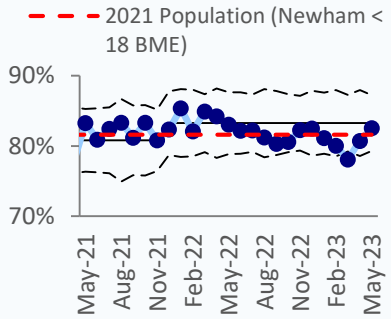
Average weeks waited from Autism Spectrum Disorder referral to first appt. (I chart) Quality



Children receiving ASD diagnosis within 2 appointments (P Chart) Value

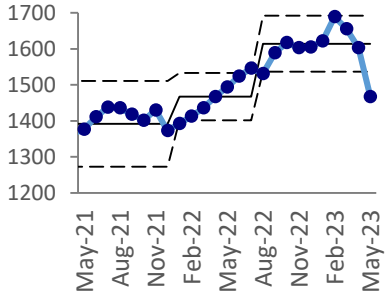


Percentage of service users referred from minority ethnic groups

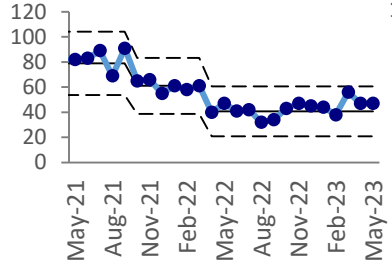


People receiving end of life care

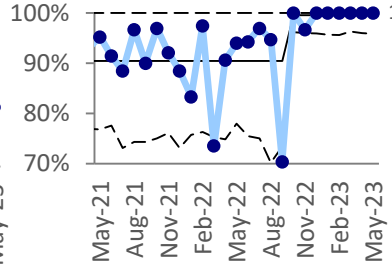
Service users on End of Life Pathway (I chart) Population Health



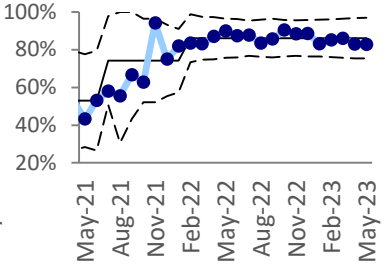
Service Users referred to Continuing Healthcare as a fast track (I chart) Population Health



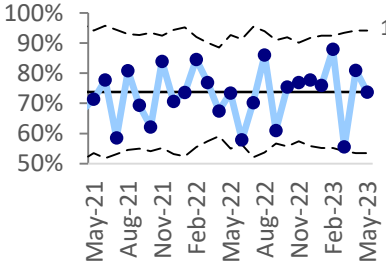
Service users with Care Plan in place (advanced) in Bedfordshire (P Chart) Quality



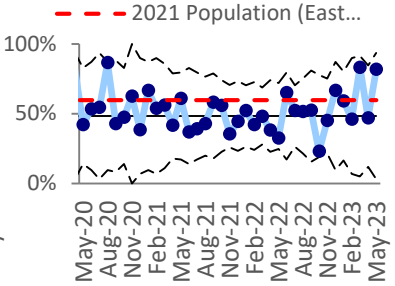
Service users with Care Plan in place (advanced) in East London (P Chart) Quality



Service users who died in their preferred place of death (P Chart) Value



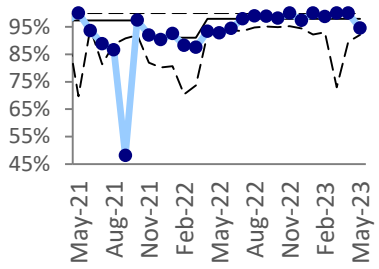
Percentage access from minority communities (East London) (P chart) Quality



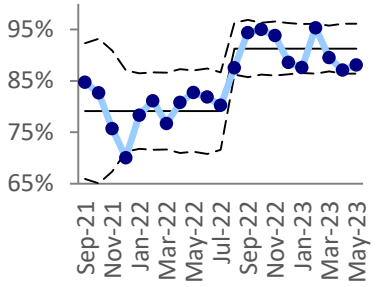
Appendix 1: System Performance dashboard Long Term Plan ( ) Special cause variation ( ) and when it's of potential concern ( )

People who are frail or have long term conditions

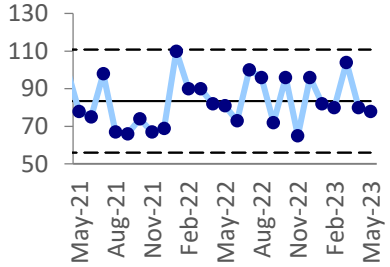
Percentage of service users who have recorded a positive experience (P chart)
Quality



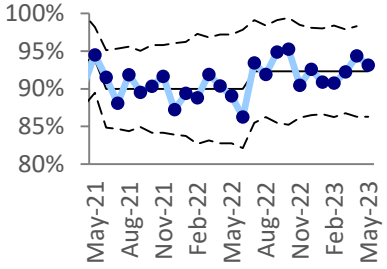
Rapid Response seen within 2 hour guideline (East London) (P Chart) Quality



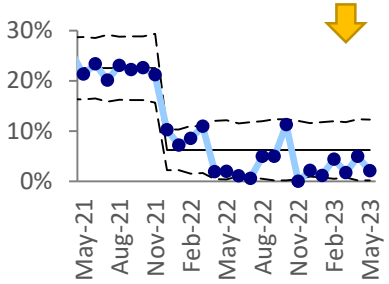
Number of Grade 2, 3 or 4 pressure ulcers non-inherited (C Chart)
Quality



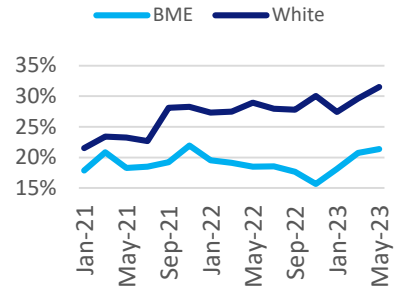
Promoting independent living - discharged within 6 weeks Bedfordshire(P Chart)
Quality



Number of inappropriate referrals into Intermediate Care - Bedfordshire (P Chart)
Value

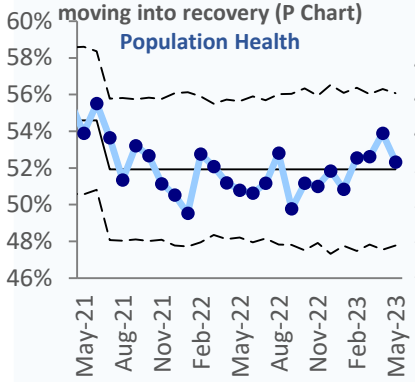


Percentage of referrals re-referred within 30 days
Quality

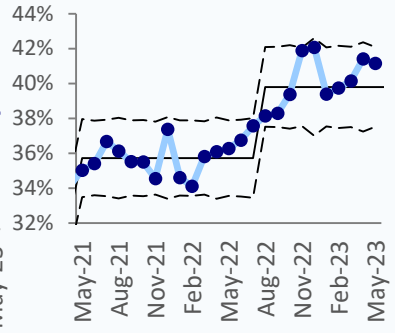


People with common mental health problems

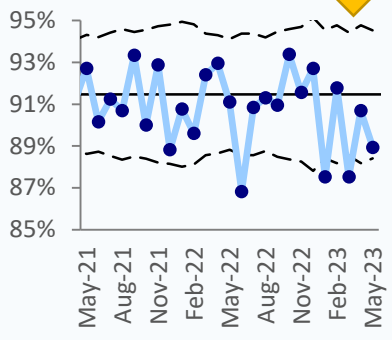
Percentage of service users moving into recovery (P Chart)
Population Health



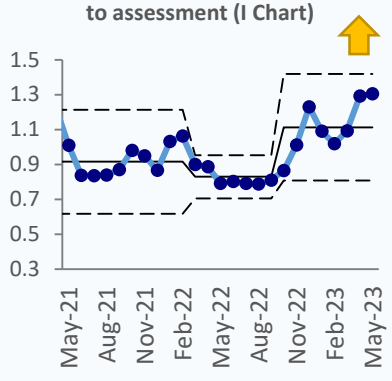
Percentage access by minority groups (P Chart)



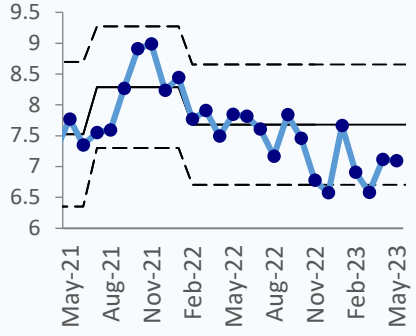
Percentage of positive comments to PEQ (P Chart)



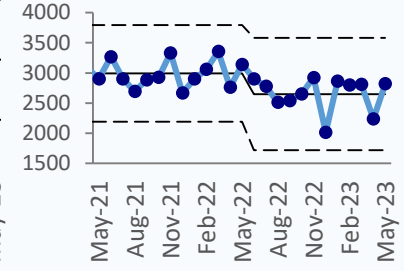
Average wait times (in weeks) to assessment (I Chart)



Average wait times to treatment (in weeks) from assessment (I Chart)

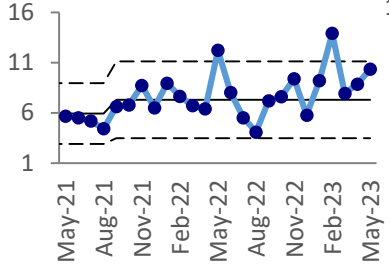


Number of people accessing IAPT services (I Chart)
Value

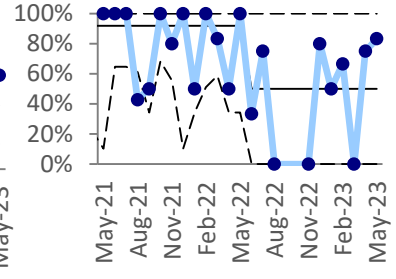


People with a learning disability

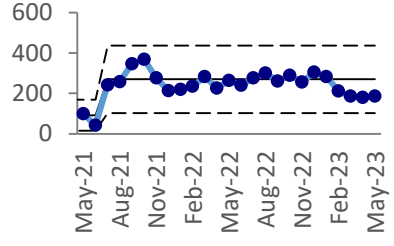
Average waiting times for new referrals seen (in weeks) for assessment (I chart) Population Health



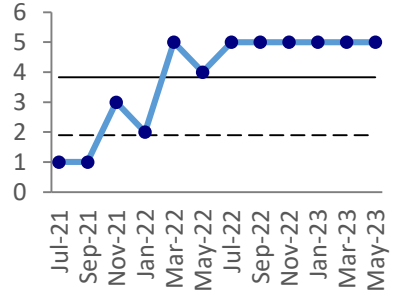
Percentage of service users that would recommend this service (P Chart)
Population Health



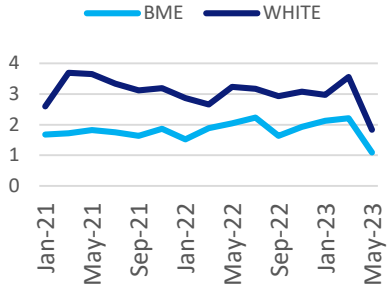
Occupied bed days used in month by service users with Learning Disability referred to LD Team (I Chart)
Quality



Number of specialist out of area inpatient placements (Run chart) Value



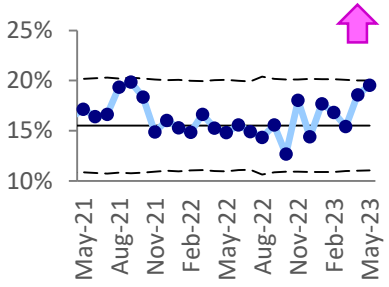
Referrals by ethnicity, per 10 000 population
Quality



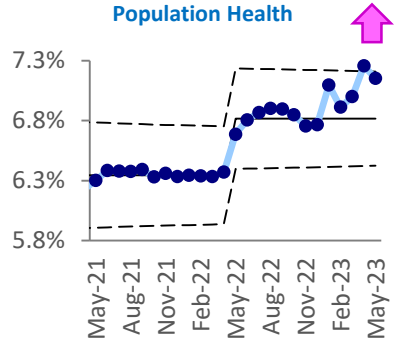
Appendix 1: System Performance dashboard Long Term Plan (●) Special cause variation (↑ ↓) and when it's of potential concern (↑ ↓)

People with Severe Mental Illness

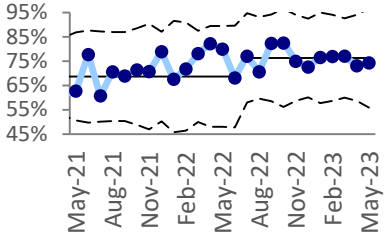
Percentage of service users receiving Individual Placement Support (P chart) Population Health



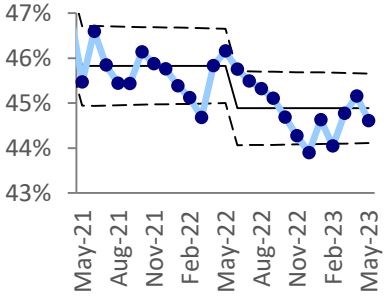
Percentage of service users in employment (P chart) Population Health



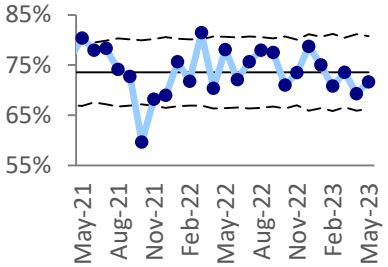
Service users receiving NICE concordant care within 2 wks of referral (EIS services – face to face) (P Chart) Population Health



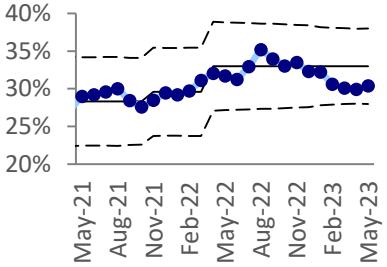
Percentage of service users in settled accommodation (P chart) Population Health



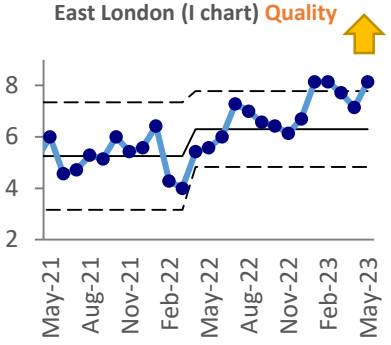
Percentage of service users followed-up within 72hours of discharge (P chart) Quality



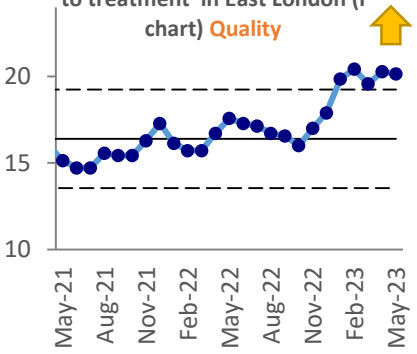
Inservice userswith paired outcome measures showing improvement (P Chart) Quality



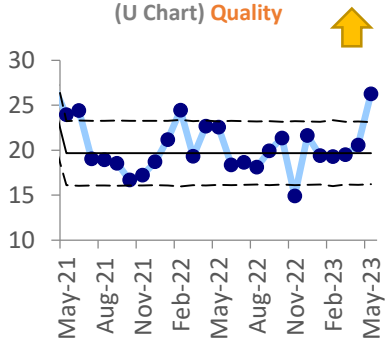
PTS average wait times to (weeks) to 1st assessment in East London (I chart) Quality



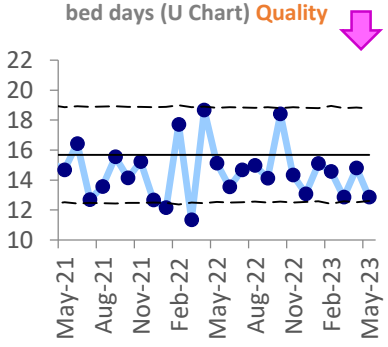
PTS average wait times (weeks) to treatment in East London (I chart) Quality



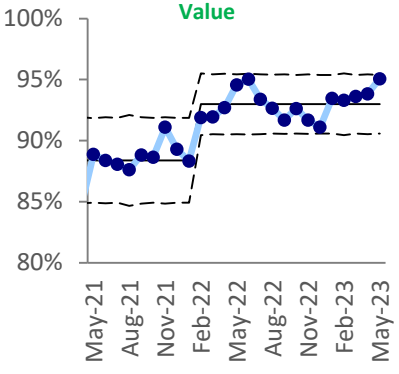
Number of restraints reported per 1,000 occupied bed days (U Chart) Quality



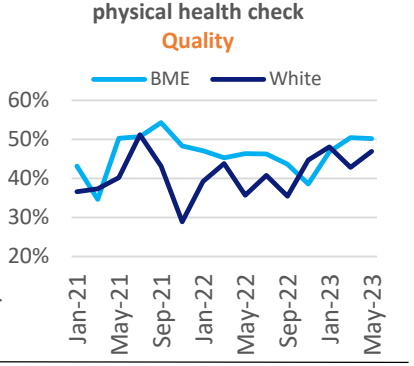
Rate of physical violence incidents per occupied 1,000 bed days (U Chart) Quality



Bed occupancy (P' Chart) Value

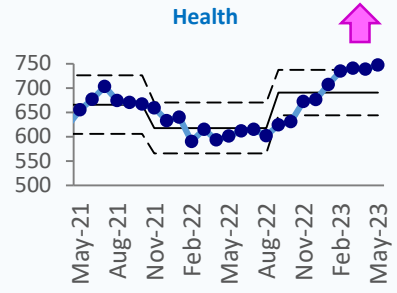


Percentage of service users with SMI recieving a full physical health check Quality

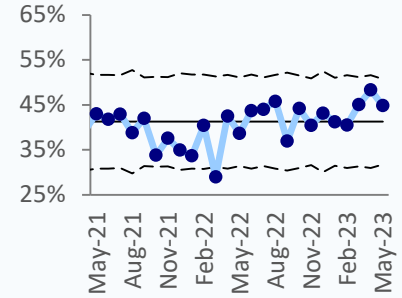


Woman who are pregnant or new mothers

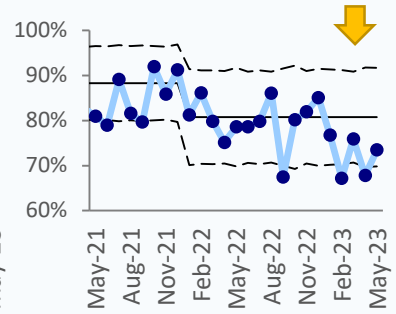
Number of woman receiving one + contact with specialist mental health services within 12 months (I Chart) Population Health



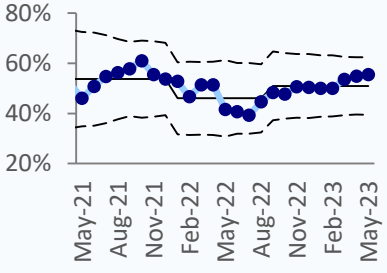
Service users seen in the month from minority communities (P Chart) Population Health



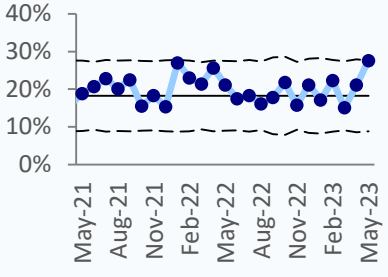
Percentage of service users seen within 28 days (P Chart) Quality



Percentage of service usersundertaking Core10 showing improvement (P Chart) Quality



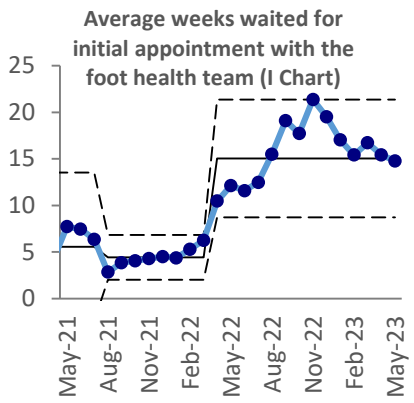
Percentage of Service Users not attending their initial appointment (P Chart) Quality

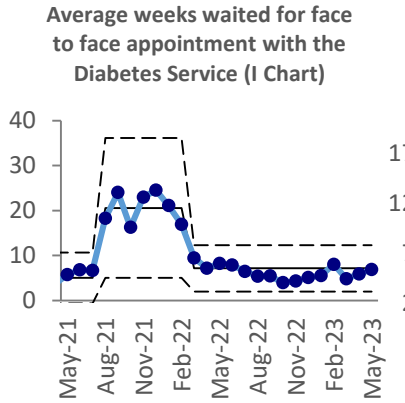


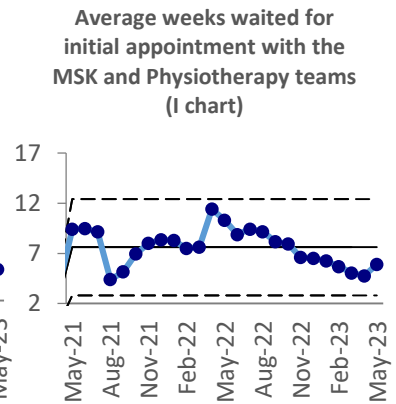
Appendix 1: System Performance dashboard

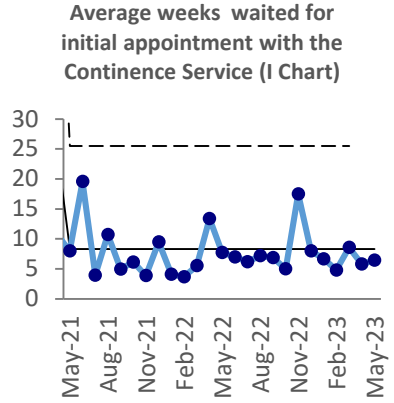
Special cause variation (⇧ ⇩) and when it's of potential concern (⇧ ⇩)

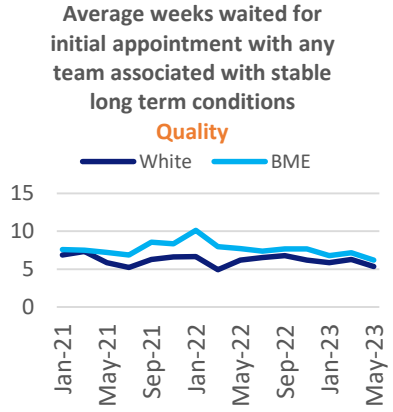
People with stable long term conditions (East London)



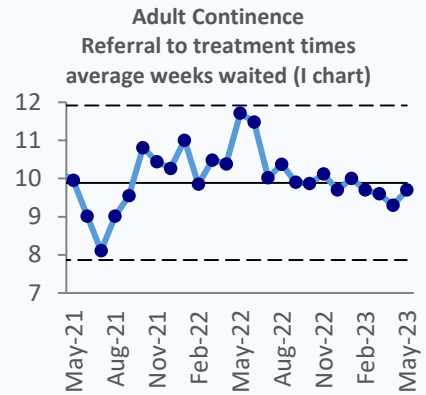


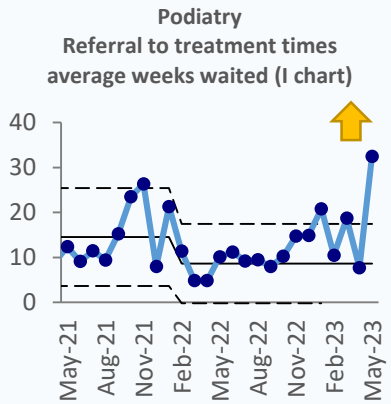


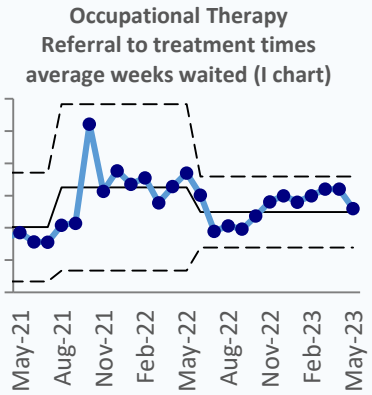


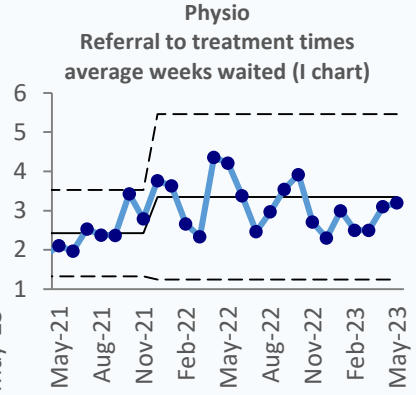


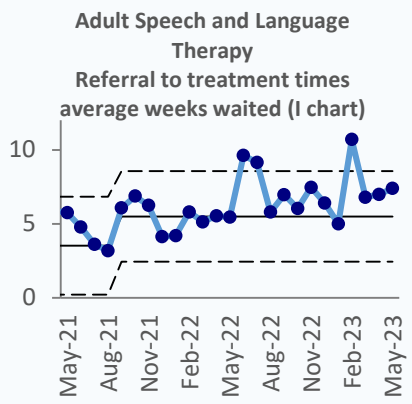
People with stable long term conditions (Bedfordshire)

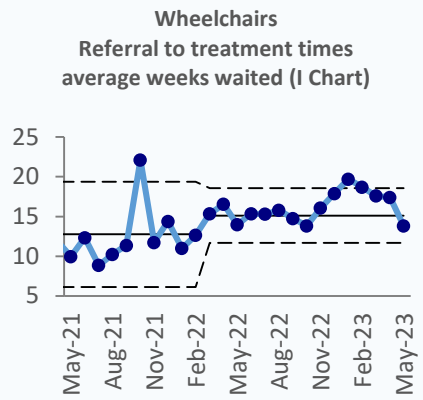


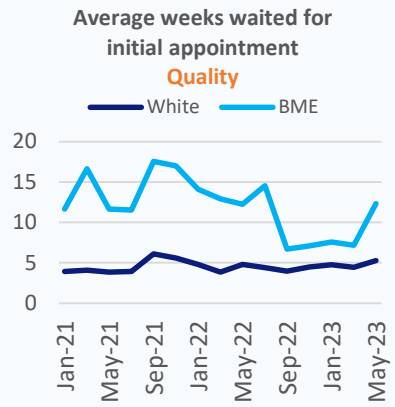












Appendix 2: Regulatory Compliance – System Oversight Framework (SOF)

NHS England and NHS Improvement have published a revised approach to NHS System Oversight (SOF) 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	Indicator code	Measure Name (metric)	Oversight Level	Target	Current performance and progress
Quality of care, access and outcomes	Urgent and Emergency Care		Proportion of service users spending more than 12 hours in an emergency department	ICB		The current position for East London is 68 breaches (8%) and 2 in Bedfordshire & Luton
	Primary Care and Community Services	S107a	Proportion of Urgent Community Response referrals reached within two hours	ICB	70%	Community Health Services are exceeding the target across Trust. The latest nationally reported figure on the NHS Digital publicly available dashboard shows the trust at 87% for April-23. Performance for East London and Bedfordshire is shown within the Access and Responsiveness section.
	Primary Care and Community Services	S105a	Proportion of service users discharged from hospital to their usual place of residence	ICB/Provider		In 2022/2023 41% of discharges with a recorded discharge destination recorded show discharge to usual place of residence. 60% of discharges in 2022/2023 have a discharge destination of Not Known/Not Recorded or Not Applicable.
	Primary Care and Community Services	S106a	Available virtual ward capacity per 100k head of population	ICB/Provider	40 per 100,000	In East London, discussions between ELFT and ICB colleagues are still ongoing in Newham with a view to potentially establishing 26 virtual beds in the borough. In Tower Hamlets, virtual wards have not yet begun, and there are ongoing discussions with Royal London Hospital regarding the quantity and nature of care to be provided. In Bedfordshire, the number of virtual ward beds within the BLMK footprint is still ongoing and it is being led regionally.
	Mental health services	S084a:	Number of children and young people accessing mental health services as a % of population	ICB		We have 14,449 children and young people who have had contact with a Community CAMHS service in the last 12 months to March 2023. The population of Young people in East London, Luton And Bedford is 1.72 million. Access rate is 0.8% or approx. 1 in 125 young people.
	Mental health services	S085a	Proportion of people with severe mental illness receiving a full annual physical health check and follow -up interventions	ICB		The current position reported by ICB for December 22 is 85.8%. This indicator is based on primary care records which ELFT doesn't have access to.
	Mental health services	S081a	Access rate for IAPT services	ICB	100%	The ELFT access rate for March is 101% with Bedford at 96% and East London at 105%. The figures for East London are elevated as the number of individuals treated in Tower Hamlets exceeded the contracted treatment number - 956 out of 805.
	Mental health services	S110a	Access rates to community mental health services for adult and older adults with severe mental illness	ICB		The current position reported by ICB for December 2022 is 103.6%. (*This is the most up to date nationally reported position)*
	Mental health services	S086a	Inappropriate adult acute mental health placement out -of-area placement bed days	Provider		Local figure: 2,4687 Occupied Bed days (2022/23 of trust placements).
	Learning disabilities and autism	S030a	Proportion of people aged 14 and over with a learning disability on the GP register receiving an annual health check	ICB	100%	As of March 74.5% of people with a learning disability aged 14 and older received an annual health check, with Bedfordshire & Luton at 78% and East London at 71%. The national target at the end of Q4 is 75%.

Appendix 2: Regulatory Compliance – System Oversight Framework (SOF)

Oversight Theme	NHS Long Term Plan Area	Indicator code	Measure Name (metric)	Oversight Level	Target	Current performance and progress
Quality of care, access and outcomes	Learning disabilities and autism	S029a	Service users with a learning disability and/or autism per million head of population	ICB	30 per 1,000,000	The current position reported by ICB for Q3 is 27 per 1,000,000
	Safe, high qualitycare	S039a	National service user Safety Alerts not completed by deadline	Provider	0	100%. In May there were 3 national patient safety alerts published, all 3 of the deadlines were met.
	Safe, high qualitycare	S038a	Consistency of reporting service user safety incidents	Provider	100%	The current position is 100% in April and May 2023.
	Safe, high qualitycare	S035a	Overall CQC rating	Provider		The current CQC rating is Outstanding
	Safe, high qualitycare	S037a	Percentage of service users describing their overall experience of making a GP appointment as good	ICB		51% responded positively to the question, 'How would you describe your appointment-making experience?' in the previous 12 months to March 2023 (n = 5,346).
	Safe, high qualitycare	S121a	NHS Staff Survey compassionate culture people promise element sub-score	Provider		The ICB position for 2021 is 7.2/10. (*This is the most recent position reported at the national level*)
	Safe, high qualitycare	S040a	Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	Provider	0	Current position is 0 cases.
	Safe, high qualitycare	S041a	Clostridium difficile infection rate	Provider	100%	Current position is 0 cases.
	Safe, high qualitycare	S042a	E. coli bloodstream infection rate	Provider	100%	Current position is 0 cases.
	Safe, high qualitycare	S044b	Antimicrobial resistance: appropriate prescribing of antibiotics and broad-spectrum antibiotics in primary care	Provider	Antibacterial items per STAR/PU - 87% % of Broad Spectrum - 10%	In May, Antibacterial items per STAR/PU is 92.2%, and as a % of Broad Spectrum is 8.34%
Preventing ill Health	Reducing inequalities		Performance against relevant metrics for the target population cohort and five key clinical areas of health inequalities	ICB/Provider		Data not available
	Prevention and long term conditions	S115a	Proportion of diabetes service users that have received all eight diabetes care processes	ICB		The 2022-23 Q4 position reported by NHS SOF Dashboard is NEL at 51.9% and BLMK at 46.8%. (*This is the most recent position reported at the national level*)
	Prevention and long term conditions	S051a	Number of people supported through the NHS diabetes prevention programme as a proportion of service users profiled	ICB		The 2022 Q3 position reported by NHS SOF Dashboard is 55.2%. (*This is the most recent position reported at the national level*)

Appendix 2: Regulatory Compliance – System Oversight Framework (SOF)

Oversight Theme	NHS Long Term Plan Area	Indicator code	Measure Name (metric)	Oversight Level	Target	Current performance and progress
Preventing ill Health	Prevention and long term conditions	S055a	Number of referrals to NHS digital weight management services per 100k head of population	ICB		The 2022 Q3 position reported by NHS SOF Dashboard is 95 per 100,000 (*This is the most recent position reported at the national level*)
	Screening, vaccination and immunisation	S117a	Proportion of service users who have a first consultation in a post -covid service within six weeks of referral	ICB/Provider		The current position reported by ICB for 2023 Q2 is 95.7%
	Screening, vaccination and immunisation	S047a	Proportion of people over 65 receiving a seasonal flu vaccination	ICB/Provider	85%	The current position reported by ICB for December 2022 is 65.6% (*This is the most recent position reported at the national level*)
Leadership & Capability	Leadership	S060a	Aggregate score for NHS staff survey questions that measure perception of leadership culture	ICB/Provider		According to Annual calendar year 2021, Trust at 7.45/10 (*This is the most recent position reported at the national level*)
	Leadership	S059a	CQC well -led rating	Provider	Outstanding	Rated 4 - Outstanding

NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
27 July 2023

Title	Appointments & Remuneration Committee (RemCo) 4 July 2023 – Committee Chair's Assurance Report
Committee Chair	Ken Batty, Senior Independent 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 Appointments & Remuneration Committee (RemCo) meeting held 4 July 2023.

Key messages

Committee's Terms of R

eference

- This was the first meeting of the Appointments & Remuneration Committee under its new terms of reference as approved by the Board at its meeting in March. The committee's main purpose as required under the NHS Act 2006 is to be responsible for identifying and appointing candidates to fill Executive Director positions, and determining their remuneration, allowances and other conditions of service including pension rights and any compensation payments
- The committee's previous roles in respect of monitoring and reviewing the delivery of the Trust's strategic objective relating to staff will be taken forward by the newly established People & Culture Committee.

Recruitment Updates

- Approved the appointment of Charlotte Augst as Chair of Compass Wellbeing CIC
- Approved the appointment of and remuneration for Lorraine Sunduza as Interim Chief Executive
- Ratified the appointment of and remuneration for Dr David Bridle as Chief Medical Officer of ELFT
- Ratified the appointment of and remuneration for Kevin Curnow as Chief Finance Officer of ELFT. For the period leading up to Kevin's start date, Dr Mohit Venkataram will be Acting Chief Finance Officer.

Executive Director Update

- Supported the role the Chief People Officer is undertaking with NHS England on reviewing their ET activity.

NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
27 July 2023

Title	People & Culture (P&CC) 29 June 2023 – Committee Chair's Assurance Report
Committee Chair	Ken Batty, Senior Independent 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 & Culture Committee (P&CC) meeting held 29 June 2023.

Key messages

Committee's terms of reference

- This was the first meeting of the People & Culture Committee (P&CC) whose terms of reference was approved by the Board at its meeting in March 2023
- The committee's main purpose, previously the remit of the Trust's Appointments & Remuneration Committee, is to monitor, review and report to the Board on the delivery of the Trust's strategic objective relating to people and the management of risks pertaining to this. This includes oversight of, and assurance on, the achievement of the Trust's people plan
- The agendas for this meeting will focus on one of the Trust's people plan priorities; for this meeting the priority area was 'belonging to the NHS'.

Industrial Action

- Junior doctors' strike 13-18 July 2023 and consultants' strike 20-21 July 2023: arrangements for cover in place as with previous strike days and the acting down policy will be applied. Assurance provided there are no concerns around ensuring appropriate cover is provided

Clinical Excellence Awards

- During the pandemic there was a process of equal distribution, using an agreed points process
- The report details the number of consultants and a breakdown by characteristics: female consultants are well represented although there is disparity around ethnicity; this will be picked up following the first submission of the Medical Workforce Race Equality Standards (MWRES) due on 30 June 2023. However, neither the gender nor ethnicity breakdowns are proportionate to the make-up of the Trust or community
- There is a QI project under way focusing on the gender pay gap for medics
- A review of the process for award year 2023 for pre-2018 CEAs being undertaken, recognising that the focus should be on rewarding excellence overall and equal distributions is not the preferred way going forward.

WRES Submission and Action Plan

- Overall the metrics are positive
- There are slight deteriorations in BME representation across bands 1-4, 8a and 8b; and despite more BME staff accessing non statutory and mandatory training, there is a deterioration in the likelihood of BME staff being recruited against their white counterparts and the likelihood of BME staff going through disciplinary action has also increased. A deep dive into all current disciplinary processes is being undertaken and the Fair Treatment process is being reviewed and relaunched alongside retraining for the advisors and managers.
- There is a decrease in the level of bullying and harassment for BME staff overall and work to analyse and triangulate the results by location is underway.
- Discussions taking place with the RaCE network on further initiatives to remove the structural inequalities in recruitment and other measures to create more opportunities for BME staff
- A three year action plan is being developed

- A detailed report will also be presented at the Trust Board in July.

WDES Submission and Action Plan

- Although there has been an increase in the number of people disclosing their disability and an improvement in the likelihood of disabled staff being appointed, analysis between the 2018 and 2022 submissions and staff survey questions shows a deterioration across all metrics
- Assurance provided that a range of actions are being taken including a full QI process to examine where and why there are major issues and a deteriorating direction of travel for the Trust, the findings of the report will be the subject of a Trust-wide Directorate Management Teams meeting, and a project manager is being appointed to lead on the development of a reasonable adjustments plan which is an area that requires improvement
- A three year action plan is being developed
- A detailed report will also be presented at the Trust Board in July.

EDI Plan and Governance Structure

- A new EDI governance structure has been introduced which includes service user representatives on the Equalities Board
- The EDI plan aligns with NHS England's high impact actions launched earlier this year
- Measurable indicators have been lifted from the staff survey and in consultation with the staff networks will cover all protected characteristics and capture data around intersectionality
- The committee highlighted the mixed level of ambition around the 2024-2026 targets and requested an indication of current baseline data
- A detailed report will also be presented at the Trust Board in July.

Board Assurance Framework: People Risk

- The recommendation to amalgamate risks 5 and 6 was approved; these risks are inextricably linked and there is a significant overlap in terms of mitigating actions, thus providing a more focused and less repetitive overview. The new risk is *If issues affecting staff experience including the recruitment and retention of people with the right skills are not effectively planned for and addressed, this will adversely impact on staff motivation, engagement, retention and satisfaction*
- Approval was provided to increase the current risk score from Significant 16 to Significant 20 due to increasing external factors (including recruitment shortages, retention challenges, etc) as well as cost of living concerns for staff – many of these factors are outside of the Trust's control; in addition the target risk score was increased from High 9 to High 12.

Belonging in the NHS:

Workforce Race Equality Standard (WRES)
Workforce Disability Equality Standard (WDES)
Equality & Diversity Plan

July 2023

NHS
East London
NHS Foundation Trust

Title	Belonging in the NHS - Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Equality Plan
Author Name and Role	Juliana Ansah, Head of Equality, Diversity and Inclusion
Accountable Executive director	Tanya Carter, Chief People Officer

PURPOSE OF THE REPORT

To provide assurance to the Board on overall performance of the organisation, in terms of the People Plan priority areas: Belonging in the NHS, in support of the delivery of the Trust strategy.

KEY MESSAGES

Workforce Race Equality Standard

In 2014, NHS England and the NHS Equality and Diversity Council agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. It was agreed that a Workforce Race Equality Standard (WRES) should be developed. The WRES was introduced to the NHS in April 2015. The WRES Standards require NHS organisations to demonstrate progress against several indicators of workforce race equality, including a specific indicator to address the low levels of Black and Minority Ethnic (BME) Board representation.

In summary, this year, there is still an over representation of BME staff in Bands 3-6 (63.7%) which is greater than the overall BME percentage (55.4%), specifically in clinical roles (65.7% between Clinical Band 3-6). However, in the clinical roles there has been improved BME representation in all Bands, excluding Band 4 and in consultant roles where percentages have been consistent with a slight percentage increase since last reported. Similarly, there have been further positive developments of BME representation in non-clinical roles Band 4, 7, 8B and 8C.

BME representation in non-clinical roles Bands 8A & 8B has dropped by 2.9%. However, this could be due to promotion of individuals. In the clinical roles, Bands 8B &8B have slightly reduced by 0.2% but bands 8C-VSM have grown slightly by 1.9% in BME representation from last year. There has been a significant decrease in the number of BME staff that have been appointed from shortlisting from 1006 in 2022 to 899 in 2023, whilst compared to white staff with 707 appointments in 2022. In 2022, white staff were 1.05 times more likely than BME staff to be appointed from shortlisting. This likelihood has increased slightly to 1.4 in 2023; this means that whilst white staff are still 1.4 times more likely of being appointed from shortlisting than their BME colleagues, the overall number of disciplinary cases has reduced for both white and BAME staff in the latest report. The number of BAME disciplinary cases is still higher than white staff, and has increased in inequity, unlike last year's reporting where the relative likelihood of BME staff entering the formal disciplinary process compared to white staff had decreased. This year, this likelihood has increased (from an 0.5 decrease in likelihood between 2021 to 2022) to doubling from 1.45 in 2022 to 2.91 in 2023, meaning that BME staff are 2.91 times more likely to enter the formal disciplinary process when compared their white colleagues. In 2021, the relative likelihood of BAME staff entering the disciplinary process had increased from 1.19 in 2020 to 1.95 in 2021. It then decreased to 1.45 in 2022 and then spiked to 2.91 in 2023.

KEY MESSAGES (continued)

Workforce Disability Equality Standard

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used by the relevant NHS organisation to develop a local action plan, and enable them to demonstrate progress against the indicators of disability equality.

The WDES has been commissioned by the Equality and Diversity Council (EDC) and developed through a pilot and extensive engagement with Trusts and key stakeholders. It is mandated through the NHS Standard Contract and is restricted to NHS Trusts and Foundation Trusts for the first two years of implementation.

The WDES is important because research shows that a motivated, included, and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The implementation of the WDES will enable NHS Trusts and Foundation Trusts to better understand the experiences of their disabled staff. It will support positive change for existing employees and enable a more inclusive environment for disabled people working in the NHS. Like the Workforce Race Equality Standard (WRES) on which the WDES is in part modelled, it will also allow us to identify good practice and compare performance regionally and by type of Trust. The 2023 submission shows that the Trust has significantly deteriorated in a number of metrics and in a number of metrics. The experience of disabled staff at ELFT is consistently less positive than that of non-disabled colleagues and of the Trust average. Additionally, we are below average in the benchmark group for all WDES indicators, and in the majority, we are one of the lowest scoring Trusts.

- The Trust is below the benchmark group median in all WDES metrics. In five of the seven, we are ranked in the bottom eight Trusts.
- This is a negative shift as in previous years ELFT was one of the top performing Trusts in the benchmark group in three metrics. This decline undoes previous progress and puts us in a position of being one of the worst performing Trusts.
- At Trust level, Metric 5 (Career progression) has seen a slight improvement and whilst the rise is negligible, it is accompanied by improvements in indicators relating to appraisals and development.
- Disabled staff are below the Trust average and significantly poorer than non-disabled staff in all metrics except metric 4b where there has been an improvement in relation to the Trust average. This improvement is due to a poorer experience in the Trust overall, rather than an improvement for disabled staff.

KEY MESSAGES (continued)

The deterioration in the WDES metrics are disappointing. In order to address the challenges in the WDES metrics, extensive analysis has been undertaken to better understand where the areas of focus should be, based on the staff survey results. Working with the ELFT Ability network we have identified three priority areas to focus on, so that we can progress the 1 year plan from October 2022 -October 2023 whilst we create a three-year plan 2023-2026.

Equality, Diversity and Inclusion Plan (EDI)

We have worked in partnership to co produce an EDI Plan. The plan also supports the achievement of national strategic EDI outcomes, which are to address discrimination, enabling staff to use the full range of their skills and experience to deliver the best possible patient care.

- Increase accountability of all leaders to embed inclusive leadership and promote equal opportunities and fairness of outcomes in line with the NHS Constitution, the Equality Act 2010 and the Messenger Review
- Support the levelling up agenda by improving EDI within the NHS workforce, enhancing the NHS's reputation as a model employer and an anchor institution, and thereby continuing to attract diverse talents to our workforce
- Make opportunities for progression equitable, facilitating social mobility in the communities we serve. The plan focuses on the removal of systemic barrier.

This includes policies, practices or procedures across a whole system (e.g. the Trust) that result in some people having unequal access or being excluded. They can also be psychological barriers caused by fear and mistrust based on personal experiences. It is therefore important that we look at solutions to addressing these barriers to make sure that people have equal experiences of services/employment and equity of access to our services.
Intersectionality is a term used to describe multiple types of discrimination that someone might experience when their identity overlaps across a number of different groups, such as gender, age, ethnicity, sexuality etc. This means we have to get better at understanding people as a whole so that we understand how to reduce inequalities for them and others. In doing this we make to make sure that no protected characteristic outweighs another and that we understand someone's entire experience.
The plan is designed to achieve a significant, measurable, change in advancing equality of opportunity for all staff coming into contact with the organisation. The action plan will be monitored by the Equality Programme Board and reported to the Trust People and Culture Committee for end of year assessment and evaluation. The previous Equality Plan focused on 4 protected characteristics whereas the new plan focuses on all 9 protected characteristics.

Executive Summary

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

Improved service user experience	☒	If the Trust are better able to reflect the populations we serve, then the quality of care is likely to improve and better the experience of service users and patients. If the experience of staff is improved, and they feel as though they belong that will address recruitment, retention staff wellbeing and the overall staff experience, which will in turn positively impact the patient experience.
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, Joint Staffside Committee (JSC) and the People & Culture Committee.

Implications

Impact	Update/detail
Equality Analysis	This report aims to close the gaps in the experience and opportunities between white and BME staff and staff with a disability within the Trust.
Risk and Assurance	This report details the progress and deteriorations across the 2023 WRES and WDES metric submissions, and highlights Trust's diversity and human rights practice demonstrates economic, legal, moral and reputational sense.
Service User/Carer/Staff	The needs of service users, carers and staff sit at the heart of equality, diversity and human rights work.
Financial	Excellent equality, diversity and human rights practice demonstrates economic, legal, moral and reputational sense.
Quality	A number of the WRES and WDES indicators are directly linked to the National NHS Staff Survey outcomes and there is a casual link between staff satisfaction and the quality of patient care.

Belonging in the NHS:
ELFT Equality and Diversity Plan

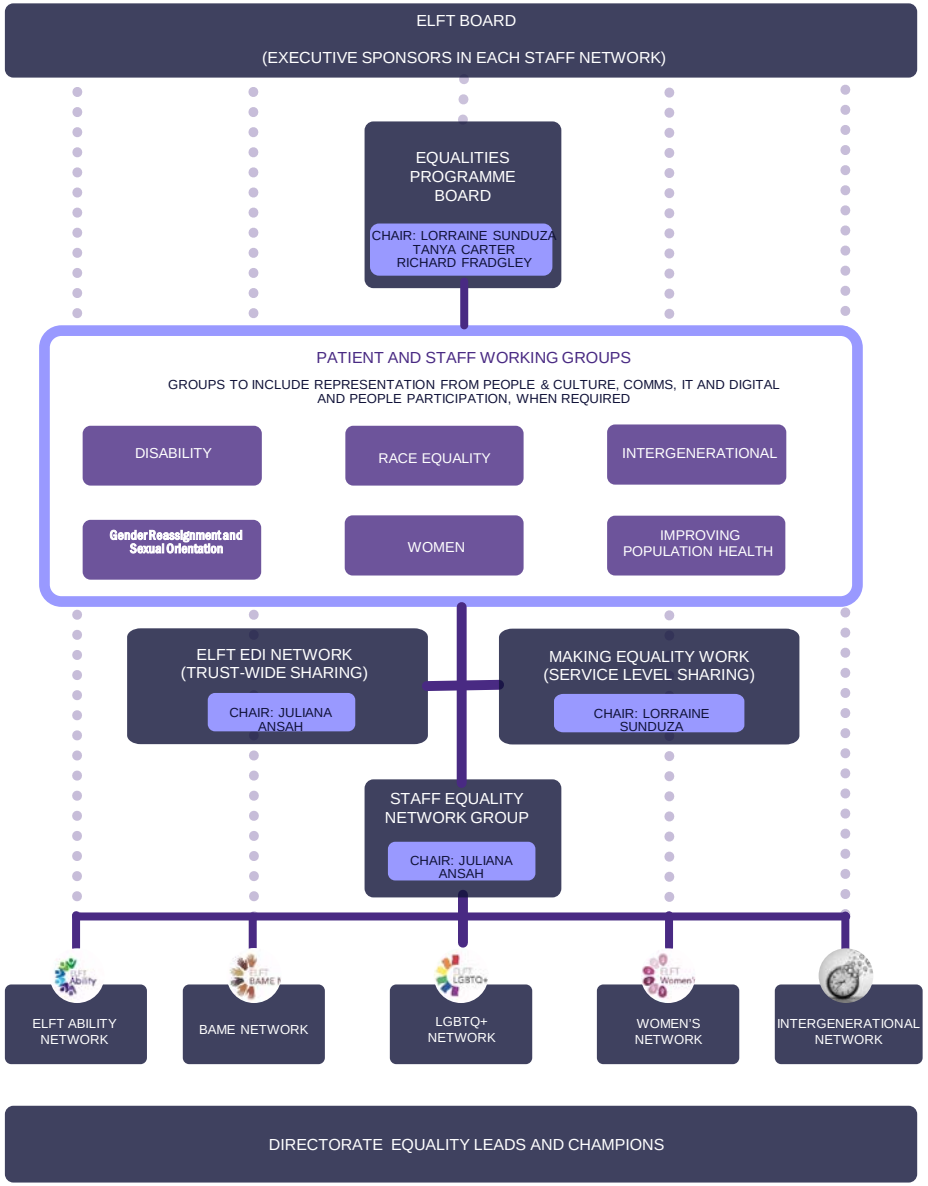
July 2023

NHS
East London
NHS Foundation Trust

ELFT Equalities Governance

The purpose of this plan is to provide a robust governance framework to shape and progress the equalities agenda for our Trust.

The Equalities Programme Board will provide trust-wide guidance and oversight to equality projects. Each work stream will be comprised of such members that can facilitate the unblocking of challenges to equality initiatives at ELFT.



Belonging in the NHS: EDI Targets (2023-2026)

July 2023

NHS
East London
NHS Foundation Trust

EDI Targets for Intersectionality

East London NHS Foundation Trust

ELFT's position for the following indicators scored amongst the worst nationally in the 2022 NHS Staff Survey, regardless of protected characteristics.

Trust Strategy

Staff Experience

Indicators from NHS National Staff Survey	2024	2025	2026
Increase confidence in reporting of harassment, bullying or abuse experienced at work	57%	60%	65%
Reduce experience of discrimination from line managers and colleagues	11%	7%	4%
Improve fair experience to career progression, training and development opportunities	60%	62%	65%
Reduce experience of musculoskeletal problems (MSK) as a result of work activities	26%	22%	20%

EDI Targets by Protected Characteristic

Trust Strategy

Staff Experience

Protected Characteristics	Indicators from multiple sources	2024	2025	2026
Age	Reduce experience of discrimination due to age	19%	17%	15%
Religion or belief	Reduce experience of discrimination due to religion or belief	8%	5%	4%
Sex and pregnancy and maternity	Reduce gender pay gap	4.5%	3.5%	2%
Gender reassignment and sexual orientation	Improve position on Stonewall Index	Top 200	Top 150	Top 100
Disability (WDES)	Improve ESR declaration rates for disabled staff	8%	8.6%	9.5%
	Reduce likelihood of disabled staff entering the formal capability process, compared to that of Non-disabled staff	5.5	3.5	1
	Increase percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	76%	78.5%	81%
Race (WRES)	Reduce relative likelihood of BME staff entering formal disciplinary	1.5	1.2	1
	Equalise relative likelihood of white staff being appointed from shortlisting across all posts, compared to BME staff	1.3	1.2	1
	Reduce percentage of clinical BME staff experiencing harassment, bullying or abuse from patients, relatives or the public	33%	30%	25%

Belonging in the NHS:
ELFT
Workforce Race Equality Standard (WRES) 2023

July 2023

NHS
East London
NHS Foundation Trust

ELFT WORKFORCE RACE EQUALITY STANDARD (WRES) REPORT AND ACTION PLAN 2023/24

East London NHS Foundation Trust

Introduction

East London NHS Foundation Trust is committed to meeting the requirements of the Workforce Race Equality Standard (WRES) for NHS Trusts. ELFT submitted the Trust's workforce data to the national WRES team on 31 May 2023 as per our contractual obligations.

This WRES action plan focuses on objectives for the financial year 2023/24 where some actions have already been completed. To ensure that this plan plays a key role in our journey towards becoming an anti-racist organisation, we have grouped this action plan into four themes to reflect the WRES return and the Trust's People Plan:

- New Ways of Working;
- Looking After Our People;
- Belonging in the NHS;
- Growing and Developing for the Future.

Monitoring and Evaluation

The action plan will be monitored by the Trust's Race Equality Working Group on a bi-monthly basis and by the newly formed Equality Programme Board on a quarterly basis, and through the Trust People and Culture Committee for end of year assessment and evaluation.

Future Plan

Outcomes from this plan will inform the ambitious 3-year WRES action plan from March 2023 to March 2026.

NHS
East London
NHS Foundation Trust

Workforce Metric 1

The following metric shows the representation of BME staff. Definitions are based on Electronic Staff Record (ESR) occupation codes, with the exception of medical and dental staff, which are based upon grade codes.

Metric 1 - Staff Representation		2022	2023		Comment
Percentage of BME staff in each of the AfC bands 1 - 9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce.	Overall BME Percentage	53.7%	55.4%	↑	There is an overrepresentation of BME staff in Band 1-4 for both Clinical and non-Clinical roles. An increase in BME staff within Clinical and Non-Clinical bandings 5-7 shows a steady improvement in recruitment. Band 8A-8B non-Clinical continues to see a downward trend whereas Clinical roles are seeing a steady year on year increase. Increased representation in Medical & Dental Consultant and Non-Consultant positions continue to increase. ELFT rank high compared to other London Trusts and Mental health Trusts across the England. CEA briefing sessions advised consultants the types of additional activities they could apply for CEAs.
	Non-clinical Band 1 - 4	59.4%	57.9%	↓	
	Non-clinical Band 5 - 7	54.5%	56.6%	↑	
	Non-clinical Band 8A - 8B	41.6%	38.7%	↓	
	Non-clinical Band 8C - VSM	22.5%	28.1%	↑	
	Clinical Band 1 - 4	65.5%	67.7%	↑	
	Clinical Band 5 - 7	55.0%	56.5%	↑	
	Clinical Band 8A - 8B	34.6%	36.4%	—	
	Clinical Band 8C - VSM	19.6%	22.5%	↑	
	Medical and Dental Consultants	41.3%	42.3%	↑	
	Medical and Dental Non-Consultants	46.8%	58.7%	↑	
	Medical and Dental Trainees	55.8%	56.2%	↑	

↓ Needs Improvement ↑ Improved — No Change

NHS East London NHS Foundation Trust

Workforce Metric 2 & 3

The following metric shows the relative likelihood for BME staff across all posts.

Metric 2 - Recruitment	2022	2023		Comment
Relative likelihood of White staff being appointed from shortlisting across all posts *(A figure below 1.00 indicates that BME staff are more likely than white staff to be appointed from shortlisting)*	1. 23	1.40	↓	ELFT were ranked best 25% nationally in 2021. Although the gap has widened, in 2022 ELFT were ranked upper 22% of NHS Trusts in likelihood ratio of hiring white/BME staff.

Metric 3 - Disciplinary	2022	2023		Comments
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation *Note: This indicator will be based on data from a two-year rolling average of the current year and the previous year.*	1.45	2.91	↓	This likelihood is significantly greater than white staff and has doubled since 2022. It is also more than double the national average. The Fair Treatment process has further managed to sustain a reduction in overall disciplinary action. However, in terms of reducing inequality in formal disciplinary action it is still inconclusive. **Headcount:** White: 2022= 52 2023= 11 BME: 2022= 90 2023= 41 Unknown: 2022= <5 2023= 0 **Note:** This indicator is based on year end data. It was previously collected 2 year rolling.

↓ Needs Improvement ↑ Improved — No Change

NHS East London NHS Foundation Trust

Training Access Metric 4

The following metric shows the relative likelihood of BME staff accessing non-mandatory training and CPD.

Metric 4 - CPD	2022	2023		Comment
Relative likelihood of staff accessing non-mandatory training and CPD *(A figure below 1.00 indicates that BME staff are more likely than white staff to be appointed from shortlisting)*	0.81	0.90	—	ELFT were ranked best 5% nationally in 2021 reporting. A new Learning Academy launched in February 2022 which transforms the way we all access learning across the Trust. BME and mainstream development programmes have been created to enable staff the choice to select programmes that will better able them to thrive. There is no inequity for this metric.

NHS East London NHS Foundation Trust

National NHS Staff Survey Metric 5 & 6

The following Staff Survey Metrics, compare the responses for both BME and white staff

Metric 5 - Bullying and Harassment		2022	2023		Comment
KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**BME**	33%	35.9	↓	Analysis shows that BME Medical and Dental (59%); Additional Clinical Services (54%); Nursing and Midwifery Registered (50%) reported experiencing the highest rate of harassment, bullying or abuse from patients. For Ethnicity, African (44%) and Bangladeshi (41%) reported experiencing the highest rate of harassment. There has been a significant increase in bullying and harassment towards BME staff. Despite being above average amongst the wider NHS, the Trust is ranked in the 81% percentile nationally in 2022.
	White	33%	26.8%	↑	

Metric 6 - Bullying and Harassment		2022	2023		Comment
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	**BME**	22%	22.4%	—	The Trust performed better than 68% of Trusts and worse than 32% of Trusts. Those from Mixed/Multiple ethnic groups (31%) and Any other White background* (27%) experienced the highest percentage of harassment in this reporting year. * Not English / Welsh / Scottish / Northern Irish / British
	White	21%	27.6%	↓	

↓ Needs Improvement ↑ Improved — No Change

East London NHS Foundation Trust

National NHS Staff Survey Metric 7 & 8

The following Staff Survey Metrics, compare the responses for both BME and white staff

Metric 7 - Career Progression		2022	2023		Comment
KF21. Percentage believing that trust provides equal opportunities for career progression or promotion	**BME**	50%	48.2%	↓	Whilst there was a 2% increase in the previous reporting year, there has been a 2% decrease this year. Within the BME group Additional Clinical Services, Add Prof Scientific and Technic, and Administrative and Clerical have reported the lowest. Allied Health Professionals (56%) and Nursing and Midwifery Registered (53%) have the highest.
	White	61%	63.3%	↑	

Metric 8 – Discrimination		2021	2022		Comment
Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	**BME**	15%	17.2%	↓	Overall, this metric has increased each year. Within the BME group, Administrative and Clerical (21%) and Nursing and Midwifery Registered (19%) have reported the highest rates compared to 10% and 13% for white groups, respectively.
	White	9%	10.3%	↓	

↓ Needs Improvement ↑ Improved — No Change

East London NHS Foundation Trust

Board Representation - Metric 9

This metric shows the percentage of BME staff on the organisations Board.

Metric 9 – Board Representation		2022	2023		Comment
Percentage difference between the organisation's Board voting membership and its overall workforce. Note: Only voting members of the Board should be included when considering this indicator.	Overall Trust Board	52.60%	50.0%	↓	ELFT were ranked best 5% nationally in 2021. All Board members are encouraged to complete their diversity data; and Staff Networks members continue to be involved in the Non-Executive and Executive recruitment process. 2023 has seen a decrease in BME Board representation.
	Voting Membership	52.94%	50%	↓	
	Non-voting Executives	50%	50%	—	
	Executive Team	50%	60.%	↑	
	Non-executive Team	55.56%	37.5%	↓	

↓ Needs Improvement ↑ Improved — No Change

Belonging in the NHS:
ELFT
Workforce Disability Equality Standard (WDES) 2023

July 2023

NHS
East London
NHS Foundation Trust

ELFT WORKFORCE DISABILITY EQUALITY STANDARD (WDES) REPORT AND ACTION PLAN 2022/23

East London NHS Foundation Trust

Introduction

East London NHS Foundation Trust is committed to meeting the requirements of the Workforce Disability Equality Standard for NHS Trusts'. ELFT submitted the Trust's workforce data, for disabled and non-disabled staff, to the national WDES team on 31 May 2023 as per our contractual obligations. This WDES action plan focuses on objectives for the financial year 2023/24 where some actions have already been completed.

The Trust's Disability Working Group has been instrumental in the development of this action plan which has been grouped into four themes to reflect the WDES return and the Trust's People Plan:

- New Ways of Working;
- Looking After Our People;
- Belonging in the NHS;
- Growing and Developing for the Future.

Monitoring and Evaluation

The action plan will be monitored by the Trust's Disability Working Group on a bi-monthly basis and by the newly formed Equality Programme Board on a quarterly basis, and through the Trust People and Culture Committee end of year assessment and evaluation.

Future Plan

In summer 2022, an in-depth analysis of the NHS Staff Survey results was undertaken to consider the experience of disabled staff and how this has changed over a five-year period. The WDES section of the analysis is summarised in this report and will support the development of an integrated and ambitious three-year WDES action plan for March 2023 to March 2026.

NHS East London NHS Foundation Trust

Workforce Metric 1

The following metric shows the representation of Disabled staff. Definitions are based on Electronic Staff Record (ESR) occupation codes, with the exception of medical and dental staff, which are based upon grade codes.

Metric 1 - Staff Representation		2022	2023		Comment
Percentage of staff in each of the AfC bands 1 - 9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce.	Overall BME Percentage	6.5%	7.3%	↑	There is an underrepresentation of staff declaring a disability. The Trust has carried out data cleansing exercises to try and capture this data. Improvements have been made in the quality of data on ESR, by encouraging employees to ensure their equalities data is up to date using self-service and specifically targeting: - New starters; - Disabled staff who become disabled after the recruitment process. Ongoing communications campaign using agreed key messages on disability has supported staff to understand of the importance and value of recording equalities data.
	Non-clinical Band 1 - 4	9.2%	7.8%	↓	
	Non-clinical Band 5 - 7	8.1%	9.7%	↑	
	Non-clinical Band 8A - 8B	8%	9%	↑	
	Non-clinical Band 8C - VSM	7%	9%	↑	
	Clinical Band 1 - 4	5.4%	7.8	↑	
	Clinical Band 5 - 7	6.9%	7.4%	↑	
	Clinical Band 8A - 8B	5%	4.8%	↓	
	Clinical Band 8C - VSM	3%	5.9%	↑	
	Medical and Dental Consultants	2.8%	3.7%	↑	
	Medical and Dental Non-Consultants	5.1%	6.7%	↑	
	Medical and Dental Trainees	2.8%	4.9%	↑	

↓ Needs Improvement ↑ Improved — No Change

East London NHS Foundation Trust

Workforce Metric 2 & 3

The following metrics compares the difference for Disabled and non-disabled staff.

Metric 2	2022	2023		Comment
Relative likelihood of Non-disabled staff being appointed from shortlisting compared to that of Disabled staff being appointed from shortlisting across all posts *(A figure below 1.00 indicates that disabled staff are more likely than non- disabled staff to be appointed from shortlisting)*	1. 11	0.7	↑	There has been improvement since 2022 reporting. We are currently a disability confident employer. Continuous review of the Recruitment and Training Policies has provided greater emphasis on disability awareness.

Metric 3	2022	2023		Comment
Relative likelihood of disabled staff entering the formal capability process, compared to that of Non-disabled staff, as measured by entry into a formal capability procedure *(A figure above 1.00 indicates that disabled staff are more likely than non- disabled staff to enter the formal capability process)*	8.12	11.65	↓	The figure of 11.63 depicts the number of people in one year, in line with new criteria set for WDES. Total number of staff entered formal capability is 9. This needs further analysis and review in order to make improvements. Disabled =3 Non-Disabled =3 Not stated =3 No disabled staff were dismissed due to their disability under this process, and none were related to sickness.

↓ Needs Improvement ↑ Improved — No Change

NHS Staff Survey Analysis

WDES Metrics: ELFT ranking in benchmark group

East London NHS Foundation Trust

Metric			Benchmark group (Rank)				
			2018	2019	2020	2021	2022
4	Harassment, bullying or abuse:	from patients/ public	Bottom 8	Bottom 8	Bottom 12	Bottom 16	Bottom 8
		from managers	Average range 27th out of 48	Bottom 9	Average range 28th out of 48	Bottom 6 trusts	Bottom 3
		from colleagues	Bottom 11	Average range 24th out of 48	Bottom 9	Bottom 10	Bottom 4
	Report harassment, bullying and abuse		Bottom 18	Bottom 14	Bottom 14	Top 20	Bottom 8
5	Career progression		Bottom 17	Bottom 20	Bottom 15	Bottom 9	Bottom 8
6	Presenteeism		Top 3 trusts	Average range 21st out of 48	Bottom 4	Bottom 12	Bottom 4
7	Feeling valued		Top 5	Top 12	Top 5	At least top 13 (prob. Top 11)	Average range 27th out of 51
8	Workplace adjustments		Data not published	Data not published	?20th percentile (Different source)	Data not published	Bottom 2
9a	Engagement score		Top 3	Top 5	Top 8	Top 4	Average range 29th out of 51

East London NHS Foundation Trust

National NHS Staff Survey Metric 4

The following Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff.

Metric 4 – Staff Survey Q.13a-d			2022	2023		Comments
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	% experiencing harassment, bullying or abuse from Patients/service user, their relatives or members of the public in the last 12 months	**Disabled**	34%	35%	↓	The data from recent NHS Staff Survey highlights ongoing concerns of bullying and harassment, and abuse. Detailed analysis for Disabled Workforce is complete. The report uses data from WDES and NHS staff Survey to identify patterns and staff experience across the Trust since 2018.
		Non- Disabled	30%	30%	—	
	% experiencing harassment, bullying or abuse from managers in the last 12 months	**Disabled**	18%	20%	↓	
		Non- Disabled	9%	12%	↓	
	% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	**Disabled**	23%	26%	↓	
		Non- Disabled	14%	16%	↓	
	% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	**Disabled**	60%	56%	↓	
		Non- Disabled	64%	57%	↓	

↓ Needs Improvement ↑ Improved — No Change

East London NHS Foundation Trust

National NHS Staff Survey Metric 5 & 6

The following Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff

Metric 5 – Staff Survey Q.14		2022	2023		Comment
Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	**Disabled**	50%	51%	↑	ELFT's new Learning Academy system transforms the way we access learning across the Trust. The system promotes training opportunities to all staff and encourages disabled staff to apply and to declare their disability. Although there has been a slow improvement, a targeted approached is required in order to provide disabled staff with career development resources and support.
	Non- Disabled	58%	59%	↑	

Metric 6 – Staff Survey Q.11e		2022	2023		Comment
Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	**Disabled**	23%	25%	↓	Trust wide Policies are being reviewed in relation to disability related absence and formal processes. Black/ African/ Caribbean/ Black British 26% (Caribbean 35%) whereas Asian is 34% (Indian 39%).
	Non- Disabled	17%	17%	—	

↓ Needs Improvement ↑ Improved — No Change

East London NHS Foundation Trust

National NHS Staff Survey Metric 7 & 8

The following Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff

Metric 7 – Staff Survey Q.5f		2022	2023		Comment
Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	**Disabled**	47%	43%	↓	We have published key messages about the importance of managing diversity and being a compassionate and inclusive leader. The Respect and Dignity at Work project was expanded to include disability themes. Lowest: Asian 23% (Bangladeshi 17%) Highest BME: Black/ African/ Caribbean/ Black British 42% (African 47%)
	Non- Disabled	56%	54%	↓	

Metric 8 – Staff Survey Q.26b	2022	2023		Comment
Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	76%	71%	↓	Further work is being led to understand the impact of the Workplace Adjustment Process and Guidance for Disabled staff.

↓ Needs Improvement ↑ Improved — No Change

East London NHS Foundation Trust

NHS Staff Survey and the engagement of Disabled staff – Metric 9a & 9b

Metric 9a compares the difference for Disabled and non-disabled staff (9a); and 9b is collection of evidence.

Metric 9a		2022	2023		Comment
The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	**Disabled**	7.0	6.7	↓	This decline means that the Trust has ranked below average this year. Trust has previously been in the top 10 of benchmarking group since 2018. In 2022, Trust are ranked 29 of 51.
	Non-Disabled	7.4	7.3	↓	

Metric 9b	2022	2023		Comment
Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?	YES	YES	—	ELFT Ability has been empowered to act as a safe supportive space for staff to share their experience, to review policies, constructively challenge and advise on projects which highlight inequalities for disabled staff and work with FTSU Guardian to raise concerns and agree actions.

↓ Needs Improvement ↑ Improved — No Change

NHS East London NHS Foundation Trust

Board Representation - Metric 10

This metric compares the difference for Disabled and non-disabled staff.

Metric 10		2021	2022		Comments
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: By Voting membership of the Board By Executive membership of the Board	**Total Board members**	10.53	11.11%	↑	Board members are encouraged to declare their disabilities and lead in communication campaigns around this topic.
	Voting Board members	11.76%	12.5%	↑	
	Non-Voting Board members	0.00%	0.0%	—	
	Exec Board members	10.00%	10.0%	—	
	Non-Executive Board members	11.11	12.32%	↑	
	Difference (Total Board - Overall workforce)	5%	3.79%	↓	
	Difference (Voting membership - Overall Workforce)	4%	5.18%	↓	
	Difference (Executive membership - Overall Workforce)	5%	2.68%	↓	

↓ Needs Improvement ↑ Improved — No Change

NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD PUBLIC
27 July 2023

Title	Inpatient Safer Staffing 6 Monthly report
Author	Claire McKenna - Director of Nursing Ruth Bradley - Director of Nursing Sasha Singh - Director of Nursing John Peers - Safer Staffing Lead
Accountable Executive Director	Lorraine Sunduza, Chief Nurse / Deputy CEO

Purpose of the Report

To present to the Board in-patient Registered Nurse and unregistered staffing levels. It updates the board on planned versus actual staffing levels and the clinical workforce within the Trust. It outlines workforce recruitment and retention challenges, mitigation in place to minimise impact on quality and safety of service delivery.

Key Issues

The paper focuses on our approach to ensuring that levels of inpatient nurse staffing which includes registered and unregistered staff matching the dependency needs of patients during the period November 2022 – April 2023. The paper identifies causes and actions taken to address issues relating to safe staffing.

Generally, the period April 2022 to April 2023 saw a reduction in absences due to Covid; however, short term Covid absences continues to impact all services. There remains challenges nationally in relation to clinical workforce recruitment. The Trust has programmes for recruitment and retention of nursing staff including international recruitment, recruiting from local Higher Education Institutes (City, University of London, and University of Bedfordshire), diversifying the workforce to include peer support workers, nurse associates and advanced clinical practitioners and local recruitment fairs.

Mitigation plans remain in place locally with support and oversight from Directors of Nursing. The Board can be assured there is local monitoring and oversight of staffing to ensure it does not impact patient and staff safety.

Strategic Priorities this Paper Supports

Improved population health outcomes	☒	The right staffing enables constant care to take place.
Improved experience of care	☒	The right staffing numbers to meet the service user needs and respond accordingly.
Improved staff experience	☒	The right staff numbers creates 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 clinical workforce.
Risk and Assurance	The following clinical risks are associated with inadequate staffing capacity and capability
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.

1.0 Background

1.1 Further to the Robert Francis Report (2013), the National Quality Board (NQB) published guidance that sets out the expectations of commissioners and providers for safe nursing and midwifery staffing. This guidance aims to ensure high quality care and positive outcomes for service users. 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 NHS Trusts. In October 2018 the NQB issued the Developing Workforce Safeguards "*supporting providers to deliver high quality care through safe and effective staffing". T*his document is designed to help trusts manage common workforce problems. It contains new recommendations to support them in making informed, safe and sustainable workforce decisions, and identifies examples of best practice in the NHS. It was developed with sector leaders and frontline staff and builds on the NQB's guidance. In essence, this rolls out the requirement to review and evaluate all clinical services based on a triangulated approach:

- Evidence-based tools (where available)
- Professional judgment
- Outcomes.

1.2 This also includes the regular six-monthly report to the Board summarising the results of the Trust monitoring of staffing levels across all inpatient wards and covers the six month period from November 2022 to April 2023. Part 2 is a summary covering April 2022 to April 2023 for the clinical workforce.

2.0 Inpatient Nurse Staffing Levels

2.1 The Average Fill rate is where a minimum standard of two registered nurses per shift for all inpatient wards. Fill rate of a 100% indicates the minimum achieved. However, acuity and clinical need (for example seclusion, segregation, enhanced observation) may increase the fill rates to above 100%. From November 2022 to April 2023 there were instances where the fill rate was both above and below 100% This is reported at ward level via a unify report to NHS England (NHSE) (Model Hospital) and is published monthly on the Trust website https://www.elft.nhs.uk/information-about-elft/safer-staffing-levels (**Appendix 1**).

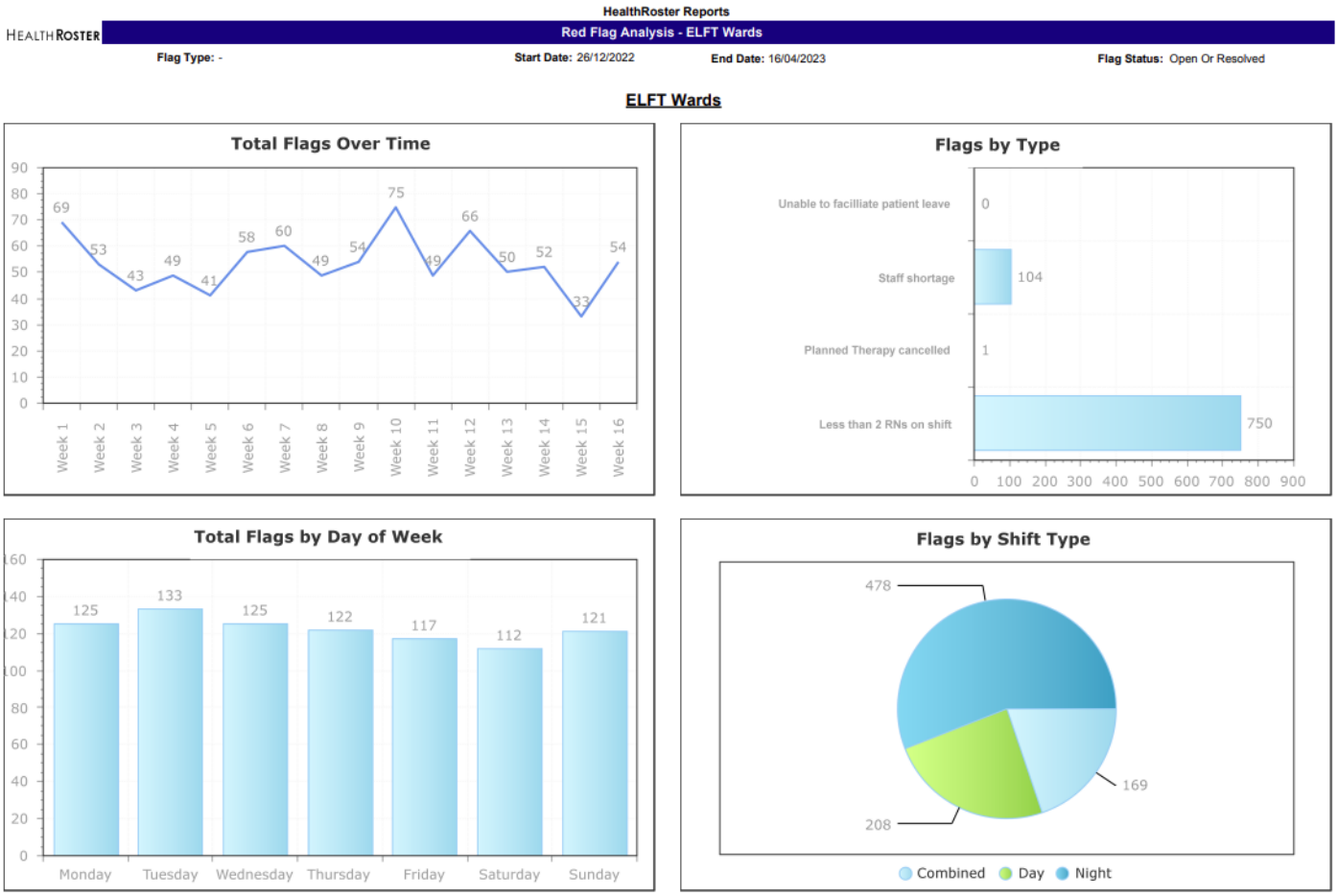
2.2 To give additional assurance in relation to minimum staffing the trust has applied a red flag system. Red flags are applied via the electronic Healthroster system. They are used to identify, escalate and monitor ward staffing concerns.

2.3 There are currently four red flags being reported on:

- Less than two registered nurses on duty;
- Staff shortage;
- Unable to facilitate patient escorted leave off the ward;
- Unable to facilitate planned therapy.

2.4 The available reports have raised awareness and have been used as part of specific service and ward reviews to understand local patterns. Forensic Service are yet to adopt the red flag system but will do so in the next quarter.

Trustwide Red Flags



2.5 Inpatient mental health wards in Newham, Hackney, Tower Hamlets and CAMHS are showing the most red flags for registered nurses during the night, with less red flags in Luton and Bedford. These reported gaps are mitigated by the actions of senior clinical staff through redeployment of staffing.

2.6 Care Hours Per Patient Day (CHPPD) is formally the principal measure of workforce deployment in ward-based settings and increasingly forms an integral part of a ward/unit/trust review and oversight of quality and performance indicators to inform quality of care, patient outcomes, people productivity and financial sustainability.

2.7 To calculate CHPPD, monthly returns for safe staffing and the daily patient count at midnight (i.e., the total number of patients on the ward at 23:59) are aggregated for the month.

2.8 As yet, there is no nationally agreed CHPPD standard. The latest available (January 2023) Model Hospital average data set shows ELFT CHPPD as 8.5 and a national median of 10.8. This indicates that our patient care hours are lower than the national average.

CHPPD and Fill Rate

			Day		Night	
	Cumulative count over the month of patients at 23:59 each day	CHPPD	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses
November 2022	23628	8.5	108%	137%	102%	169%
December 2022	26371	8.2	103%	134%	99%	166%
January 2023	24338	8.5	97%	126%	92%	155%
February 2023	22209	8.6	105%	141%	104%	176%
March 2023	24759	8.6	102%	135%	99%	165%
April 2023	23821	9.0	107%	148%	99%	173%

3.0 Mitigation

3.1 The three data sets show us that there are challenges in consistently meeting minimum standard of two registered nurses per shift. Below is an outline of the mitigating actions that are in place to reduce impact on safe effective care The data shows that staffing is responsive to changes in acuity and service user need.

3.2 The red flag data and themes are discussed in the Lead Nurse meeting with the Safer Staffing lead and Directors of Nursing for ongoing monitoring and management.

3.3 To ensure appropriate staffing levels are maintained several actions have continued: a review of staffing levels shift by shift by nursing staff and immediate managers, during the daily safety huddle the Duty Senior Nurses have an opportunity to move resources to meet staffing deficits and to address issues of risk or acuity. Overall, staffing issues are subject to review in the weekly locality senior nurse meetings and three monthly rota reviews with the Director of Nursing, Service Lead Nurse and the Safer Staffing Lead.

3.4 At points of high acuity or staff challenge services put a peripatetic team in place. This team sits outside of ward rota and is a small team that can be utilised to cover short notice staffing deficits. As the peripatetic team rota sits outside of the ward rota, it will be displayed as a staffing deficit but in most cases will be covered by floating staff. In addition, there is a Duty Senior Nurse role that monitors acuity and is able to balance staff according to need.

3.5 Where gaps remain, there is an escalation to the service directors and out of hours to the managers on call for their services and it is recorded as an incident. The incident sign-off process will review whether the gap was avoidable and take forward any learning.

3.6 Professional judgement has been paramount in managing unplanned absences or increased demand, alongside the skill mix and competencies of the nursing staff. Within Mental Health and Community Health Services wards, who is on duty can be as important as actual numbers. During restoration and recovery, professional judgement is particularly important and experienced staff have been available to support teams to make decisions to provide the safest care possible across the organisation.

3.7 Establishment reviews were undertaken across all inpatient wards during the autumn of 2022. The review was informed by safer staffing data and information in relation to CHPPD hours in comparison to national averages. This resulted in a number of recommendations:

- Establishment increased in Older Adults and working age wards based on reviews carried out and benchmarking with similar services;
- CAMHS review did not indicate that additional staffing was required;
- Revision and update to protocols for escalation of staffing concerns;
- Revision and updating rota review processes.

4.0 Community Health Services

4.1 NHSE introduced a new licenced Community Nursing Safer Staffing Tool (CNSST) for use of all community nursing providers. ELFT Community Services is a trial sites for the tool. The tool includes a service-quality assessment assessing team structures, care processes, and outcomes by examining patient records, interviewing patients, family carers, and staff. The outcomes will be contained in the next Board report.

4.2 All staff in extended Primary Care teams in ELFT carried out a safer staffing audit in May 2023. The findings are currently being collated for reporting and analysis and will form part of the next safer staffing report.

5.0 Conclusion

5.1 There remain challenges nationally in relation to clinical workforce. The Trust has programmes for recruitment and retention of nursing staff including international recruitment, recruiting from local Higher Education Institutes (City, University of London, and University of Bedfordshire), diversifying the workforce and local recruitment fairs.

5.2 There current clinical and operational activity remains high and sustained. This would suggest that the review process of registered and non-registered staff will need to remain very dynamic alongside the various mitigations the different services have in place.

5.3 Mitigation plans remain in place as detailed above. The Board can be assured there is local monitoring and oversight of staffing, and no current impact on patient safety.

6.0 Recommendations

6.1 The Board are asked to **receive** and **note** the actions and plans in place to ensure safe staffing.

Appendix 1

Nov-22

Ward name	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day: Average fill rate - Registered Nurses	Day: Average fill rate - Non-registered Nurses	Night: Average fill rate - Registered Nurses	Night: Average fill rate - Non-registered Nurses
Total	23628	**8.5**	**108%**	**137%**	**102%**	**169%**
Aldgate Ward	284	12.7	110%	166%	110%	300%
BED Ash Ward	521	6.9	113%	106%	102%	98%
BED Cedar House	477	5.4	135%	95%	100%	100%
BED Fountains Court	750	10.8	102%	134%	108%	143%
BED Townsend Court	602	6.9	87%	103%	102%	108%
BED Willow Ward	321	9.3	118%	108%	102%	211%
Bevan Ward	488	8.6	84%	134%	103%	121%
Bow Ward	450	8.3	83%	145%	57%	349%
Brett Ward	497	6.2	91%	140%	82%	229%
Brick Lane Ward	487	7.0	105%	142%	90%	230%
Broadgate Ward	484	6.8	115%	138%	154%	253%
Butterfield Ward	480	5.7	117%	112%	117%	214%
Clerkenwell JHC	270	17.2	137%	199%	207%	333%
Clissold Ward	510	6.0	122%	121%	127%	205%
Coborn Acute	317	11.6	98%	160%	72%	153%
Coborn PICU	109	23.1	68%	243%	137%	104%
Coborn-Galaxy Ward	212	25.2	88%	221%	89%	171%
Cazaubon Unit	516	7.7	191%	139%	100%	223%
Conolly Ward	496	6.1	126%	105%	94%	217%
Emerald Ward	511	6.1	91%	89%	93%	142%
Fothergill Ward	670	7.5	106%	116%	102%	100%
Gardner Ward	550	5.5	81%	132%	95%	257%
Globe Ward	552	7.1	93%	238%	92%	284%
Hoxton Ward	510	5.1	122%	90%	135%	190%

Nov-22

Ward name	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day		Night	
			Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses
Joshua Ward	559	6.5	110%	138%	104%	237%
Lea Ward	553	6.5	100%	184%	100%	266%
Leadenhall Ward	541	7.7	91%	238%	97%	300%
Limehouse Unit	479	5.5	100%	105%	127%	220%
LONDON Crystal	359	11.1	131%	136%	90%	135%
Loxford Ward	489	5.4	104%	106%	134%	201%
LU Coral Ward	583	8.1	88%	164%	102%	119%
LU Onyx Ward	571	6.6	87%	212%	96%	114%
LU Poplars Ward	481	9.7	84%	164%	97%	222%
Ludgate Ward	508	8.4	147%	210%	223%	220%
LUTON Crystal Ward	528	9.2	130%	147%	93%	212%
LUTON Jade	268	13.9	95%	124%	102%	122%
Millharbour	316	13.4	108%	218%	86%	392%
Moorgate Ward	60	67.4	145%	88%	71%	98%
Morrison Ward	480	6.5	123%	154%	175%	177%
Mother & Baby Ward	190	18.8	108%	118%	73%	220%
NEW Ivory	412	8.3	102%	139%	88%	110%
Opal Ward	587	6.3	91%	139%	88%	230%
Roman Ward	446	7.2	108%	111%	93%	223%
Rosebank Ward	335	14.3	120%	118%	105%	129%
Ruby Triage Ward	422	8.6	103%	162%	87%	107%
Ruth Seifert Ward	413	6.9	106%	115%	88%	210%
Sally Sherman Ward	522	11.1	157%	125%	116%	184%
Sapphire Ward	443	6.8	126%	87%	99%	113%
Shoreditch	420	14.3	180%	166%	223%	290%
Topaz Ward	497	7.6	149%	195%	98%	167%
Victoria Ward	504	6.0	150%	132%	136%	161%
West Ferry	237	19.6	94%	164%	98%	198%

Nov-22

Ward name	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day: Average fill rate - Registered Nurses	Day: Average fill rate - Non-registered Nurses	Night: Average fill rate - Registered Nurses	Night: Average fill rate - Non-registered Nurses
Woodberry Ward	360	8.1	114%	133%	176%	168%

Dec- 22

Ward name	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day: Average fill rate - Registered Nurses	Day: Average fill rate - Non-registered Nurses	Night: Average fill rate - Registered Nurses	Night: Average fill rate - Non-registered Nurses
Total	26371	**8.2**	**103%**	**134%**	**99%**	**166%**
Aldgate Ward	279	12.3	115%	135%	107%	304%
BED Ash Ward	575	6.3	95%	115%	100%	97%
BED Cedar House	492	5.7	127%	103%	100%	102%
BED Fountains Court	806	10.2	106%	122%	98%	142%
BED Townsend Court	698	6.3	71%	108%	92%	110%
BED Willow Ward	396	8.5	95%	129%	102%	245%
Bevan Ward	469	10.4	101%	139%	104%	138%
Bow Ward	464	9.1	85%	152%	66%	332%
Brett Ward	528	7.0	104%	155%	82%	264%
Brick Lane Ward	552	6.7	95%	147%	102%	230%
Broadgate Ward	491	6.8	113%	136%	164%	203%
Butterfield Ward	481	5.9	107%	103%	137%	191%
C&H HBPOS	62	28.9	63%	21%	75%	33%
Clerkenwell JHC	279	18.3	127%	206%	213%	368%
Clissold Ward	503	5.9	109%	109%	152%	149%
Coborn Acute	291	16.0	101%	197%	65%	201%
Coborn PICU	127	29.0	78%	466%	123%	156%
Coborn-Galaxy Ward	239	22.2	86%	189%	71%	157%
Cazaubon Unit	561	7.8	171%	127%	109%	321%
Conolly Ward	627	5.1	126%	110%	110%	200%

Dec- 22

Ward name	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day		Night	
			Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses
Emerald Ward	541	5.6	79%	75%	89%	126%
Fothergill Ward	732	7.2	97%	116%	100%	100%
Gardner Ward	668	4.6	91%	117%	90%	226%
Globe Ward	677	6.4	114%	245%	102%	245%
Hoxton Ward	527	5.3	123%	83%	166%	165%
Joshua Ward	768	4.9	98%	143%	97%	220%
Lea Ward	679	5.9	108%	208%	92%	239%
Leadenhall Ward	632	8.1	95%	258%	88%	474%
Limehouse Unit	488	6.1	85%	123%	127%	257%
LONDON Crystal	611	6.1	118%	110%	89%	118%
Loxford Ward	465	6.4	94%	122%	151%	198%
LU Coral Ward	623	7.4	68%	150%	100%	112%
LU Onyx Ward	722	5.9	101%	220%	94%	131%
LU Poplars Ward	523	8.7	79%	153%	87%	184%
Ludgate Ward	508	7.1	114%	154%	173%	213%
LUTON Crystal Ward	611	6.9	122%	132%	100%	160%
LUTON Jade	266	14.0	101%	106%	105%	115%
Millharbour	339	13.5	107%	205%	97%	362%
Moorgate Ward	62	76.7	125%	109%	79%	115%
Morrison Ward	489	6.5	102%	162%	163%	185%
Mother & Baby Ward	331	11.8	101%	135%	81%	211%
NEW Ivory	414	9.8	120%	130%	87%	160%
Opal Ward	692	5.4	78%	136%	87%	229%
Roman Ward	553	6.1	109%	119%	87%	238%
Rosebank Ward	294	16.3	119%	120%	83%	126%
Ruby Triage Ward	485	8.0	99%	162%	87%	124%
Ruth Seifert Ward	505	6.2	113%	108%	98%	197%
Sally Sherman Ward	543	11.2	148%	130%	103%	184%

Dec- 22

Ward name	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day		Night	
			Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses
Sapphire Ward	505	6.6	104%	116%	100%	139%
Shoreditch	434	14.0	160%	156%	219%	298%
Topaz Ward	565	6.7	139%	192%	108%	168%
Victoria Ward	527	5.8	138%	137%	140%	193%
West Ferry	300	13.2	123%	100%	92%	175%
Woodberry Ward	372	7.7	114%	110%	170%	168%

Jan-23

WardName	PatientCount	CHPPD	Day		Night	
			Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses
Total/Average	**24338**	**8.5**	**97%**	**126%**	**92%**	**155%**
Aldgate Ward	279	12.3	115%	135%	107%	304%
BED Ash Ward	555	6.6	95%	115%	100%	97%
BED Cedar House	472	5.6	127%	103%	100%	102%
BED Fountains Court	778	10.0	106%	122%	98%	142%
BED Townsend Court	599	7.0	71%	108%	92%	110%
BED Willow Ward	328	9.8	95%	129%	102%	245%
Bevan Ward	458	10.3	101%	139%	104%	138%
Bow Ward	465	8.8	85%	152%	66%	332%
Brett Ward	522	6.8	104%	155%	82%	264%
Brick Lane Ward	541	6.6	95%	147%	102%	230%
Broadgate Ward	501	6.3	113%	136%	164%	203%
Butterfield Ward	471	5.7	107%	103%	137%	191%
C&H HBPOS	26	68.8	63%	21%	75%	33%

Jan-23

			Day		Night	
WardName	PatientCount	CHPPD	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses
Clerkenwell JHC	285	17.3	127%	206%	213%	368%
Clissold Ward	502	5.6	109%	109%	152%	149%
Coborn Acute	229	19.1	101%	197%	65%	201%
Coborn PICU	91	37.5	78%	466%	123%	156%
Coborn-Galaxy Ward	227	21.9	86%	189%	71%	157%
Cazaubon Unit	544	7.7	171%	127%	109%	321%
Conolly Ward	512	6.0	126%	110%	110%	200%
East India	0	-	0%	0%	0%	0%
Emerald Ward	456	6.4	79%	75%	89%	126%
Fothergill Ward	768	6.6	97%	116%	100%	100%
Gardner Ward	580	5.0	91%	117%	90%	226%
Globe Ward	601	7.0	114%	245%	102%	245%
Hoxton Ward	527	5.0	123%	83%	166%	165%
Joshua Ward	584	6.2	98%	143%	97%	220%
Lea Ward	580	6.6	108%	208%	92%	239%
Leadenhall Ward	560	9.0	95%	258%	88%	474%
Limehouse Unit	496	5.7	85%	123%	127%	257%
LONDON Crystal	336	10.7	118%	110%	89%	118%
Loxford Ward	476	5.9	94%	122%	151%	198%
LU Coral Ward	587	7.5	68%	150%	100%	112%
LU Onyx Ward	560	7.5	101%	220%	94%	131%
LU Poplars Ward	544	8.0	79%	153%	87%	184%
Ludgate Ward	518	6.7	114%	154%	173%	213%
LUTON Crystal Ward	537	7.6	122%	132%	100%	160%
LUTON Jade	274	13.6	101%	106%	105%	115%
Millharbour	331	13.3	107%	205%	97%	362%

Jan-23

			Day		Night	
WardName	PatientCount	CHPPD	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses
Moorgate Ward	62	75.2	125%	109%	79%	115%
Morrison Ward	460	6.8	102%	162%	163%	185%
Mother & Baby Ward	264	14.1	101%	135%	81%	211%
NEW Ivory	396	9.9	120%	130%	87%	160%
Opal Ward	616	5.9	78%	136%	87%	229%
Roman Ward	493	6.8	109%	119%	87%	238%
Rosebank Ward	315	15.0	119%	120%	83%	126%
Ruby Triage Ward	462	8.4	99%	162%	87%	124%
Ruth Seifert Ward	440	6.8	113%	108%	98%	197%
Sally Sherman Ward	576	10.3	148%	130%	103%	184%
Sapphire Ward	440	7.2	104%	116%	100%	139%
Shoreditch	408	14.6	160%	156%	219%	298%
Topaz Ward	517	7.4	139%	192%	108%	168%
Victoria Ward	522	5.9	138%	137%	140%	193%
West Ferry	296	13.4	123%	100%	92%	175%
Woodberry Ward	371	7.7	114%	110%	170%	168%

Feb-23

			Day		Night	
WardName	Cumulative count over the month of patients at 23:59 each day	CHPPD	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses
Total	**22209**	**8.6**	**105%**	**141%**	**104%**	**176%**
Aldgate Ward	234	11.9	103%	108%	142%	288%
BED Ash Ward	534	6.4	104%	119%	100%	104%
BED Cedar House	407	5.9	116%	109%	104%	104%

Feb-23

WardName	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day: Average fill rate - Registered Nurses	Day: Average fill rate - Non-registered Nurses	Night: Average fill rate - Registered Nurses	Night: Average fill rate - Non-registered Nurses
Total	**22209**	**8.6**	**105%**	**141%**	**104%**	**176%**
BED Fountains Court	686	11.0	120%	129%	111%	153%
BED Townsend Court	505	7.4	79%	103%	99%	102%
BED Willow Ward	309	11.1	119%	145%	96%	374%
Bevan Ward	400	10.9	91%	133%	152%	126%
Bow Ward	420	9.7	141%	142%	118%	321%
Brett Ward	451	6.5	92%	137%	83%	244%
Brick Lane Ward	456	6.4	88%	123%	70%	257%
Broadgate Ward	427	7.8	96%	200%	129%	286%
Butterfield Ward	476	5.6	105%	149%	211%	107%
C&H HBPOS	25	77.4	70%	25%	78%	64%
Cazaubon Unit	478	7.2	143%	141%	98%	262%
Clerkenwell JHC	476	9.2	108%	274%	218%	375%
Clissold Ward	479	5.2	118%	114%	136%	164%
Coborn Acute	262	14.0	110%	179%	68%	156%
Coborn PICU	4	803.9	111%	482%	115%	130%
Coborn-Galaxy Ward	478	8.5	68%	199%	66%	135%
Conolly Ward	496	5.3	111%	86%	102%	204%
Emerald Ward	466	7.0	89%	80%	84%	300%
Fothergill Ward	485	9.8	114%	116%	100%	100%
Gardner Ward	555	4.5	67%	127%	97%	200%
Globe Ward	487	7.0	111%	189%	100%	218%
Hoxton Ward	476	4.8	102%	103%	141%	165%
Joshua Ward	527	6.4	100%	141%	95%	282%

Feb-23

WardName	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day		Night	
			Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses
Total	**22209**	**8.6**	**105%**	**141%**	**104%**	**176%**
Lea Ward	487	6.3	122%	154%	89%	204%
Leadenhall Ward	467	8.7	88%	253%	82%	361%
Limehouse Unit	443	5.6	114%	108%	119%	200%
LONDON Crystal	328	11.7	117%	148%	73%	138%
Loxford Ward	476	5.5	81%	137%	154%	232%
LU Coral Ward	606	6.9	82%	144%	105%	141%
LU Onyx Ward	517	7.7	108%	203%	95%	164%
LU Poplars Ward	482	8.6	88%	168%	110%	176%
Ludgate Ward	475	6.8	123%	157%	186%	207%
LUTON Crystal Ward	415	10.3	153%	153%	102%	159%
LUTON Jade	242	18.4	106%	153%	113%	203%
Millharbour	292	14.3	91%	223%	94%	455%
Moorgate Ward	56	81.7	155%	129%	95%	103%
Morrison Ward	435	6.6	99%	160%	158%	200%
Mother & Baby Ward	204	16.3	102%	172%	80%	166%
NEW Ivory	378	8.5	108%	134%	86%	113%
Opal Ward	515	7.2	98%	158%	86%	250%
Roman Ward	464	6.1	77%	105%	82%	242%
Rosebank Ward	347	12.1	103%	103%	94%	140%
Ruby Triage Ward	392	8.0	84%	197%	102%	128%
Ruth Seifert Ward	378	7.1	95%	124%	99%	200%
Sally Sherman Ward	492	10.2	89%	127%	90%	193%
Sapphire Ward	402	8.3	112%	137%	93%	204%

Feb-23

WardName	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day: Average fill rate - Registered Nurses	Day: Average fill rate - Non-registered Nurses	Night: Average fill rate - Registered Nurses	Night: Average fill rate - Non-registered Nurses
Total	**22209**	**8.6**	**105%**	**141%**	**104%**	**176%**
Shoreditch	392	13.3	163%	149%	207%	291%
Topaz Ward	462	7.1	100%	188%	89%	218%
Victoria Ward	476	6.0	145%	125%	146%	192%
West Ferry	279	13.4	129%	110%	111%	152%
Woodberry Ward	308	8.1	121%	100%	142%	204%

Mar-23

WardName	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day: Average fill rate - Registered Nurses	Day: Average fill rate - Non-registered Nurses	Night: Average fill rate - Registered Nurses	Night: Average fill rate - Non-registered Nurses
Total	**24759**	**8.6**	**102%**	**135%**	**99%**	**165%**
Aldgate Ward	279	10.8	118%	98%	103%	265%
BED Ash Ward	593	6.2	126%	96%	102%	97%
BED Cedar House	499	6.1	117%	114%	100%	103%
BED Fountains Court	773	10.3	122%	118%	110%	139%
BED Townsend Court	605	6.7	74%	93%	111%	109%
BED Willow Ward	336	9.6	101%	157%	98%	210%
Bevan Ward	371	13.7	95%	139%	151%	140%
Bow Ward	465	9.4	121%	146%	105%	335%
Brett Ward	524	6.6	92%	150%	74%	296%
Brick Lane Ward	503	7.0	119%	127%	91%	223%
Broadgate Ward	522	6.6	103%	171%	129%	284%
Butterfield Ward	522	5.4	101%	136%	216%	106%
C&H HBPOS	35	60.2	63%	42%	53%	139%

Mar-23

WardName	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day: Average fill rate - Registered Nurses	Day: Average fill rate - Non-registered Nurses	Night: Average fill rate - Registered Nurses	Night: Average fill rate - Non-registered Nurses
Cazaubon Unit	521	8.8	170%	179%	105%	303%
Clerkenwell JHC	310	17.8	117%	326%	169%	413%
Clissold Ward	527	5.3	115%	115%	133%	181%
Coborn Acute	217	22.3	128%	235%	73%	181%
Coborn PICU	99	36.0	100%	563%	110%	145%
Coborn-Galaxy Ward	183	23.8	77%	180%	66%	126%
Conolly Ward	530	5.6	116%	79%	102%	210%
Emerald Ward	522	6.3	97%	67%	82%	229%
Evergreen Ward	96	34.9	65%	56%	100%	77%
Fothergill Ward	690	7.9	117%	102%	102%	100%
Gardner Ward	572	5.0	74%	126%	89%	226%
Globe Ward	572	6.7	120%	184%	85%	261%
Hoxton Ward	501	4.9	102%	102%	93%	186%
Joshua Ward	574	6.6	110%	144%	100%	210%
Lea Ward	584	6.0	92%	190%	95%	241%
Leadenhall Ward	579	8.8	101%	264%	87%	450%
Limehouse Unit	495	5.5	101%	120%	119%	206%
LONDON Crystal	368	11.1	129%	139%	90%	139%
Loxford Ward	522	5.4	60%	138%	91%	275%
LU Coral Ward	593	7.8	79%	149%	110%	129%
LU Onyx Ward	586	6.8	111%	197%	92%	110%
LU Poplars Ward	504	8.5	88%	132%	115%	164%
Ludgate Ward	527	6.4	111%	133%	200%	197%
LUTON Crystal Ward	545	8.6	167%	144%	105%	152%
LUTON Jade	586	7.8	92%	168%	97%	168%
Millharbour	336	14.1	98%	239%	95%	485%
Moorgate Ward	62	80.1	141%	130%	90%	102%

Mar-23

WardName	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day: Average fill rate - Registered Nurses	Day: Average fill rate - Non-registered Nurses	Night: Average fill rate - Registered Nurses	Night: Average fill rate - Non-registered Nurses
Morrison Ward	496	6.1	107%	149%	136%	206%
Mother & Baby Ward	254	13.3	92%	123%	95%	163%
NEW Ivory	371	9.7	98%	149%	77%	132%
Opal Ward	616	7.9	99%	173%	93%	427%
Roman Ward	500	6.4	94%	97%	76%	262%
Rosebank Ward	280	17.2	107%	118%	86%	137%
Ruby Triage Ward	416	8.8	86%	174%	100%	155%
Ruth Seifert Ward	438	6.8	86%	132%	97%	203%
Sally Sherman Ward	517	10.0	109%	111%	88%	167%
Sapphire Ward	456	7.6	95%	145%	89%	190%
Shoreditch	434	13.6	167%	156%	221%	277%
Topaz Ward	515	7.4	146%	161%	102%	203%
Victoria Ward	527	6.4	166%	158%	126%	158%
West Ferry	338	11.5	144%	87%	108%	144%
Woodberry Ward	372	7.4	129%	102%	138%	179%

Apr-23

Ward Name	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day: Average fill rate - Registered Nurses	Day: Average fill rate - Non-registered Nurses	Night: Average fill rate - Registered Nurses	Night: Average fill rate - Non-registered Nurses
Total	**238212**	**9.0**	**107%**	**148%**	**99%**	**173%**
Aldgate Ward	270	11.9	116%	121%	145%	263%
BED Ash Ward	545	6.3	108%	95%	102%	101%
BED Cedar House	474	5.6	132%	108%	100%	105%
BED Fountains Court	756	9.9	116%	119%	105%	135%
BED Townsend Court	544	7.8	67%	115%	102%	121%
BED Willow Ward	312	10.7	100%	174%	95%	231%
Bevan Ward	434	10.7	85%	153%	111%	146%

Apr-23

Ward Name	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day: Average fill rate - Registered Nurses	Day: Average fill rate - Non-registered Nurses	Night: Average fill rate - Registered Nurses	Night: Average fill rate - Non-registered Nurses
Bow Ward	450	10.8	127%	172%	102%	433%
Brett Ward	510	7.3	103%	179%	88%	297%
Brick Lane Ward	517	6.7	95%	162%	93%	237%
Broadgate Ward	506	6.6	114%	152%	137%	294%
Butterfield Ward	507	5.2	104%	139%	190%	134%
C&H HBPOS	41	49.9	73%	53%	56%	152%
Cazaubon Unit	530	8.7	146%	212%	103%	333%
Clerkenwell JHC	309	16.2	142%	263%	98%	433%
Clissold Ward	510	5.5	141%	116%	118%	180%
Coborn Acute	243	19.9	119%	266%	73%	181%
Coborn PICU	102	32.5	87%	572%	97%	148%
Coborn-Galaxy Ward	190	23.7	95%	202%	84%	112%
Conolly Ward	543	5.3	103%	102%	83%	245%
Emerald Ward	469	7.3	99%	85%	93%	213%
Evergreen Ward	125	26.8	65%	63%	93%	83%
Fothergill Ward	724	7.3	101%	100%	100%	100%
Gardner Ward	597	5.6	111%	145%	102%	261%
Globe Ward	542	7.0	125%	196%	103%	213%
Hoxton Ward	510	5.6	107%	110%	150%	241%
Joshua Ward	567	6.0	105%	135%	95%	217%
Lea Ward	540	6.9	101%	204%	105%	253%
Leadenhall Ward	582	7.9	91%	264%	92%	394%
Limehouse Unit	480	5.5	111%	114%	107%	207%
LONDON Crystal	358	10.9	142%	139%	80%	137%
Loxford Ward	510	5.4	76%	136%	66%	251%
LU Coral Ward	520	7.8	70%	153%	100%	104%
LU Onyx Ward	588	6.6	113%	192%	98%	117%

Apr-23

Ward Name	Cumulative count over the month of patients at 23:59 each day	CHPPD	Day		Night	
			Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses	Average fill rate - Registered Nurses	Average fill rate - Non-registered Nurses
LU Poplars Ward	520	8.4	84%	151%	106%	186%
Ludgate Ward	475	6.9	110%	153%	171%	193%
LUTON Crystal Ward	502	8.7	143%	148%	102%	166%
LUTON Jade	256	15.9	105%	145%	111%	131%
Millharbour	326	15.3	100%	288%	105%	469%
Moorgate Ward	60	79.4	134%	129%	78%	109%
Morrison Ward	480	6.2	106%	150%	148%	197%
Mother & Baby Ward	188	19.5	115%	144%	90%	193%
NEW Ivory	308	11.7	102%	154%	77%	135%
Opal Ward	629	6.7	97%	162%	97%	303%
Roman Ward	514	6.3	88%	117%	88%	233%
Rosebank Ward	275	18.6	104%	129%	81%	170%
Ruby Triage Ward	439	8.5	99%	168%	100%	125%
Ruth Seifert Ward	412	7.4	96%	156%	97%	200%
Sally Sherman Ward	516	10.1	112%	135%	102%	148%
Sapphire Ward	420	9.8	102%	173%	90%	330%
Shoreditch	411	15.1	176%	198%	216%	287%
Topaz Ward	504	7.9	164%	193%	102%	207%
Victoria Ward	508	6.0	129%	149%	70%	183%
West Ferry	313	12.5	138%	108%	107%	137%
Woodberry Ward	359	7.6	120%	110%	152%	181%

NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
27 July 2023

Title	Finance, Business and Investment Committee (FBIC) 11 July 2023 – Committee Chair's Report
Committee Chair	Sue Lees, 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 Finance, Business and Investment Committee (FBIC) meeting held on 11 July 2023.

Key messages

Finance Report Month 2

- The Trust is currently £951k adrift from a surplus plan of £88k year to date; variance to plan is mainly due to financial viability targets and pressures around the Agenda for Change pay award
- Enhanced detail on service directorate revenues and areas of overspend now form part of the monthly reporting with devolved financial viability targets also included in their baseline figures
- Areas of overspend showing in some inpatient areas relate to the impact of the safer staffing tool; the committee requested a further update on the application and impact of the safer nursing tool
- The cash position remains stable at £122.1m
- The Trust continues to be in Segment 1 (no specific support needs: maximum autonomy, minimum risk) of the NHS Oversight Framework
- The committee noted the partial assurance received at month 2, and requested a schedule of deep dives to be included in the forward plan to receive further assurance on local controls and management of budgets along with the sharing of issues and challenges across services.

Financial Viability (FV) Update Month 2

- Schemes totalling a full year value of £18.45m and an in-year value of £15.79m have been identified against the target of £20.8m, with some directorates still to fully work through their plans; dedicated PMO support is being provided
- Services have additionally been asked to develop plans to meet a 20% stretch target
- Focused FV delivery sessions planned for the year as many plans are currently weighted towards delivery in Q3 and Q4; the committee requested further consideration be given to the re-phasing due to enhanced risks around delivery being weighted towards financial year end
- Month 2 achieved delivery of £1.22m against a plan of £1.29m with waste reduction and clinical transformation being the highest proportion of identified schemes; month 3 figures already reflect a reduction in the variance again the NHS England (NHSE) plan
- More work is required around the ownership and accountability of centrally held schemes that have the potential to release cash savings Trustwide.

Agency Expenditure

- There has been positive progress with agency spend decreasing in April and May with concerted efforts to reduce locum medics
- The committee requested further granular detail on specific high cost cases alongside an update on broader medical workforce recruitment plans for assurance, acknowledging the need to avoid duplication of discussion at committee meetings particular as this would also be considered by the People & Culture Committee as part of its focus on recruitment and retention
- NHSE ceiling spend for 2023/24 is £24m; FV savings will be tracked and agreed at Month 12.

Capital and Estates Update

- Final CDEL allocation for 2023/24 is still to be confirmed though is anticipated to be £10.97m, split between estates, digital and medical equipment. This includes one land sale with an expected second sale to add approximately £300-350k
- There is an additional pressure across the system due to the full term effect of IFRS16 which is included for the first time; all new leases will require careful consideration in CDEL terms

- There is a need to remain cognisant of the CDEL constraints and to work in an agile way to utilise support across the NEL system to ensure the continued quality of patient care and safety
- The capital plan reflects clinical priorities as advised by clinical leads and service directors
- The estates environment strategy has been published and the new Estates Strategy Board (ESB), meeting for the first time in August, will receive detailed information on projects, ideas and solutions, with assurance on schemes implementation and delivery to be reported to the FBIC
- A detailed statutory compliance review of de-carbonisation work is due to be completed in 2023 with details of gaps and funding requests to be brought to the Committee.

Procurement Update
- Savings of £60k have been realised in Q1 against a target of £600k for 2023/24
- Further embedding of social value weighting scores into all contracts continues with a focus on local suppliers who employ from identified priority groups and young adults. The Trust's targets for sub-contractors around payment of the Real Living Wage and agreed net zero ambitions expect to be met by the end of the financial year
- Collaborative working across NEL to achieve economies of scale.

Aged Creditors
- Assurance provided that focused work is ongoing to improve the Trust's performance against the Better Practice Code and, in particular, to address challenges with purchase order invoices
- The committee requested priority be given to the backlog of payments to smaller suppliers where the impact of unpaid invoices will cause the greatest hardship.

Investment Register: No investment planned as the Trust's bank account interest is currently at a more advantageous level.

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*: There is a change in the management actions, broadening them out to include environment and sustainability work and clearer identification of cost benefits
- **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:* Assurance received around the work being undertaken to ensure organisational resilience in relation to the recent cyber incident at Barts.
- The committee agreed no changes to the risks scores and that appropriate controls are in place and operating effectively.

Green/Sustainability Plan
- There has been positive movement and progress in this area, including the development of a Climate Network and six workstreams with people participation and service user involvement
- The NHS Green Plan support tool has been launched centrally along with baseline carbon footprint data for every trust
- Performance measures and benchmarks are now in place
- Green plan currently being redrafted and will be presented to ESB to enhance green incentives around estates and facilities initiatives
- Challenges remain around local ownership of sustainability plans and the committee encouraged the accessing of shared resources in the system for smarter ways of working
- Work around social value in the procurement process and Anchor organisation work will link to and benefit the Trust's green agenda.

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

NHS
East London
NHS Foundation Trust

REPORT TO TRUST BOARD IN PUBLIC
27 July 2023

Title	Finance Report Month 2 (May 2023)
Author	Haffejee Knight, Deputy Director of Finance
Accountable Executive Director	Dr Mohit Venkataram, Executive Director of Commercial Development and Acting Chief Finance Officer

Purpose of the report

This report highlights and advise the Board on the current finance performance and issues.

Committees/meetings where this item has been considered

Date	Committee/Meeting
28/06/2023	Service Delivery Board
11/07/2023	Finance, Business and Investment Committee

Key messages

Summary of Financial Performance:

- As at month 2 the Trust is reporting a deficit position of £863k year to date, which is £951k adverse to plan. The key drivers of this variance are;
    - Financial Viability (FV) slippage
    - Staffing levels above the planned establishment and agency premium
    - Inflation above funding
- The Trust's cash balance at 31st May was £122.1m.
- Capital expenditure as at 31st May 2023 was £77k.
- Better Payment Practice Code performance is 81.8% by volume and 83.8% by value.
- The Trust is currently forecasting to be back on track by the end of the year.

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 Executive Summary

1.1 Background and Financial Framework

For 2023/24 the financial architecture has continued with a contracting model, where funding is based on prior year, adjusted for non-recurrent items, funding growth, services changes and a net 1.8% uplift anticipated for pay and price increases, is distributed to a system level and then allocated based on agreed methodologies to Provider Trusts.

The Trust final plan submission to NHS England (NHSE) on 4th May is an income and expenditure surplus of £5.4m plan, in line with NEL ICS plan submission, which was breakeven. The final plan submission by the Trust includes Financial Viability target of £20.8m. The Trust also submitted a capital plan of £9.8m in line with its allocation share based on depreciation, however Trust capital requirements far exceed this and additional NEL prioritisation work and Regional and National discussions are underway regarding the required increase to CDEL for ELFT and NEL ICS.

1.2 As at month 2, the Trust is reporting;

- An income and expenditure deficit position of £863k year to date, which is £951k adverse to plan. The key drivers of this variance are;
    - Slippage on Financial Viability delivery (£842k).
    - A continuation of expenditure pressures across Home Treatment Teams.
    - Staffing levels above the planned establishment to cover staff shortages arising mainly from long term sickness, high acuity (enhanced observations), and activity pressures.
    - New safer staffing rotas not being fully implemented in inpatient wards.
    - High levels of agency usage which continues to be at last year's level.
    - The impact of the continued effect of hyperinflation and high RPI contract renewals, particularly within estates.

  Adverse variances on Financial Viability delivery and other expenditure overspends are currently being partly offset by underspends against planned investments and vacancies in other directorates.

- Trust's cash balance stands at £122.1m, a decrease of £4.3m from 30 April 2023 because of the deficit, quarterly payments in advance and payment of invoices related to capital recorded in 2022/23. The Trust's ongoing cash requirements have not changed materially in terms of staff pay and capital expenditure, and the Trust continues to strive to pay suppliers early in the current economic climate.

- Capital expenditure as of 31st May 2023 was £77k which is below the phased plan, this is a reflection that the Trust's principal capital projects are yet to get fully underway for this fiscal year.

2 Summary of Income & Expenditure Performance to 31st May 2023

2.1 The Trust year to date financial position as at 31st of May is a deficit of £863k against a planned surplus of £88k.

2.2 **Income** at Month 2 is reported as over performing against plan by £2.51m. The over performance is mainly due to the additional income included in the position for the additional 1.6% Pay Award funding (£1.4m) and Section 256 income from Newham (£0.2m).The additional income is being offset by additional costs included in the position.

2.3 **Pay** is off plan by £3.6m year to date. May staff cost are at £39.5m, which is £2.8m higher than the previous month. The increase is mainly due to the accumulated additional staff pay award payment accounted for in May (£1.7m) and which is being offset by the additional income. The remaining variance is mainly due to;

- Inpatients bank and agency usage which is over and above substantive vacancies to cover staff shortages arising mainly from long term sickness, high acuity (enhanced observations), activity pressures, and the new safer staffing rotas not being fully implemented.

- Agency staff usage to cover vacancies in Home Treatment Team (HTT) and medical staff. The HTT and Medical teams are experiencing difficulties in recruiting and retaining staff.

- Slippage on Financial Viability delivery

We are expecting to see reduction in inpatients pay overspends going forward when the new safer staffing rotas are fully implemented and substantive staff are recruited.

2.4 **Non-pay** is underspend by £41k year to date. In month non-pay expenditure run rate remained in line with prior month. The key areas with adverse variances are NCEL £625k which is being offset by additional income received, Corporate Services £414K, Estates £655k which is mainly being driven by increases in contractual arrangements due to inflation.

2.5 Adverse variances on Financial Viability delivery and other expenditure overspends are currently being partly offset by underspends against planned investments and vacancies in other directorates.

2.6 The income and expenditure plans will be updated in month 3 to reflect the additional funding.

2.7 Financial performance is summarised in Table 1 below:

Table 1: Summary of Financial Performance

	In Month			Year To Date			Annual Plan £000	YTD Prior Month Variance £000	Change +/- £000
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000			
Income									
NHS Clinical Income	41,766	42,768	1,003	83,399	84,964	1,566	500,534	566	1,000
Non-NHS Clinical Income	1,168	1,418	250	2,575	2,674	99	15,491	(151)	250
Other Operating Income	1,161	1,330	169	2,323	2,520	198	13,937	29	169
NCEL CAMHS Service (Lead Provider)	2,811	2,895	84	5,622	5,706	84	33,732	0	84
NCEL Forensic Service (BEH)	4,088	4,690	603	8,175	8,781	605	49,052	-	605
Deferred Income Released	219	219	-	267	267	-	7,721	-	-
Income Total	**51,212**	**53,320**	**2,107**	**102,362**	**104,913**	**2,551**	**620,467**	**444**	**2,107**
Pay									
Substantive	(35,677)	(32,644)	3,033	(72,429)	(62,326)	10,102	(434,153)	7,069	3,033
Bank	(57)	(4,478)	(4,420)	(97)	(9,037)	(8,940)	(581)	(4,522)	(4,418)
Agency	(14)	(2,354)	(2,340)	(18)	(4,808)	(4,790)	(106)	(2,454)	(2,336)
Pay Total	**(35,748)**	**(39,475)**	**(3,727)**	**(72,543)**	**(76,171)**	**(3,628)**	**(434,840)**	**93**	**(3,721)**
Non-Pay									
Non Pay	(13,015)	(12,282)	734	(24,580)	(24,551)	29	(149,331)	(699)	728
Non-Pay Total	**(13,015)**	**(12,282)**	**734**	**(24,580)**	**(24,551)**	**29**	**(149,331)**	**(699)**	**728**
EBITDA	**2,449**	**1,563**	**(886)**	**5,238**	**4,191**	**(1,047)**	**36,296**	**(161)**	**(886)**
Post EBITDA									
Depreciation	(2,263)	(2,263)	(0)	(4,527)	(4,527)	(0)	(27,160)	(0)	(0)
Finance Income	563	498	(65)	786	882	96	4,714	161	(65)
Finance Expenditure	(224)	(224)	(0)	(448)	(448)	(0)	(2,687)	(0)	(0)
PDC Dividend	(519)	(519)	-	(1,038)	(1,038)	-	(6,225)	-	-
Total Post EBIDTA	**(2,443)**	**(2,508)**	**(65)**	**(5,226)**	**(5,130)**	**96**	**(31,358)**	**161**	**(65)**
	6	**(945)**	**(951)**	**12**	**(939)**	**(951)**	**4,938**	**(0)**	**(951)**
Less									
Depreciation: Donated Assets	**(38)**	**(38)**	**-**	**(76)**	**(76)**	**-**	**(462)**	**-**	**-**
Reported Surplus /(Deficit)	**44**	**(907)**	**(951)**	**88**	**(863)**	**(951)**	**5,400**	**(0)**	**(951)**

EBITDA – Earnings before Interest, Depreciation and Amortisation
PDC – Public Dividend Capital

2.8 **Next Steps:**

- Continue to sharpen delivery focus for each area of financial improvement, and closing the risk gap.
- Continue to work on Financial Viability closing the unidentified gap and to identify non recurrent mitigation savings.
- Implementation and embedding of the new safer staffing rotas in inpatients.
- Reduce WTE usage in line with funded establishment.
- Identify mitigations for inflationary pressures through further non pay opportunities.

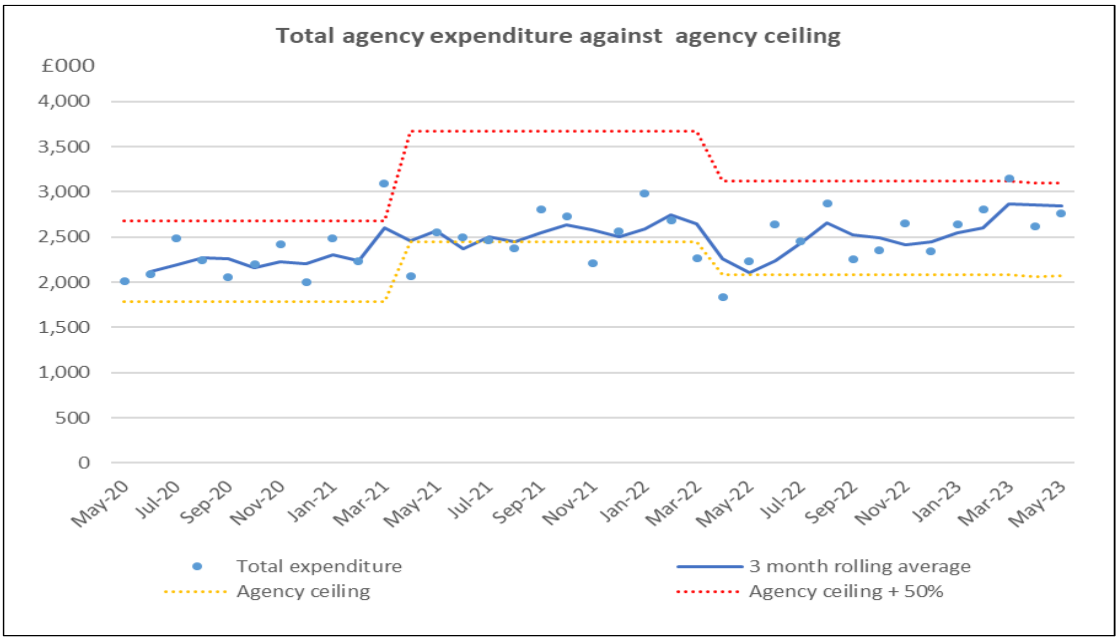
3 Agency Expenditure and Ceiling

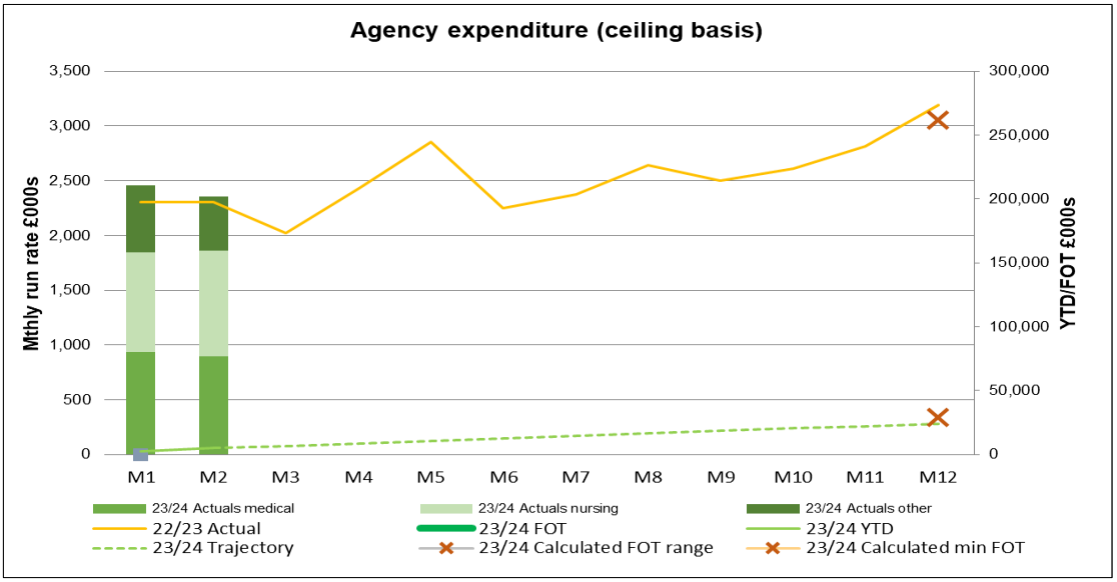
The Trust submitted an annual financial plan for 2023-24 with planned agency usage of £24,215k.

Total monthly agency expenditure has been consistently above the 2022-23 and 2023-24 agency plans. 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 or revert to Bank spend where necessary, and further work is required to review the longer term agency use.

Year to date (as at May 2023) ELFT agency expenditure is £4.8m, £1.2m (30%) above the ceiling. Year to date agency expenditure is 7.1% of total pay expenditure. May 2023 agency expenditure was £2.4m. Further action is required to reduce agency spend

Agency expenditure is summarised in the charts below:





4 Financial Viability Programme (FVP)

4.1 2023-24 Financial Viability Targets

The Financial Viability target for 2023-24 is £20.8m. The agreed Directorate targets have been allocated to Clinical and Corporate divisions as part of 2023-24 budgets with the unallocated FV and central schemes held centrally.

4.2 Financial Viability Year to Date Performance

The year to date planning target for month 2 was £2,062k with a total reported delivery of £1,222k. This has been delivered largely through the pay costing exercise and interest from investments, with £185k being delivered through bottom up Directorate plans.

Directorate	2023/24 FV Target Allocated £'000	YTD Plan £'000	YTD Actuals £'000	YTD Variance £'000	Actuals vs YTD Plan %
Specialist	1,975	233	22	-211	9%
Forensic	1,110	131	28	-103	21%
CHS Bedfordshire	760	90	27	-62	31%
Beds and Luton AMH	2,316	273	6	-267	2%
CHS Newham	795	94	52	-42	56%
CHS Tower Hamlets	449	53	0	-53	0%
City & Hackney AMH	1,223	144	85	-59	59%
Tower Hamlets AMH	1,365	161	233	72	145%
Newham AMH	1,111	131	127	-4	97%
Clinical Services Total	**11,104**	**1,310**	**580**	**-729**	**44%**
Corporate Services	1,065	126	0	-126	0%
Estates & Facilities	47	5	0	-5	0%
Central	8,584	623	642	19	103%
GRAND TOTAL	**20,800**	**2,064**	**1,222**	**-842**	**59%**

4.3 The table below shows delivery against identified plans and the gap between the Trust plan of £20,800k and full year identified plans.

Plans continue to be worked on to close the unidentified gap and to scope the 2023/24 impact based on start dates

Directorate	2023/24 Identified Full Year Plan £'000	YTD Identified Plan £'000	YTD Actuals £'000	YTD Variance against Identified Plan £'000	Actuals vs YTD Identified Plan %	2023/24 Un-identified Full Year Plan £'000
Specialist	1,095	55	22	-33	39%	880
Forensic	740	69	28	-42	40%	370
CHS Bedfordshire	811	27	27	0	100%	-51
Beds and Luton AMH	981	6	6	0	100%	1,335
CHS Newham	748	52	52	0	100%	47
CHS Tower Hamlets	234	0	0	0		215
City & Hackney AMH	867	85	85	0	100%	356
Tower Hamlets AMH	1,940	233	233	0	100%	-575
Newham AMH	2,097	127	127	0	100%	-986
Clinical Services Total	**9,514**	**655**	**580**	**-75**	**89%**	**1,590**
Corporate Services	159	7	0	-7	0%	906
Estates & Facilities	21	0	0	0		26
Central	7,648	629	642	13	102%	936
GRAND TOTAL	**17,342**	**1,291**	**1,222**	**-69**	**95%**	**3,458**

5 Statement of Financial Position (SoFP)

5.1 Balance Sheet

The net balance on the Statement of Final Position as at 31st May 2023 is £340.6m, down from £341.5m at 30th April 2023 due to a reported deficit of £862k.

The Trust's overall Receivables decreased by £3m to £24.1m in May compared to the prior month. Included within this balance is £9.5m of trade debtors, which have decreased by £3.4m month-on-month. NEL ICB with £5.3m outstanding forms the Trust's most significant debtor.

Statement of financial position summary	Year to date			Forecast outturn		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£000s	£000s	£000s	£000s	£000s	£000s
Non-current assets	364,057	371,728	(7,671)	365,081	365,081	0
Current assets	162,728	145,932	16,796	166,622	165,977	645
Current liabilities - borrowings	(11,109)	(12,014)	905	(11,109)	(11,109)	0
Current liabilities - other	(107,746)	(83,513)	(24,233)	(106,603)	(101,638)	(4,965)
Total assets less current liabilities	**407,930**	**422,134**	**(14,204)**	**413,991**	**418,311**	**(4,320)**
Non-current liabilities - borrowings	(85,900)	(80,895)	(5,005)	(85,900)	(85,900)	0
Non-current liabilities - other	(5,223)	(649)	(4,574)	(6,363)	(6,363)	0
Total net assets employed	**316,807**	**340,589**	**(23,782)**	**321,728**	**326,048**	**(4,320)**

5.2 Capital

The Trust submitted a 2023-24 capital plan of £9.8m in line with its allocation share based on depreciation plus £4k relating to IFRS 16

Capital expenditure as of 31st May 2023 was £77k, this is a reflection that the Trust's principal capital projects are yet to get fully underway for this fiscal year.

5.3 Cash

As at the end of May, the Trust's cash balance stands at £122.1m, a decrease of £4.3m from 30 April 2023. The cash balance is lower than March's figure and £18.4m lower than Plan. The Trust's ongoing cash requirements have not changed materially in terms of staff pay and capital expenditure, and the Trust continues to strive to pay suppliers early in the current economic climate.

5.4 Better Payment Practice Code (BPPC)

The Trust is signed up to the NHS commitment to improve its Better Payment Practice Code (BPPC) whereby the target is to pay 95% of all invoices within the standard credit terms.

Overall, the Trust's BPPC is 81.8% by volume and 83.8% by value. The BPPC for non-NHS invoices is 82% by volume and 84% by value.

6 Conclusions

6.1 The Trust is reporting net deficit of £863k (0.8%) which is worse than plan by £951k. The adverse variance is mainly due to under delivery of Financial Viability, inpatients wards pressures and pay award funding shortfall.

7 Equalities

7.1 This paper has no direct impact on equalities

8 Financial Implications

8.1 These are as stated in this report.

9 Risk

9.1 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).

10 Actions Being Requested

10.1 The Board is asked to:

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

b. **NOTE** the assurance provided and **CONSIDER** if further sources of assurance are required

Trust Board Forward Plan 2019-21 at July 2020

PART 1	Item	26/01/2023	30/03/2023	26/05/2023	27/07/2023	28/09/2023	30/11/2023	25/01/2024	28/03/2024
Standing Items	Declarations of interests	✓	✓	✓	✓	✓	✓	✓	✓
	Minutes of previous meeting and action log	✓	✓	✓	✓	✓	✓	✓	✓
	Matters Arising from Trust Board private	✓	✓	✓	✓	✓	✓	✓	✓
	Chair's Report	✓	✓	✓	✓	✓	✓	✓	✓
	Chief Executive's Report	✓	✓	✓	✓	✓	✓	✓	✓
	Patient/Staff Story	✓	✓	✓	✓	✓	✓	✓	✓
	Forward Plan	✓	✓	✓	✓	✓	✓	✓	✓
	Teatime Presentation to alternate between QI and People Participation Story	✓	✓	✓	✓	✓	✓	✓	✓
Quality and Perfor	Quality Report	✓	✓	✓	✓	✓	✓	✓	✓
	Performance Report	✓	✓	✓	✓	✓	✓	✓	✓
	CQC				✓				
	Inpatient Deaths	✓						✓	
	Environment & Sustainability: Climate Emergency Declaration/Green Plan	✓						✓	
People	People Plan Update inc:	✓	✓	✓	✓	✓	✓	✓	✓
	~Equality, Diversity & Inclusion	✓						✓	
	~Staff Survey		✓						
	~ Workforce Race Equality Standard Report				✓				
	~ Workforce Disability Equality Standard Report				✓				
	Clinical Workforce Report	✓			✓			✓	
	Population Health Annual Report					✓			
	Safe Staffing	✓			✓			✓	
	Patient & Carer Race Equality Framework PCREF					✓			
Finance	Finance Report	✓	✓	✓	✓	✓	✓	✓	✓
Governance	Annual Report and Accounts				✓	✓			
	Annual Reports:								
	~ Compass Wellbeing CIC Proposal and Annual Report	✓				✓			
	~ Health & Care Space Newham Annual Report		✓						✓
	~ Internal Audit Plan		✓						✓
	~ NHS Self-Certification				✓				
	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	26/01/2023	30/03/2023	26/05/2022	01/06/2023	27/07/2023	28/09/2023	30/11/2023	25/01/2024	28/03/2024
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	Estates Strategy		✓							✓
	Digital Strategy Update									
	CQC and Well-Led									
	System Working:									
	~ East of England Collaborative Update									
	~ NEL Collaboration									
	~ System Working									
	~ NEL MH and Community Collaborative									
Emerging Issues: Internal/External	~ Briefing on finance position									
	~ Briefing on staff Covid-19 vaccinations									
	~ Financial Strategy and Sustainability and ICS									
	~ Staff Wellbeing									
	~ UK Cloud									
	~ Feasilbility Study of the Bedford Health Village						✓			
Emerging Issues: Safety	Prevention of Future Deaths Notice					✓				

Board Workshop	**Item**	**26/01/2023**	**30/03/2023**	**26/05/2022**	**01/06/2023**	**27/07/2023**	**28/09/2023**	**30/11/2023**	**25/01/2024**	**28/03/2024**
Strategy	Green Plan / Sustainability (May 2023)			✓						
Winter Planning	Winter Planning						✓			
Training	Cyber Security	✓							✓	
	Infection Control		✓							✓
	Safeguarding		✓							✓

Acronyms

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