NHS East London NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
24 March 2022

Title	Quality Report
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Purpose of the report

The Quality Report provides the board with an overview of quality across the Trust, incorporating the two domains of assurance and improvement. Quality control is contained within the integrated performance report, which contains quality measures at organisational level.

Committees/meetings where this item has been considered

Date	**Committee/Meeting**
	None

Key messages

The quality assurance section of the report includes a deep dive into the effectiveness of the Trust's approach to making changes following the learning from a serious incident. From a sample of serious incidents and interviews with leads in a number of directorates, it is clear that actions are being implemented, and there are robust mechanisms in place to share learning across services. There is variation in the processes within directorates to monitor implementation of actions from incident reviews. There are opportunities to improve the effectiveness of our actions by reducing the overall number of actions, and ensuring more actions are at the stronger end of the action hierarchy, focusing on system factors. In response to the findings, a number of steps are being taken to strengthen the way we make changes based on learning from serious incidents. Progress will be reported back to the Quality Assurance Committee.

The quality assurance section of the report also includes a brief update on the action plan developed following our CQC inspection in 2021, and updates the board on our actions following the Ockenden review of maternity services.

The quality improvement section outlines the key findings from the recent annual visit by the Institute for Healthcare Improvement, and shares how we will be encouraging and reinforcing the application of quality improvement beyond projects, into day-to-day problem solving and into our larger scale programmes of work.

In support of our strategic objective on population health, the report outlines progress with our triple aim QI work on a number of discrete population segments that the Trust serves. Quality improvement is also being utilised in our work to become a Marmot Trust, which is commencing with work in Luton and Newham.

On the topic of improving service user experience, a new QI programme on pursuing equity is being launched, which will support teams to understand disparities in experience, access and outcomes

and address these systematically through coproduction and quality improvement. To help tackle the strategic challenge of increased demand and longer waiting lists for treatment, a new programme on optimising flow is currently being designed and will commence in June, to provide deeper support for teams to manage demand, develop creative ideas to increase capacity and optimise the flow across pathways.

In support of improving staff experience, team leads are being supported to test ideas on the key drivers related to enabling healthy, thriving teams and combating the key factors that are impacting on staff experience. In addition, a priority improvement area related to the experience of new starters at ELFT has led to people receiving access to clinical systems faster, and is now moving on to enabling access to smartcards within five days. On the objective of improving value, quality improvement is being deployed in support of delivering the Trust Green plan, and in reducing the spend on agency staff. Both of these pieces of work are at an early stage, but have good engagement and ideas that now require local testing.

Strategic priorities this paper supports

Improved population health outcomes	☒	Triple aim and Marmot Trust work
Improved experience of care	☒	Large scale QI programmes on pursuing equity, and tackling waits and flow
Improved staff experience	☒	Supporting team health and wellbeing, and improving the experience of new starters
Improved value	☒	Environmental sustainability and reducing agency spend

Implications

Equality Analysis	This report includes initiatives that aim to directly impact on equalities. Many of the areas that are tackled through quality assurance and quality improvement activities directly or indirectly identify or address inequity or disparity.
Risk and Assurance	There are no risks to the Trust based on the information presented in this report. The Trust is currently compliant with national minimum standards.
Service User/ Carer/Staff	The Quality Report provides information related to experience and outcomes for service users, and experience of staff. As such, the information is pertinent to service users, carers, and staff throughout the Trust.
Financial	Much of our quality improvement activity helps support our financial position, through enabling more efficient, productive services or supporting cost avoidance. However, nothing presented in this report which directly affects our finances.
Quality	The information and data presented in this report help understand the quality of care being delivered, and our assurance and improvement activities to help provide high quality, continuously improving care.

1.0 Quality Assurance

The quality assurance section focuses on the effectiveness of action plans arising from serious incident investigations, to understand systems that are in place locally and

centrally to monitor, support and provide assurance of implementation, and ensure the sharing and embedding of learning wherever appropriate.

1.1 The Trust sets out its approach to the definition and management of incidents, and to learning from when things go wrong, in its Incident Policy. The policy defines serious incidents as 'something out of the ordinary or unexpected, with the potential to cause harm, and /or likely to attract public and media interest'. The Trust has a clear process for identifying serious incidents. Serious incidents are categorised into two levels:

- Level 1a Serious Incident – panel investigation led by an independent reviewer and a co-reviewer from a different Directorate to that where the incident took place
- Level 1b Serious Incident – panel investigation led by either a corporate SI reviewer or a Directorate reviewer plus a co-reviewer from the Directorate where the incident took place

1.2 During the 2021 calendar year there were 118 incidents reported that met the criteria for grading as a serious incident, 15 level 1a and 103 level 1b.

1.3 The Trust process for review of serious incidents and the production of a report and action plan to address the issues identified is also described in the policy, and is in line with the national guidance set out in the NHS England Serious Incident Framework (2015). It is administered and managed by the corporate Risk and Governance Team. The fundamental purpose of identifying, reviewing and responding to serious incidents is to make the care and treatment delivered by the Trust safer, addressing identified risks and reducing the chances of adverse events recurring. Creating systems that do this effectively is complex and challenging. It is acknowledged that organisations across the NHS encounter difficulties in delivering good quality investigations that consistently support the reduction of risk and deliver safer care.

2.0 Aims and method

2.1 This paper aims to provide assurance on the implementation of actions arising from a sample of serious incidents, and the processes in place to share and embed learning across directorates. In order to assess this, a small sample of serious incidents was identified across a range of services provided by the Trust. The sample included one incident from each of the following areas:

- Tower Hamlets community health services
- City and Hackney mental health services
- Newham mental health services
- Bedfordshire and Luton community mental health services
- Tower Hamlets mental health services
- Older Persons mental health services
- Forensic services

2.2 A semi-structured interview was used to review implementation of the action plan with the directorate leadership team, and then explore processes and structures in place to share and embed learning from serious incidents more generally.

3.0 Findings

3.1 Implementation of actions

All directorates were able to provide assurance on the implementation of actions associated with the sample report, and were able to support this with evidence. Some actions were easier to evidence than others, by virtue of the nature of the action. For example, an action ‘to update staff at the team away day of a particular requirement or process’ is difficult to evidence as away days are not typically documented in detail.

Directorates reported challenges managing the volume of actions arising out of multiple incident reviews, alongside other imperatives such as audits, regulatory standards, complaints etc.

Analysis of the actions in the sample of serious incidents highlighted the volume of actions generated, that many actions were actually not material to the occurrence of the incident and that a majority of actions are at the weaker end of the action hierarchy (for example, training and policy change, or focused on individual clinical practice rather than on system design).

Action Plan	Total actions	Weaker actions	Stronger actions	Root cause or contributory factor (material to occurrence)	Care or service delivery problem	Lesson learned (Incidental learning)
Tower Hamlets CHS	2	0	2	0	2	0
City & Hackney mental health	3	0	3	0	2	1
Bedfordshire & Luton mental health	5	5	0	0	4	1
Newham mental health	6	2	4	0	6	0
Tower Hamlets mental health	2	0	2	0	0	2
Older people’s mental health	4	1	3	1	3	0
Forensic	12	2	10	0	10	2

Further challenges arise when actions cross organisational boundaries. Tower Hamlets community health services highlighted an incident where care was shared with a local provider and ownership of actions became unclear. This can also be an issue internally, where an action plan is generally owned by the directorate where the incident took place, but individual actions may be owned by individuals or teams outside the directorate.

3.2 Monitoring and oversight

In exploring implementation of actions, there is evident variation in approach to monitoring and oversight. Some directorates had a clearly defined process for proactive monitoring, generally culminating in Director ‘sign off’. Some directorates had more ad-hoc arrangements, with a less defined system or process for signing off actions and action plans as complete. They will carry out the activity often in response to the prompting of the Risk and Governance team.

Irrespective of the rigour of the process in place locally, a number of directorates found oversight of action plan implementation challenging, often because of the number of

actions being tracked across multiple incidents. The Risk and Governance team uses the Datix system to track implementation of actions. However, at present, the corporate Risk and Governance team are inputting information relayed to them, rather than directorates using the system directly. There is also no current central reporting on the implementation of actions that would provide routine assurance to the Trust board.

3.3 Impact

A number of directorates highlighted that occasionally, whilst they were confident an action had been implemented, they were not able to demonstrate that doing so had had the desired effect. In some cases, there was scepticism as to whether an action actually addressed the issue identified. Directorates reported that overseeing implementation was a significant task in itself, and that they didn't feel they had the capacity to additionally test the impact of the action or actions taken. Although some new or reinforced standards of practice may become the subject of ongoing monitoring through audit or spot-checks, at present systems are not routinely in place to test how changes or improvements are embedded and sustained.

3.4 Sharing of learning

All directorates spoken to have established systems in place for sharing learning across their services. Directorates generally describe systems that combine one or more of the following:

- Initial review of findings to determine if the learning is pertinent to other services
- A forum for the review of incident reports and action plans attended by representatives of all teams (often a 'patient safety' meeting)
- Formal feedback of reports and action plans at directorate management team or directorate governance meeting
- Regular 'Learning Lessons Seminars' sharing key learning, or themes arising from serious incidents
- Use of newsletters or similar communications channels, to share learning

4.0 Conclusions

4.1 All directorates were able to provide assurance that actions resulting from serious incident reviews are being implemented.

4.2 Directorates have robust systems in place to identify when learning is relevant to other services, and for ensuring the learning is shared.

4.3 There is variation across directorates in the processes for tracking and recording the implementation of individual actions, and 'sign off' on the completion of action plans.

4.4 Implementation of actions is not currently reported centrally to provide assurance to the Trust Board on a regular basis.

4.5 Whilst there is collaboration between incident reviewer and clinical services in the development of actions, directorates sometimes don't feel fully engaged, with the result that sometimes they are not in agreement with the action required.

4.6 The number of actions being generated, cumulatively across a number of incident reports, places a high burden on directorates in terms of delivery and in assuring implementation. Many actions generated are not material to the incident being investigated, but relate to learning picked up in the course of the review process.

4.7 The impact of actions, checking that they have the desired effect, and if the implementation and impact are sustained, are not currently measured in a consistent fashion.

5.0 Actions taken to strengthen the system

5.1 It should be noted that significant changes in relation to serious incidents and patient safety are imminent, both internally with the appointment of a Director of Patient Safety, and nationally with the forthcoming publication by NHS Improvement of a 'Patient Safety Incident Response Framework' to replace the 2015 'Serious Incident Framework'. A number of actions are already being taken forward in order to improve systems for learning, to improve patient safety, and strengthen assurance.

- All directorates are developing a defined process for directorate management team oversight of the implementation of action plans
- Each action plan will have a named owner to monitor implementation
- All directorates will record the implementation of actions centrally using the Datix system ('Actions' module)
- The status of all actions will be reported regularly to the Quality Assurance Committee to ensure Board oversight of implementation of actions from serious incidents
- Human factors training will become mandatory for all serious incident reviewers to ensure the highest quality of investigation and impact of actions
- The development of action plans in future will be weighted towards systems factors and concepts that are at the stronger end of the action hierarchy

The progress of all the above actions will be reported through to the Quality Assurance Committee, as part of the regular reports on serious incidents.

6.0 Update on the CQC action plan

6.1 The Trust underwent its most recent inspection by the Care Quality Commission (CQC) in September and October 2021. The report was published in January 2022. The Trust retained its 'Outstanding' rating for the third consecutive time. The Trust is required to respond to areas for improvement identified within the report, in the form of an action plan. The report highlighted one 'Must Do' action and thirteen 'Should Do' areas for improvement. 'Must Do' Actions must be responded to ensure the Trust is compliant with the Health and Social Care Act (2008).

6.2 In response to these areas for improvement, an action plan has been produced (see appendix 1). Each action has a lead identified who is either the director responsible for the services affected, or subject matter expert. Each action is also allocated an Executive lead. The actions are wide ranging, from ensuring fridge temperature checks occur, to implementing Estates and Digital strategies, and time frames from implementation vary from weeks to months. The action plan will be monitored monthly with all action leads requested to attend a meeting to report progress. This meeting is chaired by the Chief Nurse and Executive leads are also invited. When actions are described as completed, evidence will be requested and scrutinised before the action is signed off.

6.3 It is expected that actions are discussed at local meetings on a regular basis, and then this is reported to the Action Plan group, executive team and Quality Assurance Committee, with 6-monthly updates to the Trust Board.

6.4 The Primary Care directorate also have an action plan in place in response to the CQC inspection at Leighton Road Surgery in October 2021. This covers various areas including:

- People and Culture: supervision, appraisals, and recruitment
- Recording of safeguarding risks and how this impacts the whole family
- CQC registrations for the practices to be updated to ensure all regulated activities are registered

An initial meeting has been held to assign actions to owners and the directorate are reviewing their action plan at the Quality Assurance Group meetings which occur monthly.

7.0 Update on the Ockenden review

The Ockenden Report was published in 2020 as a result of serious concerns around maternity care delivered at The Shrewsbury and Telford Hospital NHS Trust. The report outlines seven essential actions all trusts must take. Within ELFT the perinatal services consist of an inpatient unit, community perinatal teams across all the boroughs and Maternity Mental Health Services (Ocean) in London and Bedfordshire and Luton. The teams have strong links with maternity services in the boroughs and at a strategic level work closely with Local Maternity Systems (LMS) both in NEL and BLMK.

The Trustwide Lead for Perinatal Mental Health has recently been appointed as the Clinical Lead for Perinatal Mental Health in London, giving greater strategic oversight at senior level and an awareness of any evolving issues in relation to joint working between maternity and perinatal services. Future plans to address and ensure that ELFT is addressing the Ockenden report recommendations focus on:

- More robust structures in place to share learning from SUI's across maternity and perinatal mental health services in NEL and BLMK
- Further development of the specialist midwifery post in Bedfordshire & Luton

8.0 Quality improvement

8.1 ELFT's strategic partner, the Institute for Healthcare Improvement (IHI) conducted their annual visit in February 2022 and met with staff, service users and carers to learn about improvement work happening across the Trust. They gave much commendation for how improvement work was being openly shared, the leadership on people participation, the commitment to equity and taking a trauma-informed approach to staff wellbeing, safety and dignity. They offered some opportunities about extending quality improvement (QI) beyond projects and into daily work within teams and into larger-scale change across the Trust, and about having a clear line of sight between the new Trust strategy and improvement work.

8.2 On the first opportunity to extend quality improvement work beyond projects, the following ideas are currently being tested:

- The chief quality officer will be running a leadership for improvement programme for members of our directorate management teams, supporting them to learn and

practise leadership behaviours to enable and nurture cultures of quality improvement within our teams

- Stories from teams to describe how they are using quality improvement in day-to-day problem solving will be shared
- Working with the community mental health transformation programme and the financial viability programme to strengthen the use of quality improvement in these large programmes of work
- Support to directorates through the existing quality improvement infrastructure and training will be adapted to encourage and nurture the use of improvement in broader ways. This will involve extending the role of QI coaches and improvement advisors.
- The learning platform, Life QI, for capturing and sharing quality improvement will be expanded in order to capture and share all forms of improvement work.
- A digital platform, ImproveWell, will be tested as a way for teams to continually share, vote on, and test improvement ideas, without limiting this to being within a project.

9 Improved Population Health

9.2 *Triple Aim*

There are nine projects that are working on improving population health using the Triple Aim approach, which aims to simultaneously improve health outcomes, experience of care, and value for an identified population. Two new projects started in January 2022, one will be working on reducing inequalities in school age children in the South Luton neighbourhood and the other for children in North, East and Central London are still working to identify a specific population. The longer established projects have started testing change ideas. For example, the project in primary care to increase cervical screening rates has been testing and learning how to engage diverse populations, how to adapt the way information is communicated and how to preserve the dignity of women attending appointments.

9.3 *Marmot Trust*

ELFT has committed to becoming a Marmot Trust. This involves working across sectors and organisational boundaries in a place-based way to improve population health in the communities we serve. In Luton, the initial priority area of focus will be to 'c*reate fair employment and good work for all'* in line with the council's initiative to become a Marmot Town. In Newham, the initial focus will be on the wellbeing of children and young people in Newham by focusing on the two principles, 'giving every child the best start in life' and to 'enable all children, young people and adults to maximise their capabilities and have control over their lives'. We will be looking to apply QI approaches where it would enhance collaboration and improve outcomes, most likely around collaboration with a bias to action so we can test and learn in a deeper way, identifying a portfolio of projects, developing a measurement plan and supporting the testing and scaling of ideas. This work launched in February 2022 with a workshop in partnership with the IHI and a stakeholder round-table event with partners in Luton to coproduce high impact areas of focus to enhance employment and skills. A similar session is planned in Newham in March 2022.

10 Improved Experience of Care

10.2 *Addressing Inequalities*

There are more than 20 QI projects across the Trust that aim to improve the experience of care through addressing inequalities and inequity in service users' experience, access to care and outcomes. Below are a few examples:

Quality improvement aim	Team
Tackling racism against staff	East India Ward in Forensics service
Increasing representation of the South Asian community in the cancer, palliative care and clinical health psychology service	Clinical Health Psychology Service in Bedfordshire Community Health Service
Improving access to preconception counselling for women with severe mental illness	City and Hackney Perinatal Team
Improving health outcomes for homeless people living in Tower Hamlets' hostels	Tower Hamlets Mental Health
Reducing inequalities by improving cervical screening uptake	Primary Care - all teams
Increasing access to mental health services for Black, Asian and minority ethnic service Users	Dean Cross team in Tower Hamlets Mental Health
Improving access for people with a learning disability to receiving electrocardiograms	Bedfordshire and Luton Learning Disability Services
Veterans Community at ELFT: meeting the required standards of the Veterans Healthcare Alliance	Veterans Alliance Team in Corporate services
Improving COVID vaccination uptake and reducing vaccine inequalities amongst ELFT staff	Trust Wide

A new quality improvement programme aimed at 'Pursuing Equity' will launch in April 2022. The programme has been designed in partnership with public health, people participation and the staff networks. The programme will support teams to understand what contributes to inequity within the population they serve, use improvement methods to test meaningful change ideas and develop measurement plans to know if they are making an improvement.

10.3 *Reducing waiting times and improving access to services*

In 2021, four workshops were run to equip teams who were tackling long waiting lists and backlogs for assessment and treatment with the theory of flow management and quality improvement tools. Twenty-seven teams participated in these sessions. Six out of the eighteen teams that are running QI projects on this topic are seeing improvement:

- Bedfordshire Wellbeing Service increased the percentage of service users entering low intensity groups from 17% to 42%
- Bedfordshire community mental health team reduced the wait for occupational therapy appointments from 14 weeks to 3 weeks
- Luton crisis resolution and home treatment team reduced unnecessary pharmacy interventions from an average of 5.2 to 2.5

- City and Hackney integrated learning disabilities service reduced time from referral to assessment from 304 days to 81 days
- City and Hackney mother and baby unit reduced time from referral to screening from 464 minutes to 67 minutes
- Bedfordshire pharmacy team reduced the time taken to produce reports from 24 days to 10 days.

Given the strategic importance of tackling waiting lists and demand in the wake of the pandemic, a new year-long quality improvement programme on 'Optimising Flow' is currently being recruited to. This programme will launch in June, and provide support to accelerate work across pathways of care to manage demand, develop creative ideas to enhance capacity and reduce waiting times.

11 Improved Staff Experience

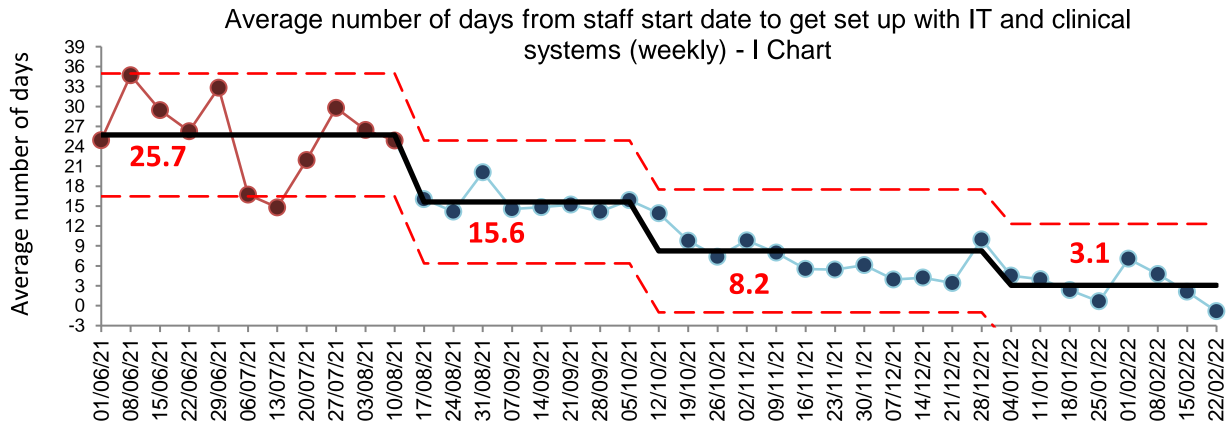
11.1 *Team Health and Wellbeing*

A range of factors have impacted on the health and wellbeing of our teams at ELFT, including the effects of the pandemic, the impact of new ways of working, and the increase in demand being seen by many teams. This topic also came up as a theme in discussions with directorate leaders during the recent annual visit by the IHI. The chief quality officer is offering sessions aimed at team leaders, to help share the evidence base on the topics of wellbeing, burnout, joy in work and applying trauma-informed principles, and offering a simple bundle of high impact change concepts that team leaders can adopt and test out within their teams.

11.2 *New starter project*

A quality improvement project is bringing together a number of corporate teams to collaborate together in order to improve the experience of new starters at ELFT. The

project has achieved their original aim of all staff receiving access to clinical systems within five days, and are now working towards ensuring all have their IT equipment and an active smartcard within five days of starting. Change ideas best tested include allocating the smartcard before the start date and ensuring IT equipment orders are received from line managers 10 days before the start date.



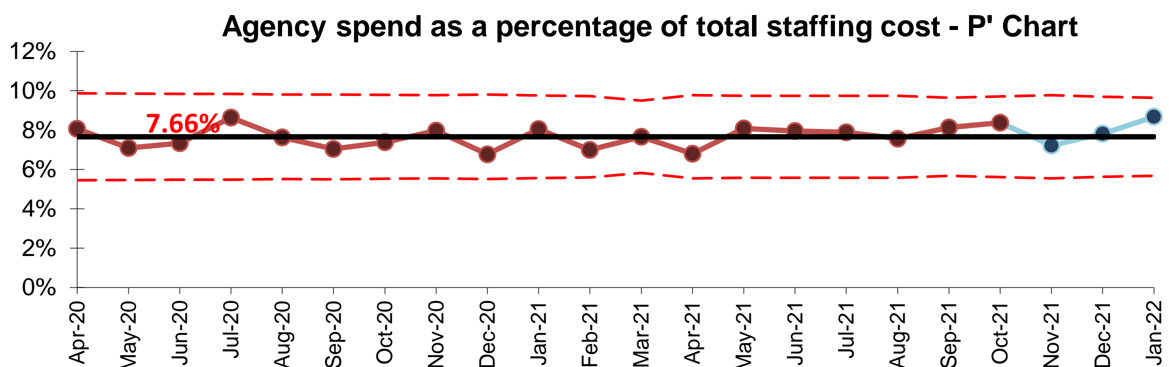
12 Improved Value

12.1 *Environmental Sustainability*

The Trust has committed to contributing to the creation of healthy and sustainable places, including taking action on climate change. The aim of the 'ELFT Green Plan' is to reduce direct and indirect carbon emissions at ELFT by 2025. The project team have created a driver diagram to visualise their theory of how to achieve the aim. They are now in the process of trying to understand key factors impacting on sustainability as well as how to measure and evidence progress when they start testing new ideas. Six workstreams have been agreed that will bring together teams working on similar areas: estates & facilities, medicines, procurement, sustainable models of care, travel and transport and workforce leadership. Each workstream will have a driver diagram and measurement plan. The work will initially focus on estates and sustainable models of care.

12.2 *Reducing Agency Spend*

A team is working towards reducing spend on agency staff by 25% by December 2022. The greatest area of opportunity for improvement is around systems and controls that are in place, or in some cases, not being applied consistently, or not in place at all. The team have run process mapping sessions with the temporary staffing team, customer feedback



sessions with matrons and have sought feedback from recruiting managers and staff who have started on the bank in the last 6 months.

The team will be testing ideas in three high impact domains:

- Introducing booking controls to prevent the booking of agencies that are not pre-approved under the agency use framework
- Exploring digital platforms to deploy staff from other organisations and bring together the fragmented staff bank systems in use across ELFT
- A recruitment video for Consultant Psychiatrists for Luton and Bedfordshire has been completed and will be tested when recruiting into new roles

13 Action Being Requested

The Board/Committee is asked to **RECEIVE** and **DISCUSS** the findings of the report.

NHS East London NHS Foundation Trust

Appendix 1. CQC action plan

#	Must do/ Should do	Exec Lead	Key actions	Target date	Status Update	Status
MD1	The trust must ensure that all wards are compliant with guidance on mixed sex accommodation. Female patients must not have to walk through areas used by male patients in order to use bathrooms. Regulation 10 (paragraph 10(2)(a))	Dr Paul Gilluley	An additional doorway will be installed that will create an airlock between male and female bedrooms, allowing privacy accessing the existing shower room. The additional door way will be placed outside Bedroom 6. This will allow direct access from both bedroom corridors without crossing existing bedrooms.	May 2022	A capital bid for building work to take place has been approved, and site visits have taken place. Waiting for contractor availability to complete works A standard operating procedure will be developed to set out how the ward will manage mixed sex accommodation going forwards.	
SD1	The trust should ensure that its work around identifying recurring themes linked to serious incidents continues, with the aim of embedding learning and minimising the repetition of poor practice.	Dr Paul Gilluley	1) Appointment of Director of Patient Safety	June 2022	Interviews took place on 7th March.	
			2) Immediate learning from any SI is shared across services if there is an indication that the circumstances of the incident have the potential to repeat in services. Director of Nursing and Patient Safety Specialists alert the Service Directors, Lead Nurses and Clinical Directors immediately for dissemination of relevant information and action.	Completed		
			3) SI committee process refocussed on themes and learning in line with the new Patient Safety Incident Review Process this is regularly fed back through DMTs to local teams	Completed		

			4) Patient Safety Forum – provides assurance to the Quality Committee that actions related to themes from Serious Incidents are appropriate, timely, fit for purpose and completed. This forum also examines the Mortality Review themes and learnings. Any Prevention of Future Deaths reports and their subsequent action plans are monitored via this forum.	Completed	Patient Safety Forum now established.	
			5) Review of mechanisms and tools used to communicate patient safety issues and learning from incidents within the Trust.	June 2022		
			6) Electronic observations to be rolled out across the trust	December 2023	Project board established and scope of project defined.	
			7) Commission a further deep-dive with Public Health colleagues into the determinants of health within ELFTs patient population and specifically those who have died unexpectedly or with long term conditions. Results to inform any future improvement work.	September 2022		
			8) Review physical health strategy to identify any areas of activity/intervention that might benefit from a QI approach.	September 2022		
			9) Each inpatient service has a forum (Time to Think) where safety issues related to violence and aggression, safeguarding, sexual safety and clinical practice are explored and discussed. This forum has a solid link to QI work and assurance around these issues and related restrictive practices.	Completed		

			10) Quarterly Learning from Safeguarding events are held online across the Trust and Safeguarding leads attend the Time to Think forums in each areas monthly to support and discuss themes.	Completed		
			11) Prevention of Future Deaths actions plans for inpatients are monitored via the Lead Nurse Meeting each month.	April 2022	Will be discussed at next Patient Safety Forum what appropriate forums will monitor Prevention of Future Death actions related to community teams.	
SD2	The trust should continue its work identified in the estates strategy to ensure that all areas where patients receive care and treatment are an appropriate standard.	Steven Course	The new Estates Strategy will continue to focus on ensuring that areas of patient care are to an appropriate standard, within the confines of CEDL and on a prioritised basis.	June 2022	The Estates Strategy refresh project has been commenced, with a draft document aiming to be completed early in the financial year 2022/23. This will be monitored and audited by a steering group and will have sign off by Board / FBIC.	
			The John Howard Centre options analysis Masterplan will ensure that any recommendations reflect appropriate patient care and treatment	June 2022	The John Howard Centre Options analysis Masterplan is underway with draft completion by April 2022. This will be monitored and audited by a steering group, with final recommendations presented to the Head of Forensics.	
			The Bedfordshire Health Village Masterplan project is awaiting approval from our partners in L&D / Beds and will ensure that any recommendations reflect appropriate care and treatment.	June 2022	Approval has not yet been received for the Bedfordshire Health Village Masterplan project - awaiting Luton & Dunstable approval.	
			A new forum of collaboration and regular update / feedback shall be established between Chief Operating Officer, Chief Nurse, Chief Financial Officer and Director of Estates to openly discuss and resolve estates, estates operations and estates environment matters.	Completed	A forum has been established.	

SD3	The trust should continue its work on improving the experience of staff when using IT and the associated systems.	Philippa Graves	In line with the digital strategy, the digital team are working on improving key areas across the digital platform. This includes: - * Systems Integration & access to patient data * Infrastructure * Networking, Wi-Fi & connectivity * Systems resilience * VDI Implementation & Upgrade of end user devices * Remote Access Active Projects such as, the implementation of a Trust integration engine (TIE) and the introduction of Virtual Desktop Infrastructure will improve the performance of end user devices and enable secure access to patient data or systems over a wide geographical area. Enhancing the data available to clinicians and staff across the organisation utilising systems integration will increase the information available to end users when viewing a patient record, this includes features such as viewing diagnostic results and the ability for clinicians to electronically request diagnostic tests. Alongside these projects the Trust is investing in an upgrade and re-design of the underlying digital infrastructure, this includes networking, Wi-Fi, systems hosting and deployment of new systems. These projects and initiatives will enable staff and clinicians to access enhanced patient data and clinical systems, across numerous devices (including mobile), on secure, robust and high performing digital infrastructure. Ultimately leading to an	March 2025	This is a 3-year strategy, and implementation starts in April 2022. Key milestones for Year 1 are workforce structure, and to ensure plans for implementation are all in place for networking and WIFI aims and VDI implementation. This action plan will just monitor connectivity aspects of the strategy.	

			improved and quality end user experience when utilising digital services at the Trust.			
SD4	The trust should ensure that all wards providing mixed sex accommodation have an area designated for the use of female patients only.	Dr Paul Gilluley	To install permanent signage on female only lounges on Cazaubon and Leadenhall wards.	March 2022	Wards now have female lounges allocated and there is clear signage on the door indicating 'Female Only Lounge'. Ward is awaiting delivery of permanent signage for the rooms.	
			To monitor use of female only lounges with environmental audits to ensure they are not repurposed.	Completed	Added to the environmental audits and starting audits on 14th February 2022. Part of health and safety audits for the ward and the standard is explicit to all staff and visitors.	
SD5	The trust should ensure that all staff have completed the appropriate level of mandatory training in safeguarding	Tanya Carter	1) Corporate Safeguarding Team will offer targeted training for staff working on the Older Peoples ward to achieve full compliance within the next three months.	April 2022	As of 8th March there were 4 members of staff outstanding for Safeguarding Adults Level 3 training and 5 for Safeguarding children Level 3 who are being actively followed up. All other members of staff are compliant or booked on upcoming training.	
			2) Corporate Safeguarding Team to set up quarterly refresher training for staff and the first training will be delivered on 1st February 2022.	Completed		
			3) Safeguarding Training Compliance in older peoples wards will be reviewed in each Safeguarding Committee	April 2022		
SD6	The trust should ensure that all time sensitive medication is administered to	Paul Gilluley	1) An extra medication trolley has been ordered to allow two nurses to administer medication at the same time. This will reduce administration time by half.	Completed	Additional Trolley now in place and two nurses dispensing medications	

	patients at the correct time		2) An audit form to devised for nurses to record their medication administration start and finish times as part of the improvement process, these are audited by the ward manager on a weekly basis.	Completed	Audit form now in use and will be reviewed in Clinical Improvement Group on an ongoing basis	
			3) An electronic report on time sensitive medication administration will be run weekly to check for administration times for the ward to seek further improvements. This will be reviewed at the ward's CIG meetings.	June 2022	Currently awaiting system set up with JAC.	
SD7	The trust should ensure that staff take appropriate action when temperatures in clinic rooms rise about the recommended range.	Paul Gilluley	1) To go through the policy and expectations with all registered nurses	Completed	This is now a standing agenda item for upcoming away days and induction for new staff.	
			2) To move the clinic room to a room with good ventilation, and for air conditioning will be installed.	April 2022	Work has begun on site and is expected to be completed within the next 4 weeks.	
			3) The ward manager to conduct weekly audits on temperature recordings and the Matrons' completes monthly audit.	Completed	Audits are now underway and will be discussed at the clinical Improvement Group for the ward.	
			4) Pharmacy departments also carry out separate audits and this will be discussed in the Clinical Improvement group.	Completed	Pharmacy complete audits quarterly and these are reviewed in Inpatient Steering Group meetings.	
SD8	The trust should ensure a programme of rolling decoration works is developed for the John Howard Centre.	Steven Course	1) We have embarked on a programme to redecorate some of the areas at JHC using non recurrent funds. 2) Half yearly reviews to be led by Estates & Facilities, IPC & Lead Nurses to report on state of the buildings , wards , estates work-Report to E & F and DMT	April 2022	A meeting with Castons who are leading the project on non-recurrent estates work has taken place, and here are weekly meetings to monitor progress. Currently awaiting a more detailed programme, the scope of work and when this can start.	

			3) To get dates for the Trust, Painting and decorating Programme 4) Half yearly reviews by HoS & Hon 5) Environment & Estates to be part of daily handover 6) Three monthly visit to wards with the nurse managers/Matron and another ward manager/Matron, Estates, Facilities & Capital Development, G4S			
SD9	The trust should ensure staff monitor the fridges within the ADL kitchens on Butterfield ward and Clissold ward to ensure food is fit to be consumed.	Lorraine Sunduza	1) Standardise the environmental security checks for all wards to include ADL and patient communal fridge monitoring twice a day 2) All perishable food to have label and expiry date, unlabelled to be disposed of 3) Night chores schedule for staff to report in daily hand over	February 2022	All Matrons & CNMs emailed of plan. It has also been discussed in Forensic Quality Committee meeting with DMT and Senior Department heads. Teams to discuss action in CIG & Away days and community meeting with services users.	
SD1 0	The service should ensure that oxygen bottles are secured appropriately when not in use on Clissold ward. The trust should also ensure that appropriate arrangements for managing medical equipment, to ensure it is suitable for use, are established on Bow and Westferry wards.	Lorraine Sunduza	1) All matrons to ensure that there is a register of all medical equipment 2) Register to monitor when equipment last serviced 3) Register to be reviewed every quarter by the ward matrons and CNMs	February 2022	Discussed in Estates & Facilities meeting. Avensy's Medical Equipment service are visited John Howard Centre from the 2nd February to the 11th February 2022.	
SD1 1	The service should ensure that medicines fridge temperatures are maintained between 2° and 8°C. Appropriate actions should be recorded if	Lorraine Sunduza	1) Standardise the environment hourly security checks for all wards to include Fridge Temperature Checks and treatment room checks 2) Weekly Checks by CPLs & CNMs 3) Monthly Checks by Matrons when completing the environmental report (to be	February 2022	A template has implemented on security form for daily checks and will be reviewed in Forensic Quality Committee. Two wards are also piloting an electronic book method of recording.	

	temperatures are recorded outside of this, as per trust guidance. The service should also ensure that ambient room temperatures, where medicines are stored, are below 25°C. Appropriate actions should be recorded if temperatures are recorded outside of this, as per trust guidance.		discussed at away days & Matrons) Meeting 4) Monthly audits of the above by physical health leads CS & CR and report monthly to FQC forum 5) Monthly checks by the pharmacist			
SD12	The trust should consider improving local broadband and mobile connectivity to ensure staff can connect to online systems.	Philippa Graves	The Digital department are currently reviewing networking arrangements across all ELFT sites, moving forward the aim is to categorise each site and transition to a standardised network setup for each category. Working with our service provider (Virgin Media) the Trust will transition to the new standardised approach across ELFT Sites. This approach will improve resilience, capacity and ultimately end user experience across Trust sites. In addition to Connectivity into ELFT Sites, the digital department is working with key partners to improve WI-FI connectivity at ELFT Sites. This includes a WI-FI upgrade, heat mapping and ensuring wireless access point are distributed accordingly. This approach will guarantee end users have a consistent, robust and first-rate wireless experience across ELFT sites.	June 2022		

SD13	The trust should consider improving the format of information displayed on Butterfield and Clissold wards to ensure is it easy to read.	Lorraine Sunduza	1.Butterfield & Clissold to review all the information displayed in liaison with colleagues from Directorate Learning Disability and People Participation 2. Lead Nurse and Head of Occupational Therapy to review 3. Action to be monitored through Bi annual Quality Reviews.	March 2022	This was discussed in the Low Secure Services senior management meeting on 16th of February 2022. Teams to discuss action in CIG & Away days and community meeting with services users.	