Safeguarding adults and vulnerable adults annual report 2022/23

1. Introduction

1.1 This annual report presents the highlights of all activities related to safeguarding and vulnerable adults and how the Trust meets its safeguarding adults statutory duties. The report provides information on performance of services under safeguarding adults, dementia and delirium care, learning disability care, mental health support and end of life care. The report is focused specifically under the areas of key developments, areas for development, lessons learnt and patient feedback.

2. Safeguarding Adults

2.1 Key developments

2.1.1 It has been a very busy year for the service with safeguarding adults referrals showing an increase of 19% from 2021-2022. The legacy of the pandemic continues with highest numbers of referrals being for self-neglect and for neglect by others. Many of the patients who were self-neglecting were also suffering from other conditions including mental ill-health and substance misuse who had refused help or were not known to services. Many of these cases were dealt with using the complex case pathway, wrapping services around the patient. Incidents of domestic abuse remain the third highest reason for referrals with 218 referrals. Domestic abuse continues to be an area of focus within safeguarding adults training. The team has also been working with the Apollo team to include asking about patient safety in their home as part of the nursing proforma.

2.1.2 Deprivation of Liberty Safeguards (DoLS) referrals rose by 58% compared to the previous year as staff awareness increased. It would be important to note that 25% (345) of referrals were made over weekends with 3% of total referrals being made over a bank holiday. This may benefit from discussion regarding a seven day working week for safeguarding adult services. However, work continues with ward teaching and visits to identify patients who require a DoLS application. With the LPS now delayed indefinitely it is even more important that we make sure that all vulnerable patients are appropriately safeguarded.

2.1.3 Great strides have been made in progressing the safeguarding adults agenda with the team being aligned to clinical groups, working together to improve the assurance framework to evidence how well safeguarding adults statutory

duties are met. There is an identified governance structure with a safeguarding adults dashboard of performance metrics used to provide assurance four-monthly at the Safeguarding Adults Operational group. There is now consistency of approach to adult safeguarding across all sites and shared learning disseminated.

2.1.4 Whilst safeguarding Level 2 remains under the agreed target compliance of 85% at 80.3%, a lot of improvement has been achieved in the last 3 months, see appendix 1. Additional sessions (including being part of the Trust wide mandatory days) continue, with face to face sessions to commenced from June. Staff who are out of date are reminded to complete training which is also available on e-learning.

2.1.5 The development of the Enhanced Care Audit Tool within the Integrated Specialist Medicine clinical group (ISM) has enabled greater oversight and assurance on the use of restrictive practice within clinical services. This assurance process is currently being rolled out across Cancer & Surgery (C&S) as well as Heart, Lung and Critical Care (HLCC). In support of this initiative the safeguarding adults team has produced a 'Restraint Rapid Read' for staff to refer to when considering restricting someone's movement/actions. This is supported with specific restraint training whilst also enhancing the restraint component within safeguarding adults Level 2 training. The Trust is also developing a training video to help support temporary staff prior to the provision of Enhanced Care.

2.1.6 The HLCC clinical group has set up a Vulnerable Persons Committee where initiatives to promote the safety of patients with vulnerabilities can be actioned and monitored. The committee meetings started in Q3 with safeguarding adults, learning disabilities, mental health, and dementia/delirium care as standing agenda items. The committee aims to ensure that there is not only a suitable channel for learning to be shared, but also for staff to have the ability to feedback on local safeguarding adults issues that are of critical importance to the HLCC group.

2.1.7 In October 2022 C&S Clinical Group held its initial Vulnerabilities Board with a remit to oversee the recording of risks, sharing learning, monitoring action plans, identification and rolling out of local and national initiatives and the analysis of safeguarding adult data.

2.1.8 There are currently no vacancies in the safeguarding adults with the Band 7 position at RBH site now recruited to. The Trust has also been invited to join the Hillingdon Safeguarding Adults Board with Harefield being within the borough of Hillingdon. This move has been very positive for joint working and sharing good practice.

2.2 <u>Areas for development and identified service risks</u>

2.2.1 Within C&S and ISM clinical groups Enhanced Care remains on their risk register. The introduction of the Enhanced Care audit and bespoke training from the safeguarding adults team have been introduced to ensure that patients are managed appropriately. It was also identified that staff needed some support in understanding the legal powers that may support the use of restrictive interventions. The safeguarding adults has been supporting with ward visits and being present at the midday huddles. Staff have found this to be helpful.

2.2.2 Within C&S and HLCC identification and referral for patients who require DoLS has the potential to improve referrals. HLCC identified low DoLS referrals on the Royal Brompton & Harefield sites, the safeguarding team have supported services through case finding wards visits to support staff in identifying patients who require DoLs. Additional training sessions focusing on DoLS were rolled out across the clinical group. As a result DoLS referrals have increasing on a quarterly basis. Matrons and senior staff within HLCC have also begun ward rounding to identify and support staff to raise DoLS referrals and escalate safeguarding concerns as required. Similar efforts have been made across C&S clinical group.

2.2.3 Accurate application of the Mental Capacity Act (MCA) especially in relation to the assessment of capacity and use of best interest meetings is an area where improvement is required Trust wide. Guidance on the MCA use has been accessible to staff through safeguarding training, GTI web page and ad hoc specific training, however there has been evidence from documentation and contact with the safeguarding team that staff continue to require support to ensure they are applying all principles of the act appropriately. Additional training for ward-based staff continues to be provided by the safeguarding team, with the team also supporting with assessment of capacity and best interest decision making for complex cases as they arise. Other areas where support has been required has included lasting powers of attorney and advanced decisions.

2.2.4 Overall there has been a reduction in the number of section 42 inquiries by the local authorities with 21 cases in the last year compared to 45 the previous year. 57% of the section 42 enquiries have closed, with 42% cases unsubstantiated, 5% (1) being substantiated, 10% were inconclusive, 24% remain under investigation and 19% are awaiting an outcome. The majority of inquiries were related to pressure damage to skin, 4 cases were due to alleged lapses in care.

2.2.5 There were 97 allegations against staff over the last year compared to 55 the previous care. Improvement of staff awareness of the allegations process may be attributed to the increase in reporting. 31% of cases were unsubstantiated, 14% substantiated, 3% were inconclusive and 15% were referred as complaints. 14% of the

allegations remain open for reasons including awaiting police investigation, awaiting court appearance and delays with engaging the person raising the allegation. The remainder 23% the referrals did not progress due to lack of patient engagement, staff having left the Trust without any forwarding contact and the cases not progressing as allegations.

2.3 Learning from Serious Incidents / Safeguarding Adults Reviews/Domestic Homicide Reviews

2.3.1 SAR adult D from Southwark is awaiting sign-off by the Local Authority Executive team. It has 10 recommendations for all partners of the partnership and will form an action plan which will be reviewed via SSAB. Final report awaited.

2.3.2 There have been 2 SARs involving GSTT patients made between July and December 2022 to Southwark with 1 of the referrals made by GSTT. 1 case involved a patient referred to the @home service and the community nursing team following discharge from KCH with heart failure and required daily medications. Staff had not managed to see the patient as he had refused staff access his home. The patient was found deceased over 10 days later. One of the learning points noted at the point of referral was that it would have been very beneficial to have held a complex case pathway meeting to risk assess the case and identify actions that could have been taken earlier such as a welfare check with police and mental health services or GP. This case was not considered for a SAR but has been suggested that a Rapid Review is undertaken instead. The review has not commenced yet.

2.3.3 The second GSTT patient case was referred by the police. Police were asked to access an elderly man's home when he had not been seen by the sheltered accommodation staff for a period of time. The gentleman was discharged from the hospital with a restart of his package of care comprising care four times a day. Unfortunately, although the carer provision was confirmed by the care agency the carers had not gone in to support the patient who was found on the floor deceased. An incident briefing was held and local learning taken place This case was considered not to meet the threshold for a SAR.

2.3.4 GSTT Safeguarding Adults Team also made a SAR referral to Lewisham, requesting an investigation for a patient with LD who appears to have been missed by the relevant teams when he returned from being in residential care. This SAR investigation is still underway.

2.3.5 Learning has been shared from SARs from other boroughs and the themes from these are were:

1. Sharing Information – the importance of sharing information with other services and statutory bodies to allow informed decisions being made to protect individuals.
2. The importance of Professional Curiosity – that staff should always endeavour to get as much information as possible and to not be hesitant to sometimes ask difficult questions.
3. The importance of Multi-Professional and Multi-Agency working and the sharing of risks, responsibility and management.

2.4. Feedback from Patients/Carers

2.4.1 Receiving patient feedback following safeguarding adults concerns is quite difficult to obtain as the safeguarding process extends into the community post discharge. The team are working on a patient and staff feedback form for patients and staff who have undergone the allegations process. There is a piece of work being discussed with Lambeth about the patient feedback about their safeguarding experience survey being started from their admission when the disclosure is made which is then sent as part of the referral. It was also discussed that the patient questions are embedded in EPIC going forward with the local authority having access to the information where they would then complete the questionnaire on the whole experience. The Apollo team has been contacted about this being included.

2 Learning Disability (LD)

3.1 Key developments - Acute Hospital LD Services and Community LD Team

3.1.1 Referrals to the LD hospital team remained high for the year 2022-2023 with 1431 referrals. Although this figure is a reduction of 11% from the previous year, it is nevertheless important as surgical activity has resumed to pre-pandemic levels with many referrals for patients who require more that one support intervention (both pre and post procedures), involving support for patients and carer with appropriate reasonable adjustments being made.

3.1.2 The Trust LD register remains a source of case findings for hospital admissions as wards will not always send a notification. This information enables rapid information sharing as the community LD team also has access and can share patient information in a timely manner together and facilitate early multi-disciplinary meetings and safe discharge. planned.

3.1.3 Investment through restructuring of the safeguarding adults team has resulted in a more robust in-patient support service for people with LD. The acute team is now made up of a Band 8A and a Band 6 LD nurse (previously one band 7 LD nurse). This has allowed better prioritisation of cases and the ability to see patients with a much quicker response time.

3.1.4 The Trust continues to participate in NHSE Reasonable Adjustment Flag Fast Follower Project**.** Making reasonable adjustments is a legal requirement to make sure health services are accessible to all disabled people. Reasonable adjustments are not always recorded or shared consistently across health and care, or when the patient moves from one care setting to another. The flag is now on the National Care Record and can be accessed via the spine. It should complement existing recording of reasonable adjustments locally and enhance the effectiveness of initiatives such as the national Accessible Information Standard. The Flag provides an immediate visible alert, provides basic context, is a prompt for key adjustments and can signpost to further information. Next steps will be to meet with Apollo to discuss how the flag will be built and engage with advocacy groups to complete the pilot and to support communication across GSTT in 2023/24.

3.1.5 Results from 4th NHSE LD Benchmarking identified that the Trust has overall done well with regard to supporting people with LD. The area requiring the most attention is routine involvement of service users in designing services, delivering training and having a voice at the Trust board. It is recommended that the Trust LD committee and associated subgroups group focus on this aspect during 2022/23 involvement of service users in policy development and planning could be improved upon. Submission of the 5th data was completed in February 2023 for the year 2021-2022.

3.1.6 COVID 19 vaccination and sedation clinic was nominated for GSTT Trust Care Awards and received a letter of commendation. The need remains for this to be established on permanent basis, further discussions are taking place.

3.1.7 Supporting health promotion for adults with learning disabilities has resulted in the LD team supporting signing training for staff in generic services. The team has supported initiatives at LD Awareness Week and the Big Health Week.

3.1.8 The LD End of Life Care working party has worked with Trust lead for Advance Care Planning to develop a number of key aims for Learning Disability services; (i) Map services locally and establish local links, (ii) Develop suite of resources, (iii) iii) Build upon work highlighted as good practice (iv) Increase confidence, skill and support within team, (v) Consider where and how we embed the processes into existing processes, (vi) What is our role as LD clinicians?

3.1.9 GSTT are working closely with SEL ICB and KHP partners to support the roll out of the mandatory Oliver McGowan Training. We are currently profiling the staff and supporting the development. At the same time KHP partners have updated KHP learning disability awareness e-learning with a task and finish group to enable training plans to progress in 2023/24.

3.2 Areas for development and identified service risks

3.2.1 There have been 31 deaths (hospital and community) involving people with LD all of whom have been referred for review via the LeDeR programme. 6 deaths occurred in the hospital sites (excluding RBHH). There was one death reported via LeDeR from the RBHH. RBHH sites are tertiary referral centres with most of their patients residing outside of SEL and therefore will be referred to their appropriate LeDeR service. The community team supports both the SEL sector meetings and borough specific meetings to review the local deaths and develop and follow up any recommendations.

3.2.3 Following the death of client who lived in a supported living service run by a provider in Southwark the community team continues to support services users and the review meetings.

3.2.3 The Michael Tippett College has a new education provider for children and young people with special needs., the community team are linked in to work jointly with them. Clinical leads from the community LD team have been supporting Lambeth review the service, and develop a plan for the college to have a new provider. We have met with the new provider and plan further meetings to support this transition process.

3.4 Feedback from Patients/Carers

3.4.1 The Trust Patient Experience team is working with Learning Disability services across all ages on the development of specific Learning Disability patient experience through development of a bespoke tool to measure service user experience. This has been piloted in community paediatric services and will be further developed to roll out across adult services.

3.4.2 Colleagues from the Trust Equality, Diversity and Inclusion team are also supporting and formal reviews of service to implement the EDS22 which will include review the accessibility and impact on service users with Learning Disabilities.

3.4.3 LD Benchmarking surveys (February 2023) were sent out to clients and carers across the Trust. In the CLDT, 8 responses were received via telephone and these agreed to share their responses with the team prior to these being amalgamated with the wider survey response to be reported later in 2023. All responses were positive.

3.4.3 The Community team received 40 compliments and no complaints which was consistent with the previous year.

4.0 Dementia and Delirium (DaD)

4.1 Key Developments

4.1.1 There were 621 DaD referrals received across the Trust over the last year, a 2% increase from the previous year. Referrals were made for a variety of reasons such as; behaviour management, medication review, dementia screening and non-resolving delirium as well as support for carers of people with dementia. The team has undertaken case finding approach to patients referred for a DoLS application, many of whom were experiencing delirium with or without underlying dementia.

4.1.2 The DaD team have adopted the new model of working in closely with Clinical Group in alignment with the Trust operating model. This has provided opportunity for CNSs to support dedicated clinical areas and work with staff together on local concerns and local solutions. The CNSs worked closely with informatics to devise a dashboard to enable effective data monitoring. This will enable Clinical Group to monitor trends and understand the risks in relation to dementia screening.

4.1.3. Dementia Level 2 training has been delivered across the RBH sites in collaboration with GSTT DaD CNSs. Training content was adapted to reflect Royal Brompton & Harefield Hospitals documentation. Dementia training is being promoted via ward visits, discussions with staff, screens savers, bulletin and email reminders.

4.1.4 The DaD team continues to support their clinical groups by completing a large portion of the dementia screen each day and offer be-spoke training to staff on how to complete the screening. The screening compliance figures per episode has improved with the compliance being over 85% or over for 10 months of the year. The aim is to achieve 90% or over compliance each month. The DaD team provided expertise to support the implementation of the 4AT assessment into ED documentation. This has helped to identify patients with a cognitive impairment in a timely manner and assist with dementia screening compliance using a standardised approach.

4.1.5 Capacity within the Trust Memory Clinic has increased by 33% per clinic through working differently to help with waiting list reduction. This is was completed within current budget and without the use of extra resources or funding.

4.1.6 There has been positive outcomes working with the Apollo team to develop a dementia and delirium referrals system which has a number of functionalities including patient lists from all inpatient sites which can be aggregated into the appropriate CNS's case load list.

4.1.7 Dementia Action week was a success with activities across all Trust sites involving dementia related webinars, stalls and personal support to GSTT staff who had loved ones with dementia in the 'Memory Pod' private areas.

4.2 <u>Areas for development and identified service risks</u>

4.2.1 C&S, HLCC and ISM all showed a lower number of DaD referrals compared to the previous year but through active case finding and ward rounding more patients were identified. DaD have been targeting high risk clinical areas to support staff in the identification of individuals who would benefit from assessment and input from the Dementia and Delirium Team.

4.2.2 Clinical services with 25% compliance rate for Dementia training have exceeded target compliance. There has been significant progress with services that require 85% target compliance. An e-learning package is being worked to support this work. The DaD CNSs have also completed multiple bespoke training sessions across the Trust over the

last year including: ICU, A&E, Mark Ward, Cardiology wards, Palliative care, newly qualified staff and volunteers. Staff are being written to and training is also provided closer to home especially those staff in the community.

4.3 Feedback from Patients/Carers

4.3.1 Carer surveys were carried out in Q1, Q2, and Q4. Surveys were not sent out in Q3 due to the National audit of dementia taking place. Our results found that overall, carers were happy with the level of patient care their loved ones had received. In most cases they felt listened to regarding the patient's wishes and preferences and felt staff did know about dementia. Majority of carers across the clinical groups report to have not been given a 'This is Me' document to complete and were not aware if one was at the patient bedside.

5.0 Mental Health

5.1 Key Developments

5.1.1 Work on the delivery of the Trust Mental Health Strategy continued throughout 2022/23. All directorates have been asked to submit a summary report outlining progress in the completion of their local delivery plans which will be included in a report to be compiled by the Trust Lead for Mental Health during Q1 23/24 summarising the work that has been completed both centrally and locally to deliver the 2019-2023 Strategy. The current strategy is due to end in April 2023, preparations began during Q4 for the development of the 2023-2026 Mental Health Strategy.

5.1.2 The Lily Sterner Mental Health Improvement Project has come to an end with the successful completion of 3 out of the 4 projects. The Mental Health Improvement Lead who delivered the projects has now left the Trust.

- 1) Mental health awareness film, "This Isn't Me" as launched in Q2, with subsequent roll-out of training.
- 2) Reducing Restrictive Practice training - 83 staff completed training commissioned from Maudsley Learning.
- 3) Mind & Body training - 45 staff were funded to complete the 5-day Mind & Body training run by KHP Project
- 4) Hot debrief training - This work had not been fully completed by the end of the lifespan of the Project and has been taken over by the Staff Psychology Team who will continue to develop hot debrief training for staff. A mental health and wellbeing training manager has been appointed by Occupational Health, who will lead on the delivery.

5.1.3 A mental health webpage on GTi has been developed. This is populated with a lot of useful information including

links to Trust policies, mental health teams, MHA information, news and events and training resources.

5.1.4 Work has continued throughout to develop the mental health and Mental Health Act fields and pathways for completion of orders on Apollo. One consequence of Apollo is that clinics operating IMPARTS will lose access to health-related questionnaires previously available through the IMPARTS programme unless they have specifically requested these to be added to Epic. Clinical groups have been advised of this and asked to consider what actions they need to take.

5.1.5 Mental Health Operational Groups were established on the Guy's & RBHH sites to oversee on-site mental health related activity (including use of the Mental Health Act and Enhanced Care), as well as mental health related incidents and complaints, and education and training. Mental Health Operational Groups already existed on the STH & ELCH sites. A decision was taken by HLCC to subsume the RBHH Mental Health Operational Group into the Heart, Lung & Critical Care (HLCC) Vulnerable Persons' Committee.

5.1.6 Work was completed during 2022/23 to develop a dashboard on SharePoint for mental health activity within the Trust. The dashboard largely focuses on mental health activity on the Emergency Floor but includes trust wide data relating to restraints, rapid tranquillisation, use of the mental health emergency procedure (Code 10) and the Mental Health Act.

5.1.7 As part of the work by the Metropolitan Police to digitise the section 136 process, a London-wide dashboard has been developed. The dashboard was launched during Q4 and provides a wealth of information, including where patients were detained, reasons for conveyance to EDs, numbers conveyed and outcomes (where available).

5.1.8 In October 2022, a 6-month pilot commenced in ISM involving the block purchase of 8 acute mental health beds from Cygnet (private mental health provider). Where a patient requires mental health admission but there is no available mental health bed, they will be assessed by the Mental Health Liaison Team for suitability for admission to commissioned Cygnet beds, with a referral for admission if considered to be appropriate and to meet the admission criteria set out by Cygnet.

5.1.9 A risk assessment of mental health service provision on the Guy's site was completed during the course of Q3/4 22/23. It will be reviewed and finalised during Q1 23/24.

5.1.10 South East London Cancer Alliance have funded a 12-month pilot of a band 7 mental health nurse specialist to work across the Lung & Thoracic Oncology Pathway supporting patients who are finding it difficult to engage due to underlying mental health or social problems or psychological distress. The successful candidate is scheduled to commence in May 2023.

5.1.11 A substantive (0.8wte) consultant psychiatrist employed by SLAM was appointed to the RBHH Mental Health Liaison Service during Q4 22/23, due to commence in post in Q2 23/24. Out of hours psychiatric cover will then be taken over by SLAM (currently provided by a private company).

5.1.12 Work was undertaken during Q4 22/23 to establish a service level agreement with CNWL for the administration of the MHA on the RBHH sites.

5.1.13 Guidance for staff working with patients at risk of suicide has been completed and will be submitted to VPAC for ratification in Q1 23/24. A mental health risk policy has been completed to provide staff with guidance and direction around the risk management of patients who present with mental health related risks. Once it has been clarified with ELCH regarding its application to children and young people, it will be brought to VPAC for ratification.

5.1.14 The Enhanced Care policy has been updated to include enhanced care for purposes of managing risks associated with functional mental illness, as well as risks related to frailty and confusion.

5.1.15 A mental health education strategy was completed during 22/23 with a stratified approach to mental health training for acute trust staff. It was agreed that Mental Health Act and suicide awareness training would become essential to role and centrally funded with co-ordination / delivery via ETD. A business case is in progress to deliver this. In addition, Clinical Groups have been asked to consider their learning needs around mental health and how these can be achieved, either through Clinical Group level commissioning of training from external providers, or via a funding commitment to an in-house centralised model of mental health training. During Q3 of 22/23, basic suicide awareness training devised by the Zero Suicide Alliance (ZSA) was put onto the GSTT College of Healthcare website. The training is available to all staff and it is intended moving forward that all staff will be required to complete it as part of their Trust induction programme.

5.1.16 During 22/23, ISM commissioned an external training provider, Mindworks, to deliver mental health training to staff on the Emergency Floor and SNPs / CRT. As of 31 October, 22, 191 non-medical staff completed 1 or more of the 7

modules., 20 staff completed all 7 modules Whilst staff reported the training was useful, they did not feel that it addressed practical or legal challenges faced on a daily basis. Whilst rich in content, was lengthy and a challenge to fit into clinical schedules.. A review of the training was undertaken by ISM during Q4 and it was decided not to renew the training contract. An interim in-house mental health training programme has been developed, led by the Enhanced Care Team Managers, with training delivered by GSTT and SLAM staff, pending a decision by ISM regarding arrangements for future mental health training.

5.1.17 Work was undertaken during 22/23 to create a patient experience feedback to be completed by individuals using the Trust's services who have mental health concerns. The work was completed jointly with SLAM and people with lived experience of mental -ill-health and will be piloted in ED in early 23/24.

5.1.18 A trust wide audit of environmental ligature risks was completed during 2022/23 with costed options. A way forward was agreed at VPAC and the Trust Health & Safety Committee during Q3 focusing on enhanced anti-ligature measures on the Emergency Floor and Addictions Care Suite. Alongside, a review was undertaken of ligature cutting equipment in the Trust to ensure that the equipment contained on emergency resuscitation trolleys was fit for purpose. The outcome of this is that wire cutters will be added to the emergency equipment in high risk areas. This will be completed during Q1 23/24.

5.1.19 World Suicide Prevention Day and World Mental Health Day events were held both in the community and on the Guy's & St. Thomas' sites. The stalls were supported by The Samaritans, London Friend (LGBT+ charity), Papyrus & James' Place (organisation supporting men), generated a lot of interest and were very well attended. On 10th October, a conference was held at Governor's Hall, St Thomas' Hospital, to mark World Mental Health Day (WMHD). The conference included speakers addressing a range of mental health related topics, including personal experiences of being a refugee, puerperal psychosis, trauma in young black males, mental health support in the armed forces and comedy for coping. The conference was attended by 93 staff from GSTT, KHP & Oxleas; feedback was very positive and the day was clearly valued by staff.

5.1.20 In June 2022, the Working Aged Adult Mental Health Liaison Team on the STH site underwent a quality accreditation peer review by the Psychiatric Liaison Accreditation Network (PLAN) (part of the College Centre for Quality Improvement, Royal College of Psychiatrists). They still awaiting the outcome of this review.

5.1.21 In January 2023, Lambeth Hospital site opened a unit for the assessment of people in mental health crisis (MHCAS).

The unit can accommodate up to 6 patients at any one time and accepts referrals from mental health crisis teams, mental health liaison teams, 0300 section 136 number (as an alternative to application of section 136), NHS 111, LAS and police.

5.1.22 Work by NHSE London to review and update the section 136 pathway for London (commonly known as "The Blue Book") was completed with a launch date in Q4. The updated pathway includes medical clearance guidance for individuals detained under S136 to provide greater clarity for teams around circumstances where a patient detained under section 136 should be conveyed to an ED for purposes of physical health assessment.

5.1.23 Communications received from NHSE in December 2022 informed the Trust that the Act itself only applies to units which are registered with the CQC for the treatment of mental disorders. The intention of the DHSC is to update their guidance to make it clearer. Advice received by NHSE from the CQC indicated that they would only consider the Act to be applicable to acute hospitals if there is a ward, unit or similar within the hospital the purpose of which is to provide treatment to in-patients for mental disorder. Further clarification was sought from NHSE regarding the status of the Addictions Suite, where patients are admitted for physical treatment and detoxification from drugs and / or alcohol, but where concurrent mental health assessment and treatment takes place. This is still being considered by NHSE and a response is awaited.

5.2 Areas for development and identified service risks

5.2.1 On 27 June 2022, the Government published the draft Mental Health Bill for consideration before it becomes law. When the Bill becomes law, it will amend the Mental Health Act 1983 and modernise mental health legislation in England and Wales. In preparing the draft bill, consideration was given to including new powers for health professionals to provide a legal framework for the detention of acutely mentally unwell individuals in Emergency Department settings pending a clinical assessment. However due to concerns from stakeholders regarding the risks and implications of introducing new powers under the MHA, as well as factors that would be required for the effective implementation of the changes, a decision has been taken by the Department of Health & Social Care not to include any new powers relating to the detention of mentally unwell patients in EDs. This means patients awaiting mental health admission will continue to be detained in ED under duty of care or best interests without a legal framework in place. The Trust Lead for Mental Health attended a meeting with the Home Office in November 2022 to raise concerns regarding the proposed lack of provisions in the amended MHA to lawfully detain a mentally unwell

individual in ED (outside of section 136 which may not always be applicable). It was agreed by the DoH that these concerns would be considered in drafting of the amended Code of Practice to accompany the ACT. The lack of legal provisions to detain in an ED (outside of section 136) remains as live on the Trust Risk Register.

5.2.2 Concerns regarding use of and the administration of MHA at GSTT led to a deep-dive of MHA processes during Q4. Concerns were identified relating to

i) the notification of the SNPs by ward staff in relation to detention of patients in the Trust under the MHA
ii) explanation of MHA rights to patients
iii) initial scrutiny of MHA papers
iv) inadequate data regarding delays in attendance of Approved Mental Health Professionals and Section 12 Drs
v) delays in the application of section 5/2 (emergency powers of short term detention) across the 4 hospital sites
vi) use of MCA/DoLS in circumstances where the MHA should be applied
vii) Poor completion of S136 monitoring forms by the SLAM MH Liaison Team
viii) Poor quality data provided by the SLAM MHA Administration Team in relation to the use of the MHA within GSTT
ix) Poor attendance at the MHA Administration Monitoring Groups
xi) Failure by SLAM to deliver training in line with the SLA for the administration of the MHA within GSTT
xii) Misuse of the MCA by the police in circumstances where section 136 MHA should be applied.

The paper was shared for comment at the Mental Health Board in March 2023; an action plan to address the concerns is being drafted; this will be reviewed at the Mental Health Board in May 2023.

5.2.3 It was noted during the course of 2022/23 that an increasing number of mentally unwell patients are being conveyed to ED by the police using the MCA rather than section 136 MHA. A precedent in case law would suggest this to be unlawful. Furthermore, the MCA does not provide a legal framework to detain a person in ED nor does it equip the person with any rights of challenge. Requests by ED staff to the police to subsequently detain a patient under section 136 upon their arrival to the ED in circumstances where the patient has attempted to leave the department have been declined; this is due to a directive issued by senior officers that police lawyers have advised that this is not lawful. An ambition has been set by NHSE London region to reduce the use of section 136 by the police by 20%. There are concerns that this may lead to an increased misuse of the MCA to convey acutely mentally unwell to the ED under the MCA, rather than utilising section 136 to convey them to a Health Based Place of Safety in a mental health establishment. In order to address this concern, in Q4, GSTT instructed DAC Beachcroft, in a joint action with KCH, to write to the Metropolitan Police lawyers to lay out the Trusts' concerns with a view to reaching an agreed

position on what act of law should be applied by police officers to convey individuals in mental health crisis to a health establishment for specialist mental health assessment.

5.3 Learning from Serious Incidents / Safeguarding Adults Reviews/Domestic Homicide Reviews

5.3.1.1 Three mental health related serious incidents occurred during 2022/23. The first related to the maternal suicide of a child open to the Health Visiting Team. A joint investigation with SLAM was submitted to the ICB in March 23. A number of multi-faceted contributory factors were identified with key learning relating to limited assessment and delayed / ineffective follow-up of the children and family, a failure to consistently follow policies and procedures, a lack of professional curiosity, inappropriate delegation of tasks, a lack of information sharing by the professionals, compounded by staffing challenges and increased caseload acuity.

5.3.1.2 The second relates to the inpatient death of a young man open to the care of the MHLT following an incident of choking. A joint investigation with SLAM was completed with recommendations for GSTT including timely referral to MHLT for assessment of MH needs, use of appropriate detention frameworks (MHA rather than MCA where it applies) and logging of all attempts to explain Section 132 rights to a detained patient.

5.3.1.3 The third incident relates to a middle-aged woman with chronic mental health problems and tonsillar cancer who suffered a significant episode of hypoxia during the insertion of a RIG feeding tube under sedation, necessitating the completion of an emergency tracheostomy. The incident resulted in a series of medical complications, including hypoxic brain injury. This incident is open to investigation by GSTT with a submission date to the ICB of 15/05/23.

5.4 Feedback from Patients/Carers

5.4.1 There were 10 mental health related complaints during the course of 22/23. Three of these were resolved informally without a written response or withdrawn. Dominant themes were treatment delays, poor communication and concerns about being detained under the MHA, as well as poor care co-ordination. Of the six complaints where investigations have been completed, four complaints were partially upheld and two were not upheld.

5.4.2 Work is underway to develop a mechanism to capture the experiences of patients presenting to the ED with mental health concerns. It is intended that a patient experience questionnaire will be co-developed with people with lived experience of mental ill-health and meetings are planned for Q.4 to take this work forward.

6.0 End of Life Care

6.1 Key Developments

6.1.1 Membership and reporting structure of the Trust EoLC committee was updated to ensure representation and accountability of clinical groups.

6.1.2 Trust EoLC strategy was launched across the organisation December 2022. Clinical groups will report on implementation through the EoLC committee.

6.1.3 EoLC dashboard: Trust Informatics have created a dashboard outlining the proportion of adult deaths supported by the Priorities for Care of the Dying Person (a proxy for quality of care and experience). The dashboard will empower services and groups to monitor and respond to their own performance.

6.1.4 A Trust EoLC education strategy and options appraisal is in development for discussion at the EoLC committee. Clear gaps in provision were identified in benchmarking against Health Education England framework and through the National Audit of Care at the End of Life.

6.1.5 Let's Talk Advance Care Planning: the project lead CNS took up her role in January 2022 and has mapped current practice (including a gap analysis and action plan against the CQC DNACPR report 'Protect, Connect, Respect – decisions about living and dying well'). The steering group has supported significant progress over the past year, including launch of a new website, co-design of a template for advance care planning across the Trust, re-launch of the Let's Talk patient information materials as well as translation of these into our top 10 languages.

6.1.6 Apollo / EPIC: An 'RDG for advance care planning (ACP), treatment escalation planning (TEP) and DNACPR decision making' and an 'SPG for palliative and end of life care' have both agreed content and flow within Apollo /

EPIC. Some but not all of the build has been seen to date, work is ongoing. We have highlighted the need to ensure appropriate training but have been informed core training is finalised and we will be able to influence Tip Sheets for non-core training. Future reporting capacity is unclear.

6.1.7 Respectful awareness, an initiative to enhance communication/ coordination when a patient has been recognised as dying as well as resources to improve the experience of the patient and family, was launched in May 2022 and has been rolled out across nine wards to date with positive evaluation which is ongoing.

6.1.8 Charitable funding has been sourced for a quality improvement project to improve communication for all patients in critical care in Guy's and St Thomas' sites. The aim of the QIP is to improve patient and family experience of critical care through the introduction of two adult critical care family liaison practitioner (FLP) who will establish early consistent daily communication with families and identify concerns and work to resolve barriers/conflicts.

6.1.9 The Medical Examiner service expanded into the community and other local providers including working with GPs. Feedback through the bereaved carer surveys is very positive.

6.1.10 T34 syringe pumps have been re-introduced for inpatient use in GSTT hospital sites with ongoing monitoring of incidents and support needs; electronic palliative care community authorisation 'MAAR' charts went live in line with updated pan-London version; Bromley is trialling a partnership with GSTT for accessing palliative care injectable medicines in the community, similar to the commissioned service across Lambeth, Southwark and Lewisham.

6.2 Areas for development and identified service risks

6.2.1 The Health and Care Act 2022 has introduced a statutory responsibility for Integrated Care Boards to commission appropriate palliative and end of life care services for their population. GSTT is represented on the SEL palliative and end of life care (PEoLC) workstream but engagement may need to be strengthened as system changes are considered.

6.2.2 We have received our GSTT and RBHH reports from the national audit of care at the end of life (NACEL) round 4 and will finalise our action plan with the EoLC committee and VPAC.

6.2.3 The organisation's capacity to meet the EoLC education and training needs of its staff in all hospital and community

sites is inadequate. The staff survey within the most recent round of NACEL (as above) identified that GSTT and RBHH staff are far less likely than (national) average to have completed EoLC training in the last three years. Options and recommendations will be laid out in the EoLC education strategy.

6.2.4 Apollo / EPIC final build, training, post go-live support and reporting structures (ACP, TEP, DNACPR, PEoLC) are awaited.

6.2.5 The London Urgent Care Plan (UCP) has been live since July 2022, (web-based electronic palliative care coordination system sharing urgent care plans with out of core hours services / teams). Since go-live, GSTT staff have (for technical reasons) not been able to utilise the in-context link within e-noting and the London care record. This cannot be addressed until Apollo /EPIC go-live in October 2023 after there should be integrated access. A risk assessment has quantified the risk in the interim and ILS / ISM is reviewing capacity to coordinate /support multiuser application for web portal log-ins.

6.2.6 Let's Talk Advance Care Planning initiative has made significant progress this year but faces some risks. The project lead has taken up another role – although we aim to replace the role, this non-clinical role is facing organisational scrutiny. The projects risks losing momentum during this hiatus. Secondly, we are waiting to hear about two significant charitable bids (for hand held devices to share digital patient information materials and for funds to create more inclusive /diverse film and written materials to improve reach and engagement.

6.3 Learning from Serious Incidents

6.3.1 T34 syringe pumps were reintroduced in GSTT hospital sites in October 2022. A higher number of continuous subcutaneous infusion (CSCI) incidents were noted in the subsequent quarter. Key categories were 'syringe pump set-up and monitoring' and 'delayed/omitted medicines'. A working group set up to oversee the re-introduction identified a pump software change (in newer pumps) which affected functionality on attempting to resume an infusion which occluded, ultimately resulting in under dosing patients. The company has been working with the Trust to rectify the issue and a clinical alert disseminated to staff. We are not aware of any recent incidents.

6.3.2 A review has been undertaken of all the incidents reported when we were using Braun/ Fresenius pumps for CSCI in place of T34. This will provide valuable intelligence if we need to change again in the future.

6.3.3 The main other themes in EoLC incidents noted over the past year have related to issues with transfer of care

(internal, on discharge, on admission), communication around DNACPR and a small peak in incidents relating to care after death in Q1 which seems to have settled again. Incidents relating to alfentanil and other opioids continue to be closely monitored.

6.4. Feedback from Patients/Carers

6.4.1 Patient/ carer and staff feedback - round 4 of NACEL: Invitations to the on-line quality survey were sent to the bereaved carers of all deceased patients (excluding sudden deaths) who died in hospital from 1 April – 31 August 2022. More than 3000 bereaved carers responded nationally. GSTT received 41 and RBHH 8 responses.

- GSTT scores just below the national average with respect to assessing the needs of families and others and just above average in their reported experience of care.
- GSTT continues to have a higher than average proportion of respondents strongly disagreeing with a number of statements including that 'family and others were asked about their needs' / '…given enough emotional help and support by staff' / '…kept well-informed and had enough opportunity to discuss… with staff' / '…felt that staff…communicated sensitively with [the patient]' / '…were communicated to by staff in a sensitive way'.
- Many others respondents, however, agreed or strongly agreed with the above statements and our overall scores have improved in comparison with the national average compared to the last round of NACEL. This indicates a small step in the right direction but ongoing room for improvement.
- RBHH scores are well above the national average with respect to assessing needs of families/ others and reported experience of families. Although based on a small number of respondents, it is notable that no bereaved carers disagreed or strongly disagreed with any of the positive statements around assessing their needs / their experience.
- Overall rating by bereaved carers for the care to the patient was outstanding / excellent / good in 77.5% of cases for GSTT (improved from 71.5% in previous round) and 100% for RBH (all outstanding or excellent) versus 71.1% nationally.
- Overall rating by bereaved carers for the care to family and others was outstanding / excellent / good in 69.2% of cases for GSTT (improved from 62.8% in previous round) and 100% for RBHH (all outstanding or excellent) versus 65.6% nationally.

- We know from national bereaved carer feedback of the significant impact of visiting restrictions on the experience of patients and families and of the deterioration in family experience measures between 2019 and 2021. This trend is also visible in GSTT bereaved carer feedback but not in RBH which is consistently excellent albeit low numbers.
- The staff reported measure had a focus on themes of staff experience, confidence, support and culture. Participants were able to send the Staff Reported Measure to any inpatient staff within the hospital/site, who were likely to come into contact with dying patients and/or those important to them. More than 11,000 staff responded nationally. GSTT received 120 and RBHH 39 staff responses.
- Both GSTT and RBHH, to varying degrees, score below the national average for staff feedback on confidence, support and on care and culture.
- Both GSTT and RBHH have a well above the national average proportion of staff respondents either disagreeing or strongly disagreeing that they have completed training specific to EoLC in the last 3 years. (49% for GSTT / 64% for RBHH versus national average 33%)
- Both GSTT and RBHH have an above the national average proportion of staff respondents either disagreeing or strongly disagreeing that there is managerial support available to help provide care at the end of life. (12.6% for GSTT / 13% for RBHH versus national average 7%). This question is open to different interpretations. We question whether it may relate to management prioritisation of the importance of releasing staff for EoLC training.
- Both GSTT and RBHH have an above the national average proportion of staff respondents either disagreeing or strongly disagreeing that they felt able to raise a concern about EoLC within the hospital if necessary. (9.3% for GSTT / 15.4% for RBHH versus national average 5.2%).
- When asked if there was 'a culture that prioritises care, compassion, respect and dignity as fundamental in all interactions with dying patients and those important to them', 81% of GSTT staff respondents agreed or strongly agreed versus 85% of RBH staff respondents (and 83% nationally).
- 85% of GSTT staff respondents and 74% of RBHH staff respondents strongly agreed or agree that they knew how to access specialist palliative care support (82% nationally).
- 83% of GSTT staff respondents and 76% of RBHH staff respondents strongly agreed or agreed that they felt supported by the specialist palliative care team (81.5% nationally).

Appendices

Appendix 1: Safeguarding Adults including RBH hospitals

Appendix 2: Dementia and Delirium

Appendix 3: Learning Disabilities

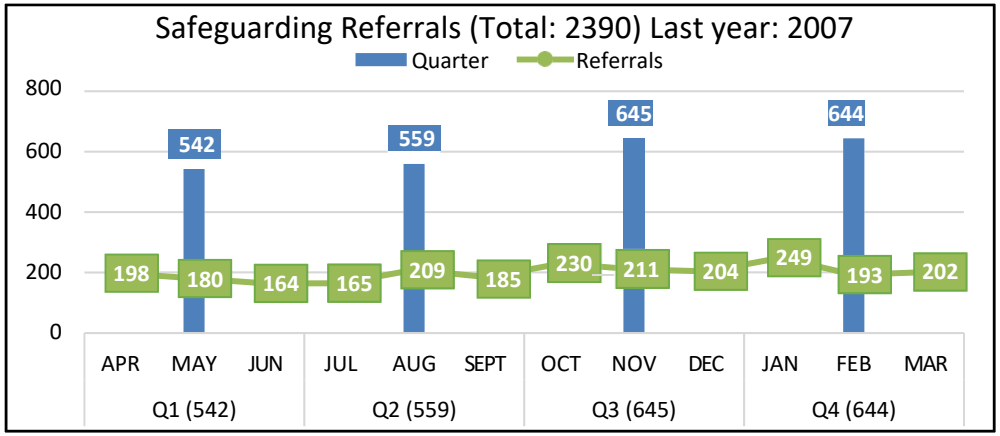
Appendix 4: Mental Health

Appendix 5: End of Life Care

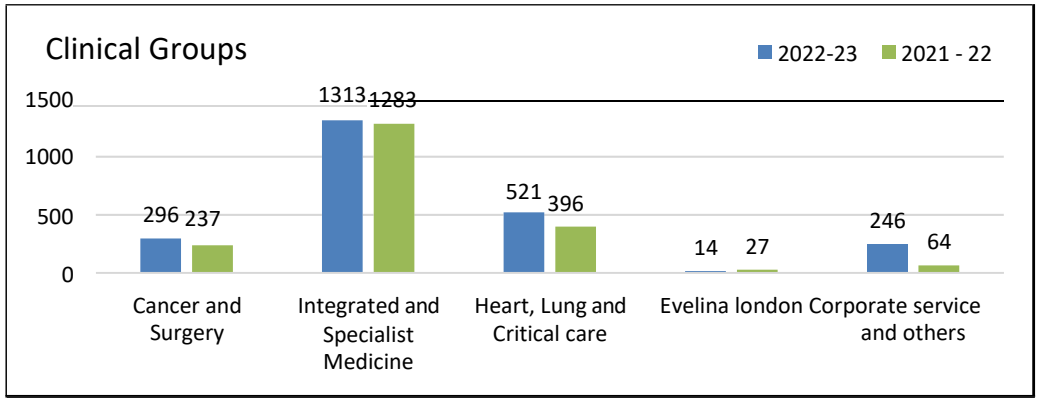
Appendix 6: Work Plans

Appendix 1

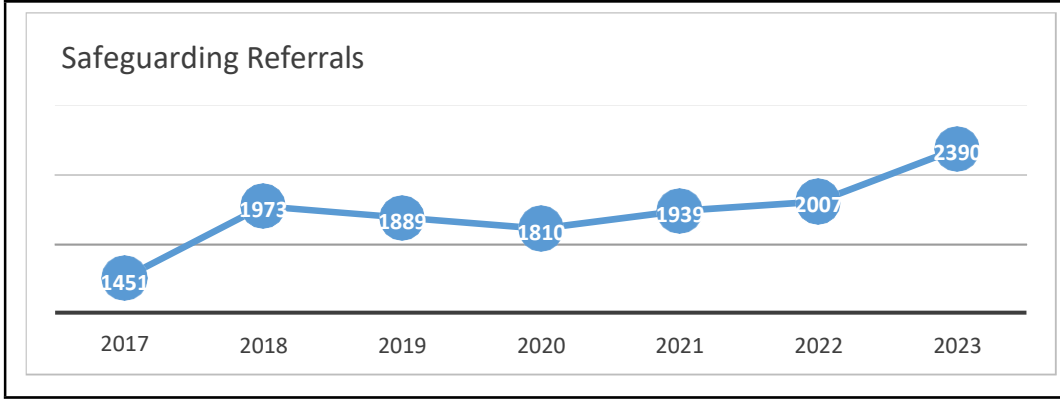
Safeguarding Dashboard



Clinical Groups	Q1	Q2	Q3	Q4	2022-23	2021-22
Cancer and Surgery	71	57	80	88	296	237
Integrated and Specialist Medicine	303	300	356	354	1313	1283
Heart, Lung and Critical care	54	131	172	164	521	396
Evelina London	4	4	2	4	14	27
Corporate service and others	110	67	35	34	246	64
Total	**542**	**559**	**645**	**644**	**2390**	**2007**



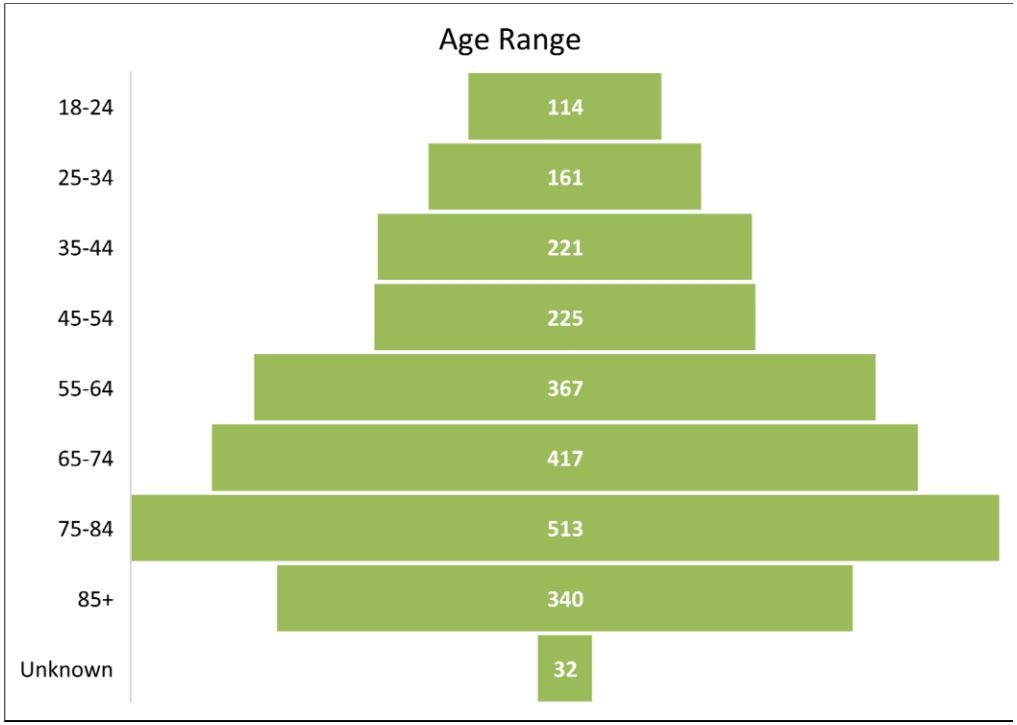
Categories	Q1	Q2	Q3	Q4	2022 -23	2021 -22
Care management	117	80	113	140	450	481
Discrimination	0	0	2	0	2	3
Domestic Abuse	69	39	58	52	218	222
Financial	42	39	27	41	149	128
Mental Health	23	29	28	30	110	0
Modern Slavery	2	3	5	1	11	14
Modern Slavery (Cuckooing)	0	0	0	2	2	0
Neglect by others	152	174	200	192	718	486
Organisation	0	0	2	3	5	1
Physical	14	18	22	22	76	106
PREVENT	3	4	8	10	25	2
Psychological	8	23	25	21	77	61
Self neglect	102	130	145	115	492	461
Sexual	10	20	10	15	55	42
Total	**542**	**559**	**645**	**644**	**2390**	**2007**



Appendix 1.Cont.

Safeguarding Dashboard

Ethnicity	Q1	Q2	Q3	Q4	Total
Asian: Any Other	7	12	10	5	34
Asian: Bangladeshi	3	1	2	2	8
Asian: Indian	8	15	12	26	61
Asian: Pakistani	3	3	3	3	12
Black: African	24	38	26	41	129
Black: Any Other	21	23	23	41	108
Black: Caribbean	43	45	69	57	214
Mixed: Any other	1	2	5	1	9
Mixed: White and Black African	0	2	5	1	8
Mixed: White and Black Caribbean	4	1	2	5	12
Not stated	129	116	136	138	519
Other: Chinese	3	0	6	3	12
Other Ethnic Group	19	17	24	16	76
White any other	50	47	44	49	190
White British	220	221	267	244	952
White Irish	7	16	11	12	46
Total	542	559	645	644	2390



Appendix 1 cont.

Concerns about the Trust service

2022-2023	Quarter 1 (15)			Quarter 2 (4)			Quarter 3 (0)			Quarter 4 (02)			Total
Months	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Section 42 (2022-2023)	5	3	7	2	1	1	0	0	0	1	0	1	21
Section 42 (2021-2022)	3	0	4	8	6	2	4	5	2	3	1	7	45

2022-2023	Q1	Q2	Q3	Q4	Total
Cancer and Surgery	1	1	0	1	3
Integrated and Specialist Medicine	8	2	0	1	11
Heart, Lung and Critical care	2	1	0	0	3
Evelina London	0	0	0	0	0
Corporate service and others	4	0	0	0	4
Total	15	4	0	2	21

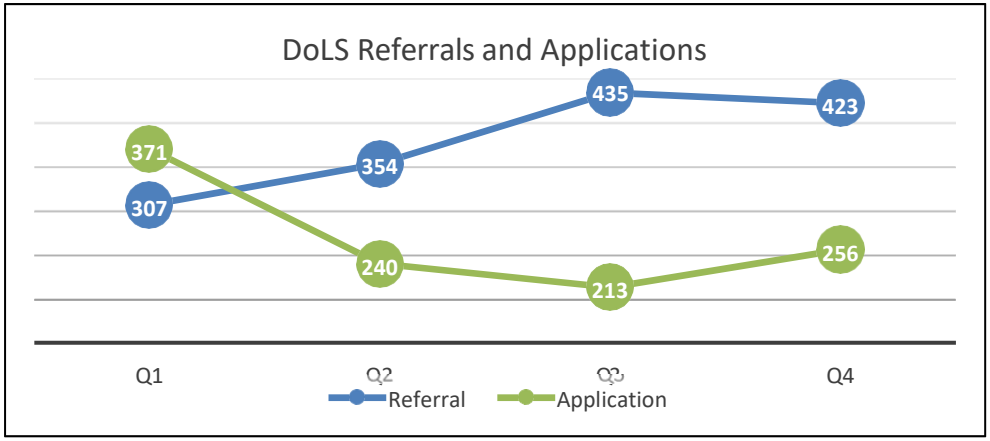
Allegations

2022-2023	Quarter 1 (26)			Quarter 2 (25)			Quarter 3 (20)			Quarter 4 (26)			Total
Months	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Allegations (2022-2023)	8	12	6	8	8	9	6	7	7	10	5	11	97
Allegations (2021-2022)	5	6	5	4	5	2	4	4	6	3	3	8	55
Allegations (2020-2021)	1	0	0	2	0	2	1	1	1	2	3	6	19

Allegations	Q1	Q2	Q3	Q4	Total
Cancer and Surgery	8	6	3	2	19
Integrated and Specialist Medicine	12	9	9	18	48
Heart, Lung and Critical care	2	5	6	3	16
Evelina London	1	1	1	1	4
Corporate service and others	3	4	1	2	10
Total	26	25	20	26	97

Appendix 1 cont.

DoLS Dashboard



DoLS outcome	Q1	Q2	Q3	Q4	2022-23	2021-22
DoLS referral	307	354	435	423	1519	958
DoLS completed	371	240	213	256	1080	1680
Authorised	5	3	4	4	16	29
Not Authorised	52	37	25	15	129	141
Not assessed	314	200	184	237	935	1510

Age Range	Q1	Q2	Q3	Q4	Total
18-24	2	2	5	2	11
25-34	7	3	6	2	18
35-44	1	2	3	7	13
45-54	18	13	15	11	57
55-64	33	22	24	38	117
65-74	63	33	34	48	178
75-84	112	81	72	62	327
85+	135	84	54	86	359
Total	371	240	213	256	1080

Referrals	Q1	Q2	Q3	Q4	2022-23	2021-22
Cancer and Surgery	50	38	48	68	204	168
Integrated and Specialist Medicine	175	237	303	265	980	565
Heart, Lung and Critical care	31	64	79	87	261	220
Evelina London	4	1	2	2	9	4
Corporate service and others	47	14	3	1	65	1
Total	307	354	435	423	1519	958

Applications	Q1	Q2	Q3	Q4	2022-23	2021-22
Cancer and Surgery	57	27	31	45	160	255
Integrated and Specialist Medicine	262	183	151	157	753	1242
Heart, Lung and Critical care	48	29	30	51	158	176
Evelina London	4	1	1	3	9	7
Total	371	240	213	256	1080	1680

Ethnicity	Q1	Q2	Q3	Q4	Total
Asian: Bangladeshi	1	0	1	1	3
Asian: Indian	2	5	3	8	18
Asian: Any other	31	18	12	6	67
Black: African	26	24	18	13	81
Black: Any Other	24	4	6	10	44
Black: Caribbean	39	22	16	27	104
Mixed: Any Other	5	2	2	0	9
Other	10	6	13	9	38
Other: Chinese	0	0	0	3	3
White any other	28	14	17	23	82
White British	203	144	117	136	600
White Irish	2	1	8	20	31
Total	371	240	213	256	1080

Appendix 1con't

Training Dashboard

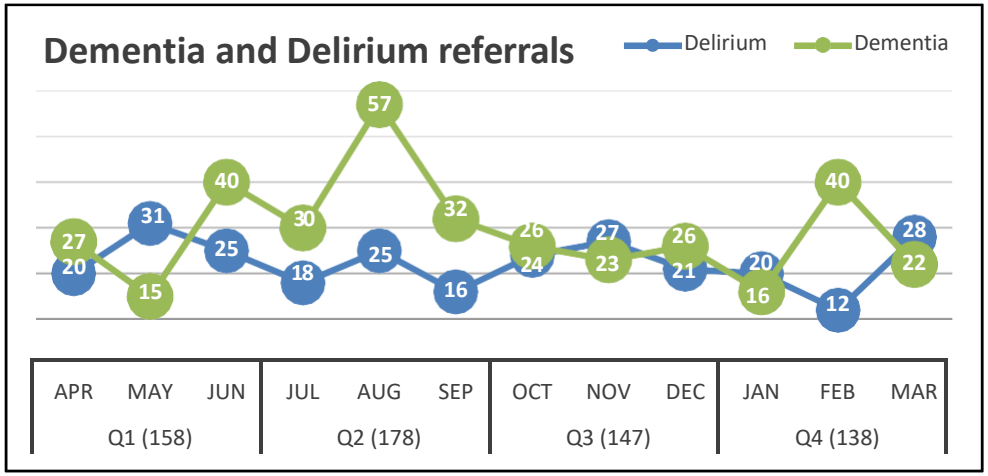
Training Current	Trust Level	C&S	HCLL	ELCH	ISM
SGA Level 1	88.16%	87.10%	85.83%	85.79%	89.34%
SGA Level 2	80.34%	81.57%	76.28%	77.93%	84.29%
Basic Prevent	88.21%	86.00%	87.20%	83.65%	89.30%
WRAP	84.33%	87.22%	77.52%	85.64%	87.31%

Dementia Level 2 Training (85%)	Q1	Q2	Q3	Q4
OPU wards	88.60%	92.38%	76.92%	68.91%
Henry	94.29%	94.59%	76.32%	65.85%
Anne	79.07%	90%	82.50%	85.37%
Alexandra	94.44%	93.33%	71.79%	70.27%
ILS	76.32%	81.67%	78.05%	76.28%
Pulross	86.21%	86.67%	81.25%	73.33%
ARU	94.74%	86.36%	85.71%	80.95%
Other clinical areas (25%)	**Q1**	**Q2**	**Q3**	**Q4**
C & S	76.70%	77.45%	72.62%	68.98%
HLCC	67.96%	68.15%	70.06%	67.58%
ISM	75.18%	77.27%	73.77%	70.75%

Trust wide Current	Q1	Q2	Q3	Q4
SGA Level 1:				
GSTT site -	89.75%	88.64%	87.59%	88.59%
RBH site –	96.49%	93.19%	94.98%	86.25%
Trust - SGA 1	92.25%	90.30%	90.31%	88.16%
SGA Level 2:				
GSTT site –	86.57%	85.17%	82.93%	82.00%
RBH site –	94.57%	92.09%	52.10%	73.27%
Trust SGA 2	87.00%	85.55%	76.78%	80.34%
Basic Prevent Awareness Training (BPAT)				
GSTT site –	89.99%	87.03%	86.91%	88.20%
RBH site –	95.70%	94.09%	90.38%	88.28%
Trust BPAT	92.14%	89.65%	88.21%	88.21%
WRAP				
GSTT site –	90.06%	88.46%	87.07%	87.08%
RBH site –	87.90%	96.96%	54.98%	72.87%
Trust WRAP	89.64%	88.93%	80.83%	84.33%

Appendix 2

Dementia and Delirium Dashboard



DaD referrals	Delirium		Dementia	
	2022-23	2021-22	2022-23	2021-22
Female	110	110	183	153
Male	157	192	171	153
Total	267	302	354	306

Delirium Referrals	Q1	Q2	Q3	Q4	2022-23	2021-22
18-24	0	1	0	0	1	0
25-34	0	0	0	2	2	0
35-44	2	0	2	0	4	4
45-54	4	4	2	1	11	11
55-64	5	8	7	4	24	31
65-74	25	9	19	13	66	74
75-84	32	27	26	21	106	119
85+	8	10	16	19	53	63
Total	76	59	72	60	267	302

Delirium Referrals	2022-2023					2021-2022				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Cancer and surgery	26	23	32	16	97	28	38	26	43	135
Corporate Service	0	0	0	6	6	0	0	0	0	0
Evelina London	0	0	1	2	3	2	0	0	2	4
Heart, Lung and Critical Care	20	13	21	4	58	16	10	15	8	49
Integrated and Specialist Medicine	30	23	18	32	103	26	37	32	19	114
Total	76	59	72	60	267	72	85	73	72	302

Dementia Referrals	2022-2023					2021-2022				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Cancer and surgery	15	23	17	14	69	15	21	12	22	70
Corporate Service	0	0	0	7	7	0	0	0	0	0
Evelina London	0	0	0	1	1	0	1	2	1	4
Heart, Lung and Critical Care	12	12	3	8	35	11	18	11	8	48
Integrated and Specialist Medicine	53	83	54	46	236	54	40	44	46	184
Other	2	1	1	2	6	0	0	0	0	0
Total	82	119	75	78	354	80	80	69	77	306

Dementia Referrals	Q1	Q2	Q3	Q4	2022-23	2021-22
35-44	1	0	1	2	4	1
45-54	0	1	2	0	3	2
55-64	1	4	4	2	11	13
65-74	14	16	5	14	49	48
75-84	39	49	30	26	144	142
85+	27	49	33	34	143	100
Total	82	119	75	78	354	306

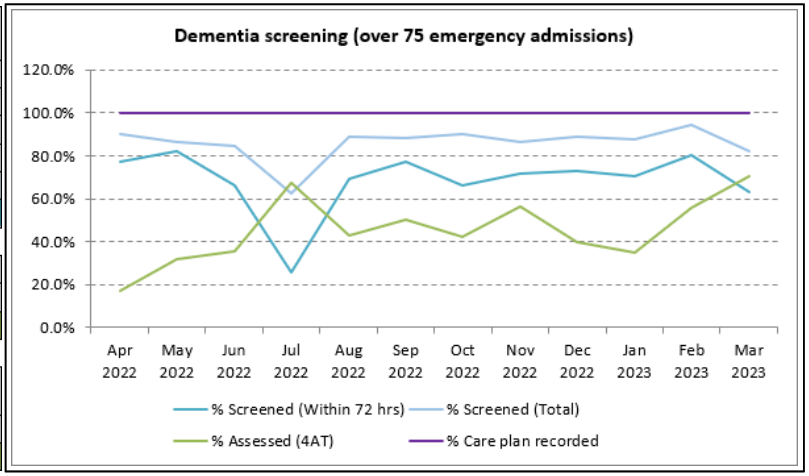
Appendix 2 cont.

Dementia and Delirium Dashboard

Delirium Referrals	Q1	Q2	Q3	Q4	2022-23	2021-22
Asian: Bangladeshi	1	1	0	1	3	1
Asian: Indian	0	0	0	0	0	1
Asian: Other	0	1	0	1	2	0
Asian: Pakistani	0	0	3	0	3	1
Black: African	4	1	2	1	8	7
Black: Caribbean	2	3	1	4	10	13
Black: Other	2	3	2	1	8	7
Mixed: Any other	0	0	1	0	1	0
Mixed: White and Black African	0	0	1	0	1	0
Mixed: White and Black Caribbean	0	0	1	0	1	0
Not stated	25	18	30	17	90	91
Other	2	0	1	1	4	9
White British	34	26	24	24	108	144
White Irish	0	0	4	6	10	13
White: Other	6	6	2	4	18	15
Total	76	59	72	60	267	302

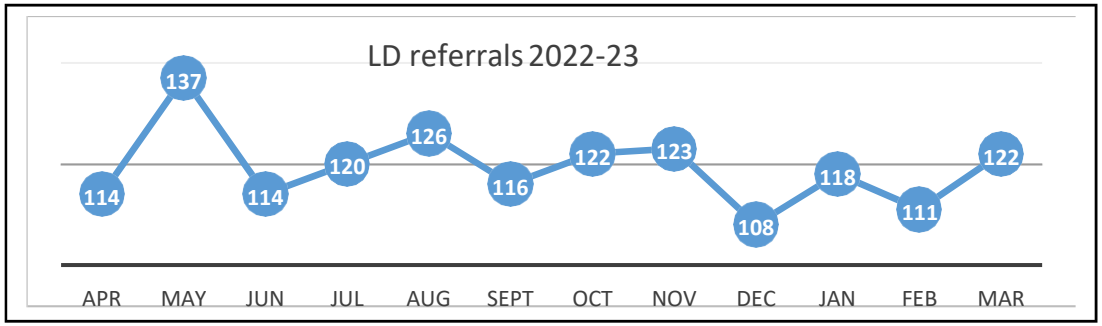
Dementia Referrals	Q1	Q2	Q3	Q4	2022-23	2021-22
Asian: Bangladeshi	0	1	0	0	1	2
Asian: Indian	2	1	0	2	5	4
Asian: Other	2	4	1	0	7	3
Asian: Pakistani	0	0	1	0	1	1
Black: African	6	6	1	2	15	7
Black: Caribbean	8	14	4	8	34	16
Black: Other	7	7	4	3	21	11
Mixed: Any other	0	0	0	1	1	2
Mixed: White and Black African	0	0	2	1	3	1
Not stated	14	26	12	10	62	65
Other	3	5	1	3	12	9
Other Ethnic Group : Chinese	0	0	1	0	1	3
White British	35	45	38	33	151	157
White Irish	0	0	3	6	9	11
White: Other	5	10	7	9	31	14
Total	82	119	75	78	354	306

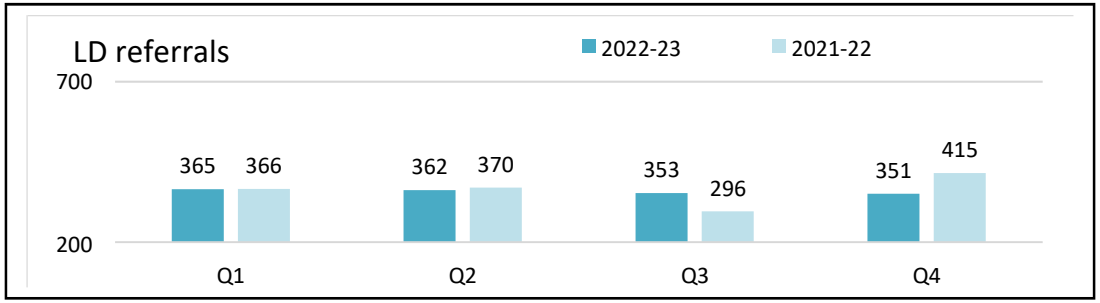
Dementia screening	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Emergency patients over 75	220	189	209	212	201	195	202	202	249	223	198	211
Screened (Within 72 hrs)	170	155	139	54	139	151	134	145	181	157	159	133
Screened (Greater than 72 hrs)	28	9	38	79	40	21	48	30	41	39	28	41
Screened (Total)	198	164	177	133	179	172	182	175	222	196	187	174
% Screened (Within 72 hrs)	77.3%	82.0%	66.5%	25.5%	69.2%	77.4%	66.3%	71.8%	72.7%	70.4%	80.3%	63.0%
% Screened (Total)	90.0%	86.8%	84.7%	62.7%	89.1%	88.2%	90.1%	86.6%	89.2%	87.9%	94.4%	82.5%
Patients needing 4AT assessment	35	28	42	31	35	34	38	48	60	54	52	61
Patients assessed	6	9	15	21	15	17	16	27	24	19	29	43
% Assessed (4AT)	17.1%	32.1%	35.7%	67.7%	42.9%	50.0%	42.1%	56.3%	40.0%	35.2%	55.8%	70.5%
Patients needing onward care plan	1	5	4	9	6	6	7	5	9	4	14	8
Patients with care plan recorded	1	5	4	9	6	6	7	5	9	4	14	8
% Care plan recorded	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Appendix 3

Learning Disability Dashboard





LD 2022 – 2023 (GSTT register)	Q1	Q2	Q3	Q4	2022-23	2021-22
A&E visits	106	138	125	126	**495**	469
All Outpatients	987	896	985	1086	**3954**	3403
non-face to face	735	684	757	627	**2803**	2634
Missed Appts	200	246	220	227	**893**	800

Autism 2022 – 2023 (GSTT Register)	Q1	Q2	Q3	Q4	2022-23	2021-22
A&E visits	17	13	24	23	77	49
All Outpatients	111	92	137	177	517	366
Missed Appts	22	21	29	15	87	79

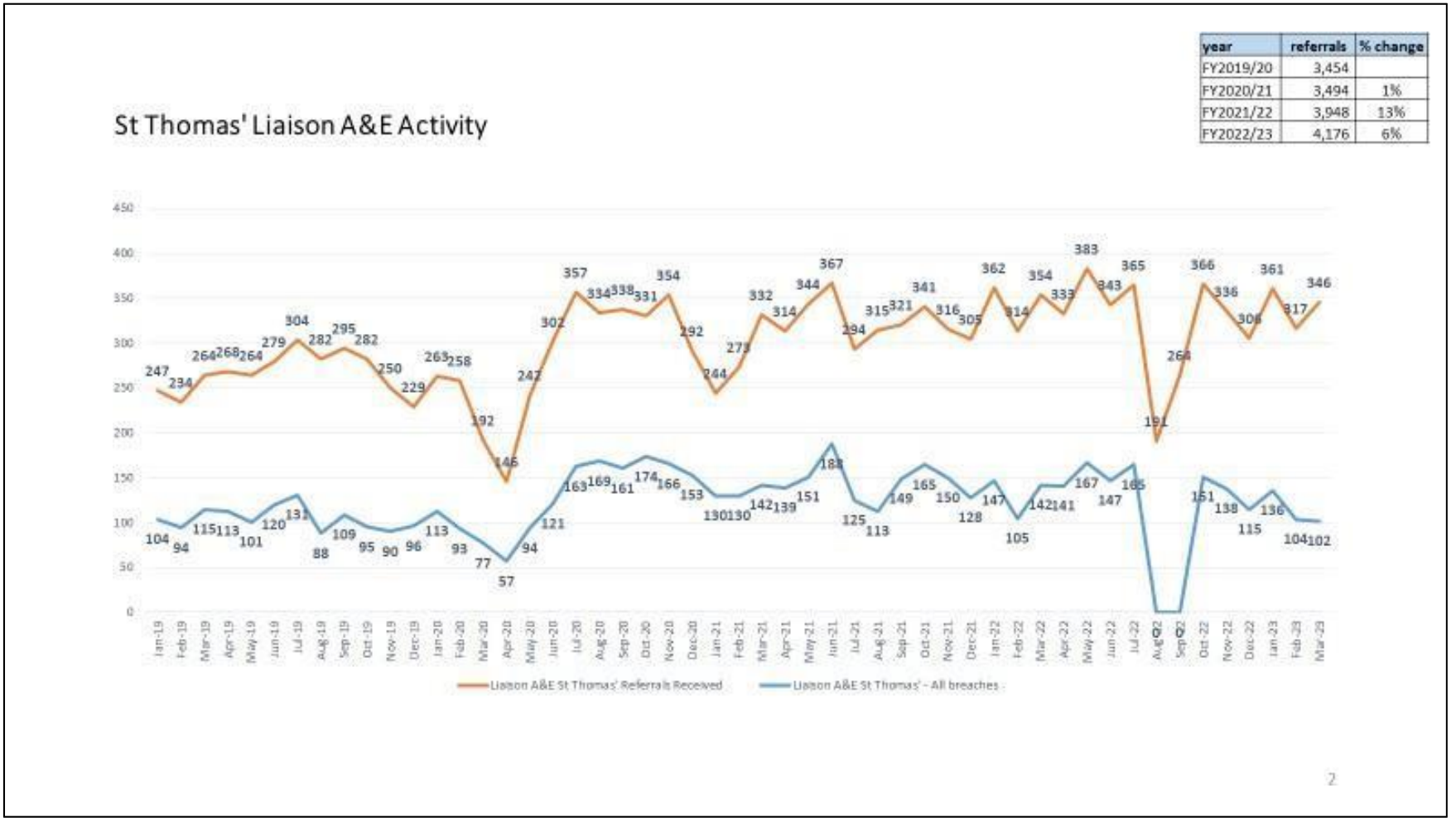
Ethnicity	Q1	Q2	Q3	Q4	Total
Asian: Bangladeshi	0	0	6	2	**8**
Asian: Indian	6	15	18	11	**50**
Asian: Other	6	9	4	10	**29**
Asian: Pakistani	0	0	1	2	**3**
Black: African	6	11	17	23	**57**
Black: Any Other	20	38	27	20	**105**
Black: Caribbean	15	23	15	13	**66**
Mixed: Any other	0	5	0	1	**6**
Mixed: Any other mixed background	0	0	1	0	**1**
Mixed: White and Black	7	3	2	10	**22**
Mixed: White and Black African	0	0	2	2	**4**
Mixed: White and Black Caribbean	0	0	0	2	**2**
Not stated	110	106	129	114	**459**
Other: Ethnic Group	12	7	2	3	**24**
Other: Chinese	0	0	1	0	**1**
White any other	20	23	19	25	**87**
White British	121	118	133	135	**507**
Total	**323**	**358**	**377**	**373**	**1431**

Age Range	Q1	Q2	Q3	Q4	Total
16-17	6	2	4	8	**20**
18-24	82	90	71	68	**311**
25-34	64	73	84	53	**274**
35-44	55	80	55	64	**254**
45-54	25	9	26	22	**82**
55-64	58	56	44	86	**244**
65-74	37	25	43	32	**137**
75-84	3	9	16	13	**41**
85+	3	0	1	0	**4**
Unknown	13	16	19	16	**64**
Total	**346**	**360**	**363**	**362**	**1431**

Appendix 4 :

Mental health

FIGURE 1 – EMERGENCY DEPARTMENT MENTAL HEALTH LIAISON REFERRALS & BREACHES 22/23



year	referrals	% change
FY2019/20	3,454	
FY2020/21	3,494	1%
FY2021/22	3,948	13%
FY2022/23	4,176	6%

FIGURE 2 – WARD REFERRALS TO SLAM LIAISON TEAMS AT GSTT 22/23

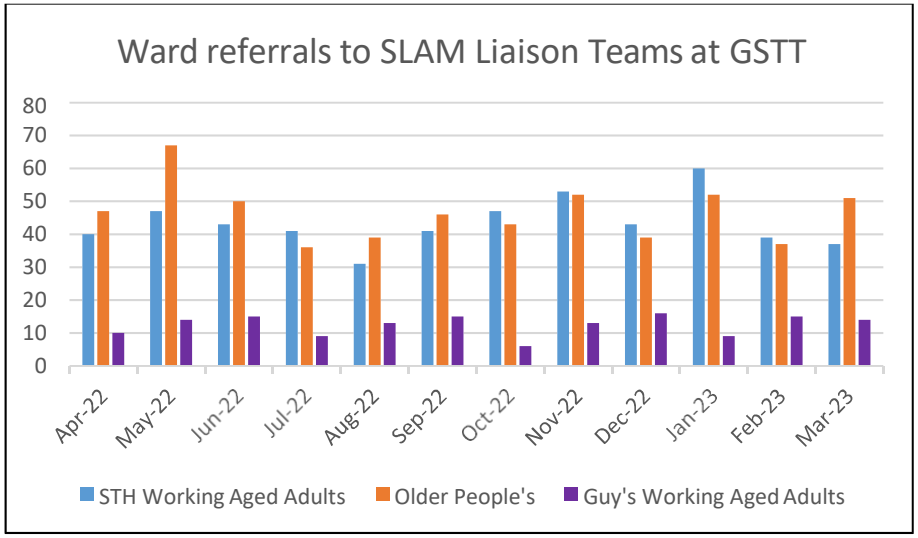


FIGURE 3) – CODE 10 INCIDENTS 22/23

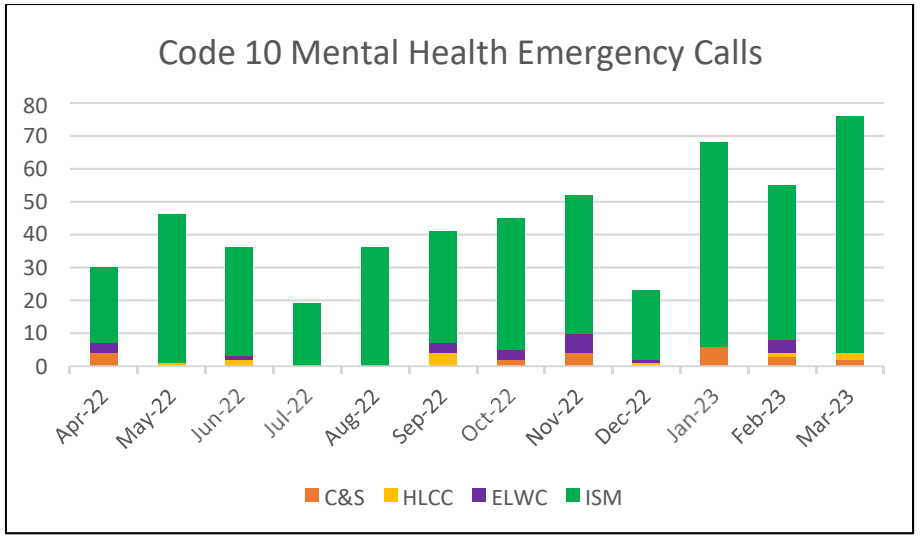


FIGURE 4 – INCIDENTS OF RAPID TRANQUILLISATION 22/23

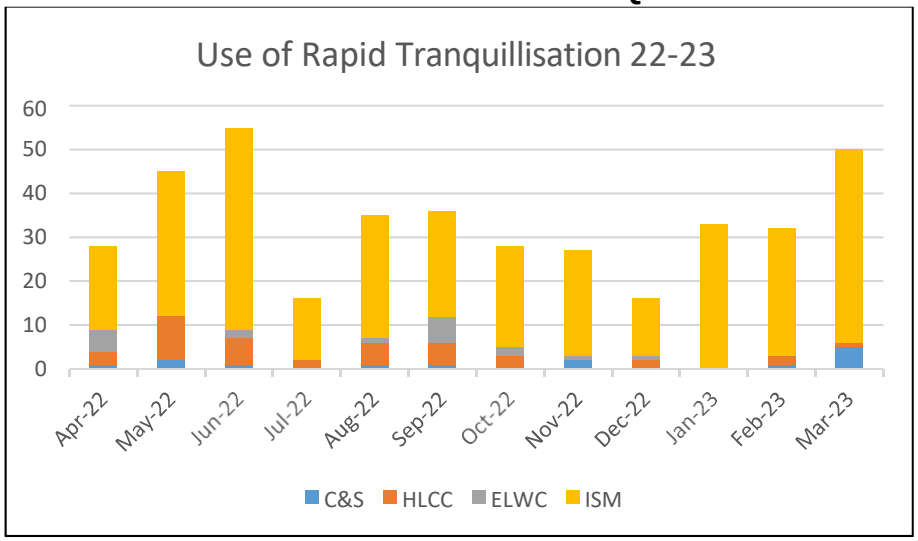


FIGURE 5 – USE OF RESTRAINT 22/23

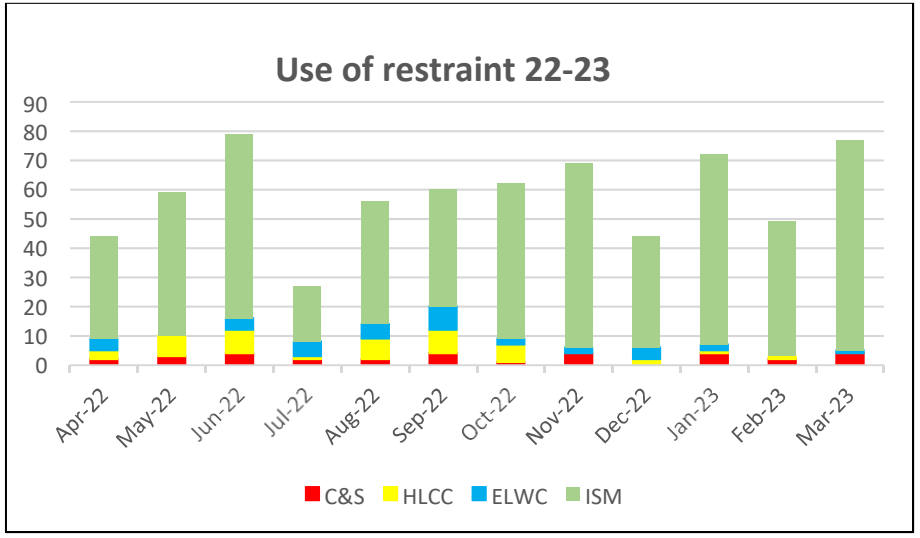
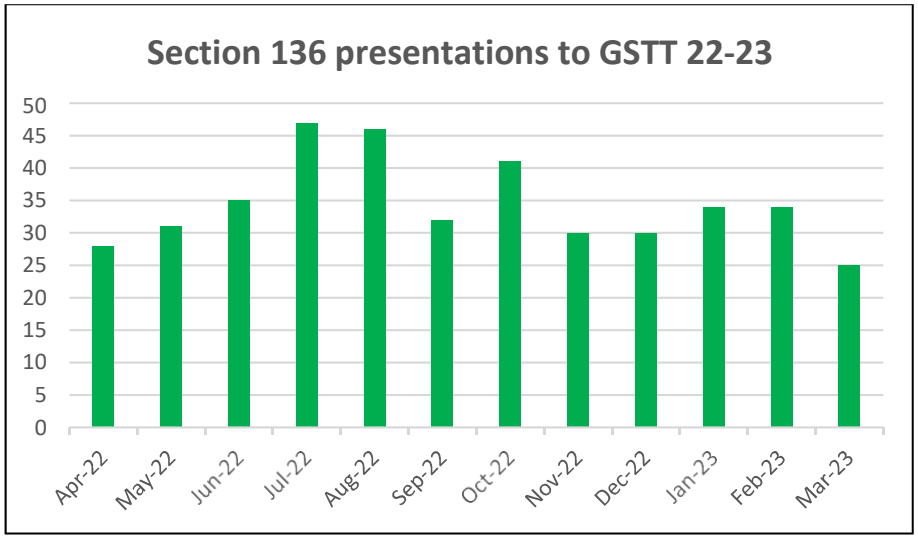
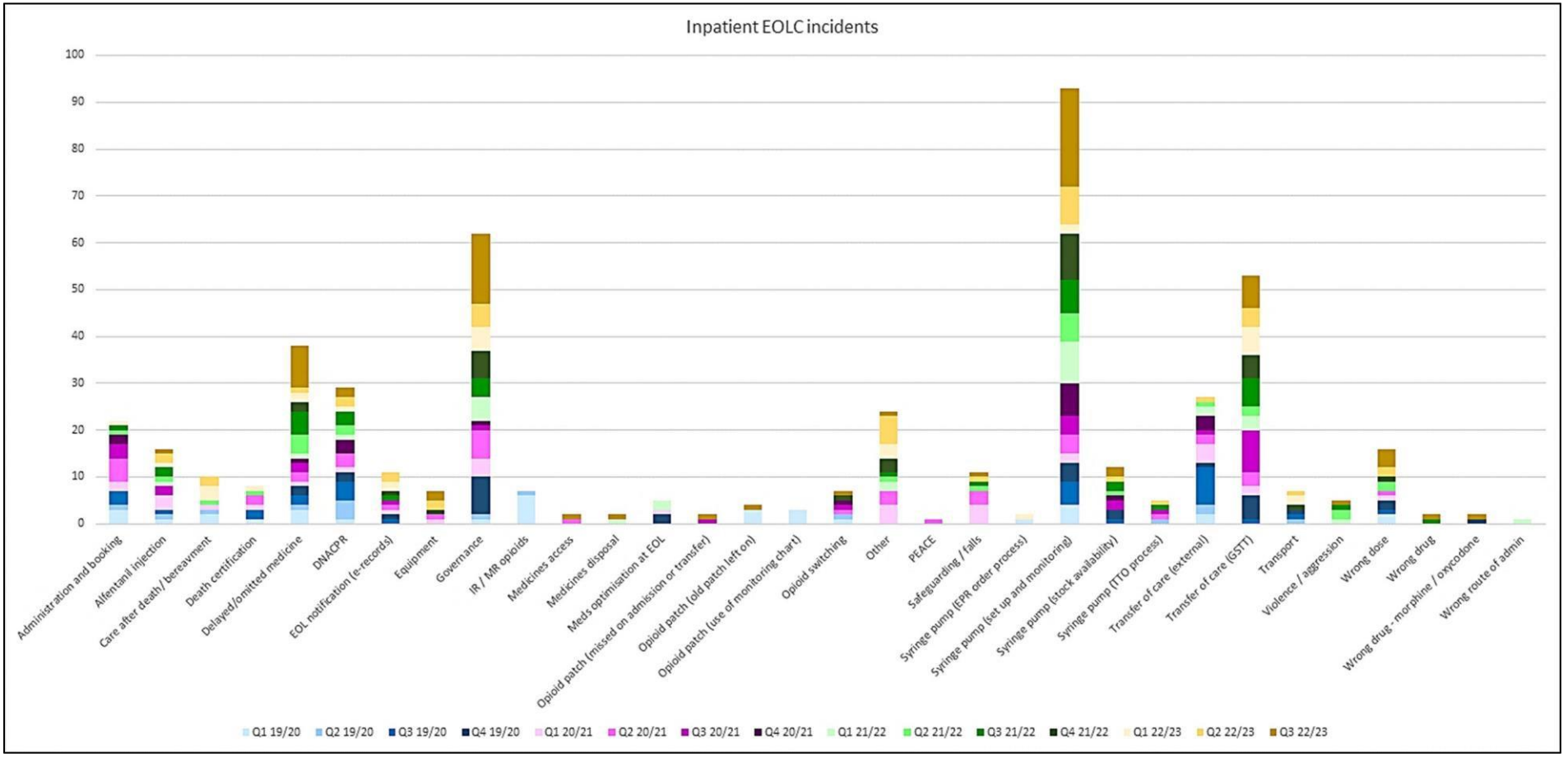


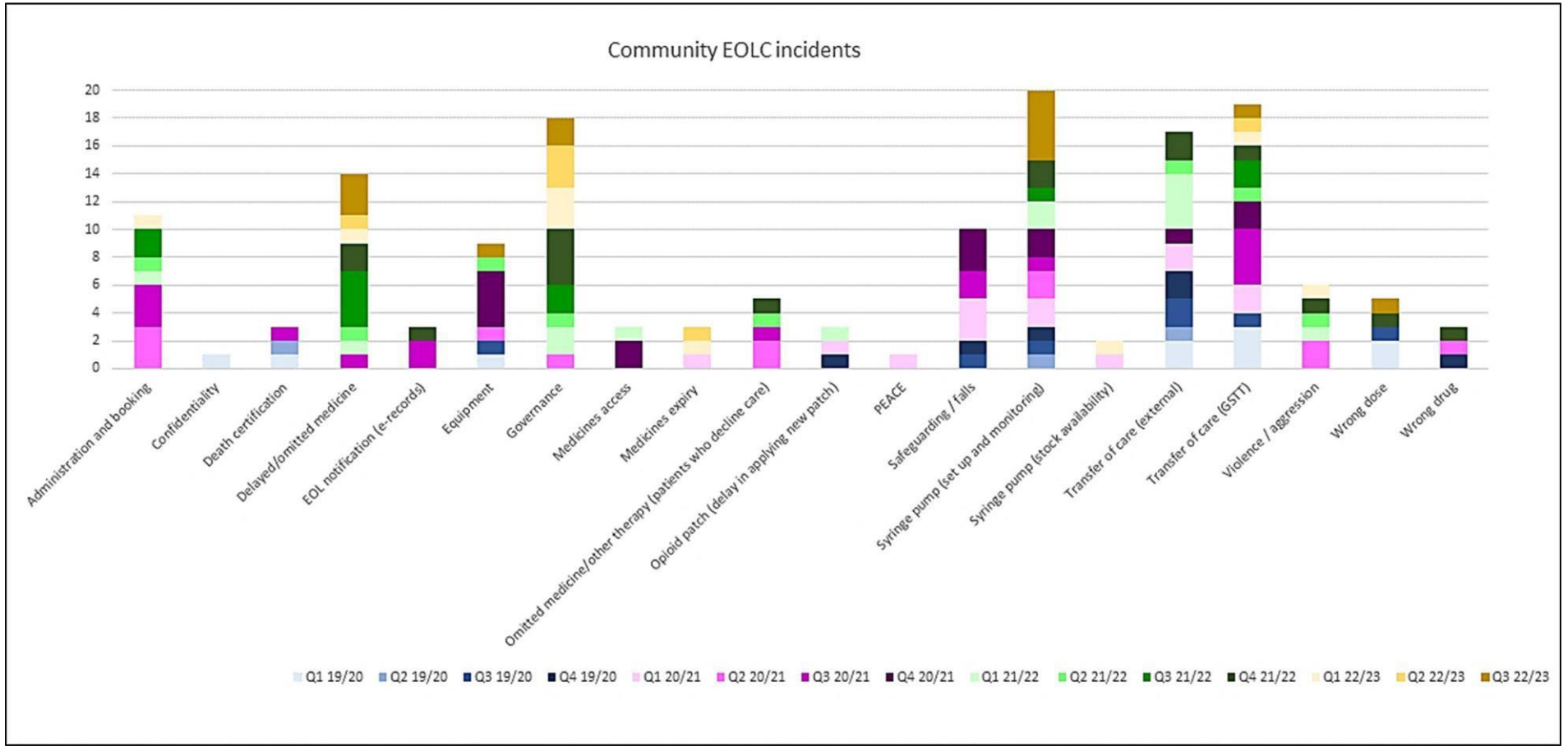
FIGURE 6 – SECTION 136 PRESENTATIONS TO STH ED 22/23



Appendix 5 :

End of Life




Community EOLC incidents
20
18
16
14
12
10
8
6
4
2
0
Administration and booking
Confidentiality
Death certification
Delayed/omitted medicine
EOL notification (e-records)
Equipment
Governance
Medicines access
Medicines expiry
Omitted medicine/other therapy (patients who decline care)
Opioid patch (delay in applying new patch)
PEACE
Safeguarding / falls
Syringe pump (set up and monitoring)
Syringe pump (stock availability)
Transfer of care (external)
Transfer of care (GSTT)
Violence / aggression
Wrong dose
Wrong drug
Q1 19/20
Q2 19/20
Q3 19/20
Q4 19/20
Q1 20/21
Q2 20/21
Q3 20/21
Q4 20/21
Q1 21/22
Q2 21/22
Q3 21/22
Q4 21/22
Q1 22/23
Q2 22/23
Q3 22/23


GSTT
National summary score
Submission summary score
Communication with the dying person
8.0
8.6
Communication with families and others
7.1
7.1
Involvement in decision making
9.2
9.4
Individualised plan of care
7.6
7.8
Needs of families and others
5.5
5.4
Families' and others' experience of care
6.3
6.6
Workforce/specialist palliative care
8.1
8.8
Staff confidence
7.5
7.4
Staff support
7.1
6.5
Care and culture
7.6
7.2


RBH
National summary score
Submission summary score
Communication with the dying person
8.0
6.9
Communication with families and others
7.1
4.2
Involvement in decision making
9.2
8.9
Individualised plan of care
7.6
4.1
Needs of families and others
5.5
6.6
Families' and others' experience of care
6.3
9.1
Workforce/specialist palliative care
8.1
6.3
Staff confidence
7.5
6.7
Staff support
7.1
5.9
Care and culture
7.6
7.2