East London NHS Foundation Trust

Quality Assurance Committee Meeting

Thursday 18 July 2024 14:00 – 17:00
By MS Teams

AGENDA

1	Welcome and Apologies for Absence	Note	Donna Kinnair	14:00
2	Declaration of Interests on Items on the Agenda	Assurance	All	
3	Annual Integrated Safety Report	Assurance	David Bridle	14:05
4	Safeguarding Annual Report	Assurance	Claire McKenna	14:20
5	Infection, Prevention and Control Annual Report	Assurance	Claire McKenna	14:35
6	Mental Health Law Annual Report	Assurance	David Bridle	14:50
7	Emergency, Preparedness, Resilience and Response Annual Report	Assurance	Edwin Ndlovu	15:05
8	Health, Safety and Security Annual Report	Assurance	Edwin Ndlovu	15:20
9	5 Minute Break			15:35
10	Guardian of Safe Working Annual Report	Assurance	David Bridle	15:40
11	Freedom To Speak Up Annual Report	Assurance	Claire McKenna	15:55
12	Complaints, PALS and Compliments Annual Report	Assurance	Claire McKenna	16:10
13	Legal Claims Annual Report	Assurance	David Bridle	16:25
14	Medical Education Annual Report	Assurance	David Bridle	16:40
15	Research and Innovation Report	Assurance	David Bridle	16:50
16	Any Other Business	Note	All	16:55
17	Issues to be brought to the Board's attention	Note	Donna Kinnair	
18	Dates of Future Meetings*: • Monday 2 September 2024 14:00-16:30 • Monday 4 November 2024 14:00-16:30 • Monday 6 January 2025 14:00-16:30 • Monday 3 March 2025 14:00-16:30 *All meetings will be held by video conference from 14:00 – 16:30 unless otherwise indicated			
19	Close			17:00

Professor Dame Donna Kinnair DBE
Non-Executive Director

Chair of the Quality Assurance Committee

ANNUAL REPORT TO THE QUALITY ASSURANCE COMMITTEE
18 July 2024

Title	Integrated Patient Safety Report
Authors	Fabiola Ojo, Head of Incident Management Kim MacGillivray, Serious Incident & Mortality Reviewer Abiola Ajay-Obe, Associate Director of Governance & Risk Ashraf Zaman, Incident Coordinator
Accountable Executive Director	David Bridle, Chief Medical Officer

Purpose of the report

This report is the annual integrated patient safety paper covering 2023-2024 (April 2023 until and including March 2024). The report includes:

- **Annualised Patient safety data**
- **Safety management update**
- **Safety learning themes & analysis**
- **Safety Improvement and Oversight Update**
- **Progress on our Safety Plan & first year objectives**

The paper is for information and assurance purposes and approval thereof.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Key messages

Strengthening Patient Safety Through Standardised Processes

- **Implementing Robust Incident Response Framework:** This year, we strengthened patient safety incident response capabilities through the Patient Safety Incident Response Framework (PSIRF). Key initiatives: Care Review Tool (CRT), 72-hour incident reporting, PSII/SEIPS methodology for investigations. These streamlined reviews, enabled timely, data-driven decisions, and achieved consistency in responding to and learning from incidents.

- **Embedding Rigorous Review Mechanisms**: we successfully implemented Daily Incident Review Meetings, Decision-Making Panels, and Sign-off Panels. Fostering rigour, transparency and accountability in incident management. An Integrated Care Board (ICB) representative attends the weekly Decision-Making Panel supporting Commissioning oversight and learning.

- **Elimination of Serious Incident investigation backlog**: In the past financial year, we cleared the backlog of serious incident investigations developed during the Covid 19 revised operational ways of working. This achievement, with the support of Quality Improvement colleagues highlights the benefits of collaborative working and our commitment to conducting timely investigations and ensuring prompt learning from each incident.

- **Driving Continuous Learning and Improvement**: This year, our priority is to build upon the work we have initiated around the Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Incidents. We aim to ensure that lessons learned are continuous, impactful and embedded into practice across the organisation.

- **Enhancing Patient and Service User Engagement:** Additionally, we will enhance patient and service user involvement in our case reviews. This will promote transparency, improve the patient experience of care, and ultimately add value to the services we provide. By incorporating the perspectives of those we serve, we can gain invaluable insights and drive meaningful improvements that truly resonate with their needs and expectations.

Strategic priorities this paper supports

Improved population health outcomes	Identifying patient safety risks, collaborating with system partners and implementing systemic learning from safety issues enables us to work towards improved population health.
Improved experience of care	Safety and patient experience are intrinsically connected. This paper supports this priority by reporting on how the Trust meets Serious Incident Framework responsibilities and actions for dealing with Serious Incidents and complaints. Reflecting and learning from patient experience are routinely included in all incident review processes.
Improved staff experience	Our patient safety work supports staff experience by empowering and supporting staff in providing them with the correct tools, policies, procedures, documentation and training to improve patient safety. Supporting staff involved in incidents is also incorporated into our incident processes and quality improvement work.
Improved value	Safer care is economically important and work to provide safer care can significantly reduce the financial burden of safety incidents.

Implications

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	This report provides assurance that incidents are appropriately reported and investigated, robust actions taken where necessary and learning is gained from investigations plus assurance regarding oversight of our safety improvement work and future work being planned to strengthen our patient safety culture and systems.
Service User/ Carer/Staff	The recommendations and action plans pertaining to the incidents investigated as serious incidents have implications for service users, carers, staff and services across the organization. This paper outlines the way we are working to increase our involvement of patients and carers and support for those affected by incidents.
Financial	There are financial implications regarding resource management & potential for litigation.
Quality	Given the fact that safety is an inherent component of quality assurance and improvement, this report interfaces with our quality reporting in these areas. There is ongoing work needed to ensure reporting is complimentary and avoids duplication where possible. The report suggests patient safety could benefit from closer working with quality improvement to address safety challenges within the organisation.

Background & Introduction

This Annual Quality Assurance Committee (QAC) Report provides a comprehensive overview of our organisation's patient safety performance and quality assurance activities for the financial year 2023/24. It consolidates the quarterly reports and presents a factual account of our progress, challenges, and future priorities in patient safety.

This report demonstrates how our patient safety initiatives align with the Trust's strategic objectives and contribute to our goal of delivering high-quality, safe healthcare.

In the last financial year, the Trust implemented significant changes in our approach to patient safety and incident response. Key developments include:

1. Implementation of the Patient Safety Incident Response Framework (PSIRF)
2. Establishment of new review mechanisms, including Daily Incident Review Meetings and Decision-Making Panels
3. Clearance of the serious incident investigation backlog
4. Introduction of Patient Safety Partners to incorporate patient and service user feedback
5. Extensive implementation of After Action Reviews (AAR)
6. Improved compliance, monitoring, and tracking of Duty of Candour (DOC)
7. Enhanced tracking and monitoring of actions from completed investigations
8. Adoption of a new incident reporting system - InPhase

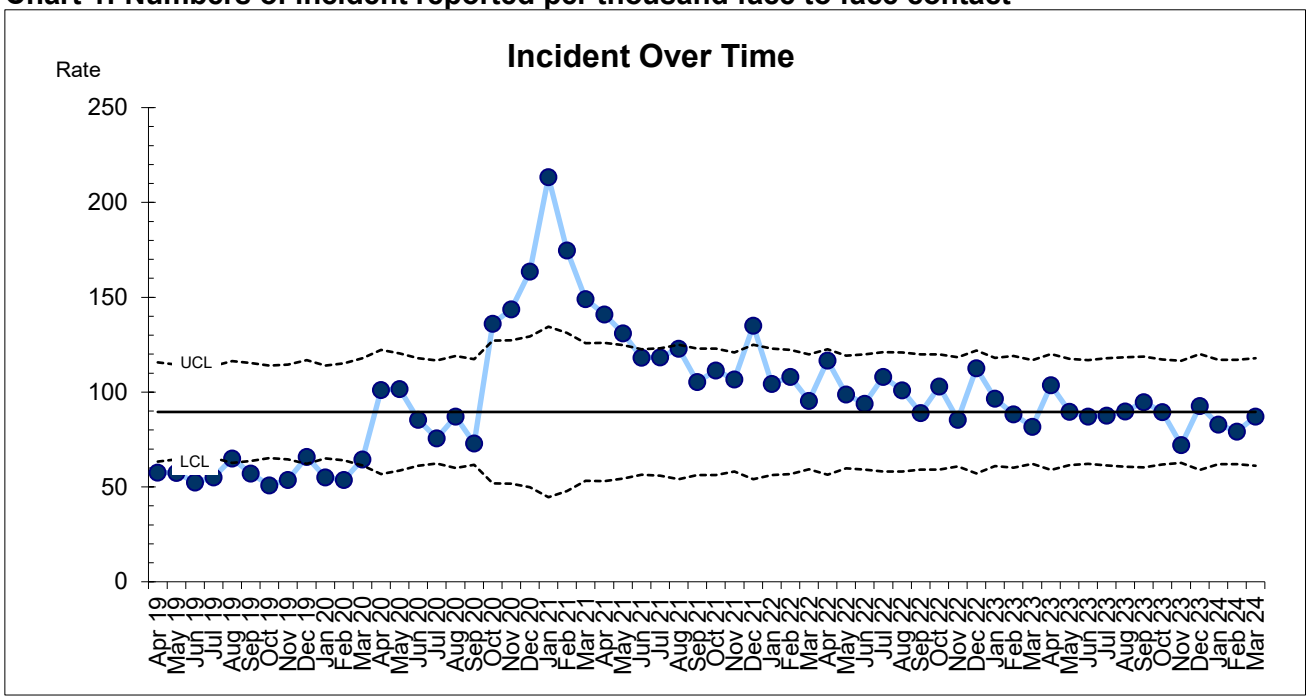
These changes reflect our commitment to continuous learning and improvement in patient safety. We are focused on translating insights from incident investigations/Learning Responses into actionable improvements, aiming to enhance both patient experiences and population health outcomes.

It is important to note that whilst progress has been made, there is still work to be done. We continue to evaluate and refine our newly implemented systems to ensure they are effective, embedded in practice, and fit for purpose.

For a more detailed analysis of how our function contributes to the wider Patient Safety strategy and its impact on population health, patient and staff experience, please refer to the accompanying Annual Safety Plan Progress Report. The document provides additional insights into our strategic impact and is available in Appendix A.

The QAC report reflects our commitment to transparency, accountability, and continuous improvement in patient safety. We acknowledge the need for ongoing review and refinement of our processes as we strive to enhance patient safety across our organisation.

Chart 1: Numbers of incident reported per thousand face to face contact



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Incidents per 1000 Face-to-Face Contacts

Rate of Incidents Reported: As depicted in graph 1 above, prior to the onset of the COVID-19 pandemic the data suggests a stable rate of incidents per 1000 face-to-face contacts, fluctuating between 52 and 58 reported incidents during April 2019 – February 2020. This level of stability indicated a consistent approach to incident reporting relative to the volume of patient interactions, setting a baseline against which subsequent changes could be measured.

In the most recent data from 2023, the rate of incidents per 1000 face-to-face contacts has settled at an average of 87. While this is a 9.77% decrease compared to 2022, it is worth noting that these figures have not reverted to pre-pandemic levels due to the increased bed occupancy rates across inpatient services which is at 100% and the increased number of acutely unwell patients accessing services post Covid 19.

This suggests that the Trust may be operating under a 'new normal', which, although stabilised, is elevated compared to historical standards.

Incidents Reported in the Last Financial Year

Overview

The table below compares the top five categories of incidents reported in the financial years 2023/2024 and 2022/2023. This comparison provides insights into the changes in the number of reported incidents, highlighting areas of improvement or concern.

Table 1: Top five categories of incident being reported in this year.

Category	Incidents 2023/2024 (LFPSE & NONLFPSE)	Incidents 2022/2023
Pressure Ulcer/Moisture Associated Skin Damage	4255	4589
Treatment/Procedure	3282	3395
Self-harm	2584	1586
Actual Physical Harm	2632	2569
Death of an Adult Service User	2963	2991

Analysis:

In the financial year 2023-24, the highest reported incident remains pressure ulcers and moisture-associated skin damage. The overall number of incidents reported this year has shown variation, with some categories experiencing a drop while others have seen an increase. The variation can be attributed to the adoption of the new InPhase reporting system, which was implemented in November 2023.

During the initial phase, a decrease in reported incidents was observed and reported during the quarterly QAC report. This has been closely monitored, and current observations show that the number of incidents is stabilising, indicating a strong reporting culture within the trust.

Additionally, the Trust started using the Learn from Patient Safety Events (LFPSE) system, which introduces new categorisation and reporting methods. This transition, occurring halfway through the year, caused further variations in reported numbers. The LFPSE system is designed to improve the recording and analysis of patient safety events, supporting better learning and safety improvement across the NHS.

The reported incidents include a 7.28% drop in pressure ulcers and moisture-associated skin damage, a 3.12% decrease in treatment and procedure incidents, and a 62.97% increase in self-harm incidents. There was a slight 2.45% increase in actual physical harm incidents and a less than 1% decrease in the death of adult service users, aligning with normal fluctuations observed in national death rates as per the five-year average used by the Office for National Statistics (ONS).

Enhancing Learning from Patient Safety Reviews and our new approaches with PSIRF

In the previous financial year, we introduced several key learning responses to streamline processes and enhance patient safety. These included After Action Reviews (AAR), 72-hour reports, the Care Review Tool (CRT), and Patient Safety Incident Investigations (PSII). Additionally, we implemented three grading panels: the Daily Incident Review meetings, the Weekly Decision-Making Panel, and the Sign-Off Panel. The introduction of these new tools and panels significantly improved consistency in declaring, managing and learning from incidents and their associated reviews.

Our activities around 72-hour reporting have increased and our use of this tool has evolved. By enhancing the quality of information captured in these reports, we have been able to more robustly identify the issues relating to an incident and the associated actions needed to introduce positive impactful change. We have been able to utilise 72 hour reports more effectively, including in coroner's courts and consequently freeing up resources for more comprehensive learning response investigations and training.

After Action Reviews (AARs): these were introduced as a PSIRF learning response in November and December 2023. AARs are being used by staff more frequently to create reflective spaces to analyse incidents. This process allows for a deeper understanding of what contributed to a patient safety event happening, understanding, how it happened, and the human and other factors which contributed to why there was a deviation from expected outcomes.

As part of the PSIRF, we have introduced the use of the Systems Engineering Initiative for Patient Safety (SEIPS) as a framework with which to conduct our investigations. This new framework enables us to view incidents through a systems focussed lens, helping to identify and address systemic issues. This is a move away from the use of the Root Cause Analysis Framework used under the Serious Incident framework which preceded PSIRF which, focussed on the identification of a single root cause of what led to an incident occurring preventing a systems wide analysis of safety factors.

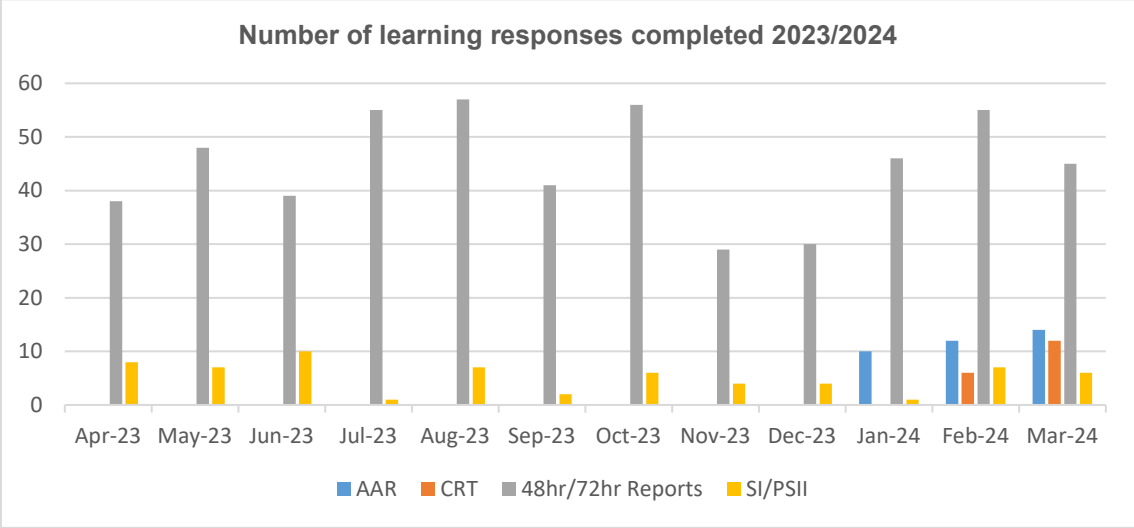
Care Review Tool: The Care Review Tool was introduced in January 2024 to act primarily as a decision making tool for those patient safety incidents which involved multiple services, to determine whether a further learning response to identify learning is necessary. The CRT is a desktop review led by a Patient Safety Reviewer which is based on the Royal College of Psychiatrists – Structured Judgement Reviews used to review unexpected and expected deaths. This tool is the last of the learning responses introduced under PSIRF at the Trust and is proving invaluable as a guidance review to determine whether additional reviews are required or not.

Patient Safety Incident Investigations (PSII): PSII was introduced last year as one of the main learning response tools within PSIRF. Replacing the Serious Incident Investigation (SI) process, the PSII aims to enhance the focus on impactful learning opportunities. To prevent the development of a backlog of PSII cases similar to what was experienced during COVID-19, we continue to monitor the completion rate of PSIIs

together with all our learning responses. By the end of the last financial year, the average completion time, for PSII was approximately 80 working days. This continues to fluctuate, however, there is ongoing efforts continue to reduce this duration to ensure timely feedback and learning.

We have transitioned from the root cause analysis methodology to the System Engineering Initiative for Patient Safety (SEIPS) framework, which supports a system-based approach to understanding the factors contributing to incidents. This shift aims to mitigate the potential for a blame culture and embed a holistic, system-oriented perspective across all our investigations, promoting a culture of continuous improvement and patient safety.

Chart 1: Data on learning responses from April 2023 – March 2024.



Analysis:

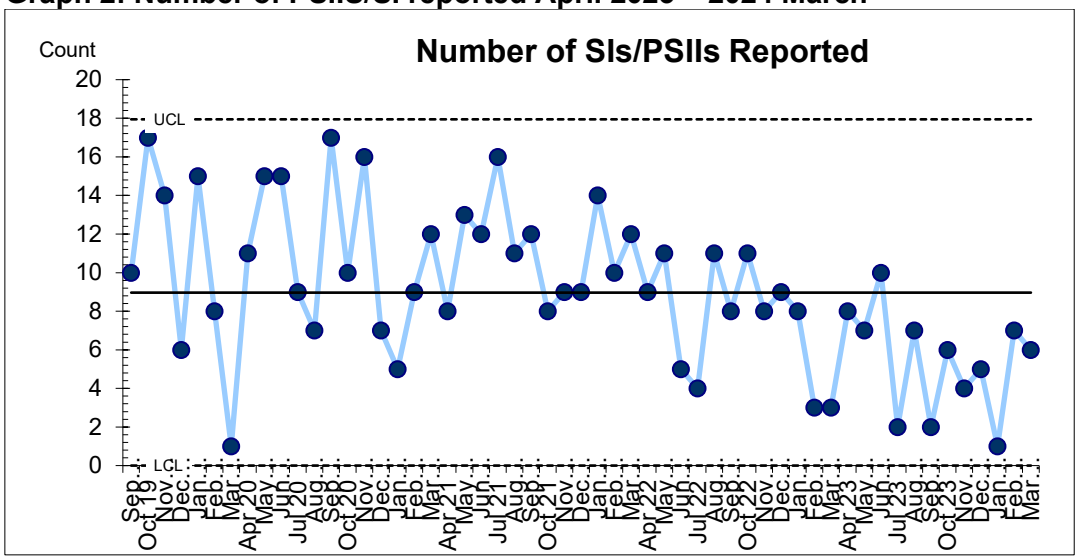
- **AARs and CRT Implementation:** The introduction of AARs in Nov/Dec 2023 and CRTs in January 2024 has been smooth, with an immediate uptake reflected in the data. This transition is expected to further enhance our ability to capture learning and improve response times.

- **48-Hour and 72-Hour Reports**: During the transition to 72-hour incident reporting and in-phase implementation, there was a temporary dip in report requests from the typical monthly average (45-50 reports) due to staff unfamiliarity with the new 72 hour report requirements. However, this did not impact the identification and reporting of critical incidents. All high-priority cases were appropriately addressed, with no missed escalations. While report volume fluctuated during this period, the quality and effectiveness of incident reporting remained uncompromised, ensuring a consistent focus on addressing key patient safety concerns.

- **PSII/SI Investigations**: The Trust transitioned from Serious Incident (SI) investigations to Patient Safety Incident Investigations (PSII) in November 2023.

Despite this change, our monthly PSII and SI investigation numbers have remained stable, averaging, six to seven per month.

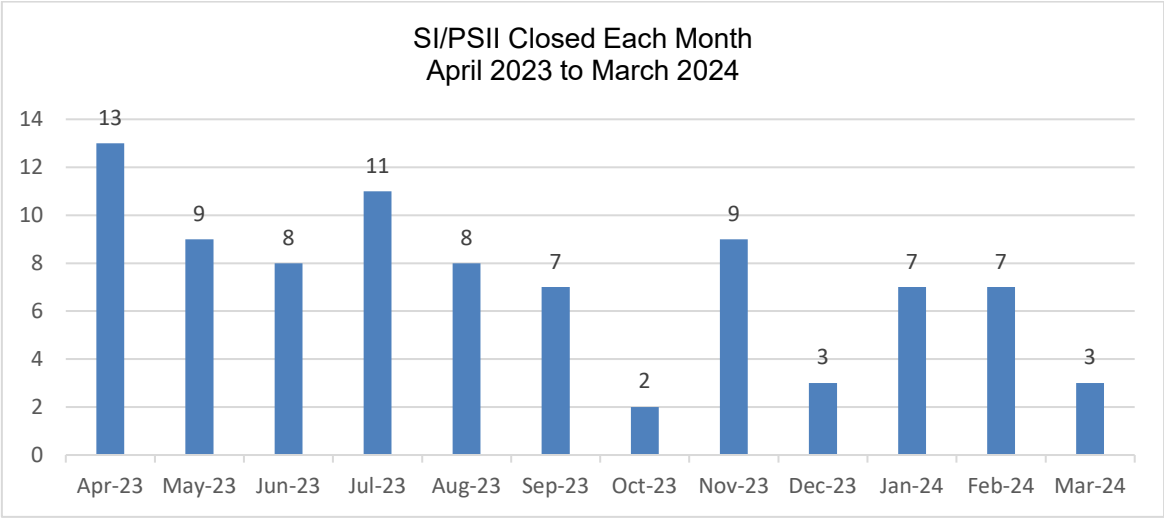
Graph 2: Number of PSIIS/SI reported April 2023 – 2024 March



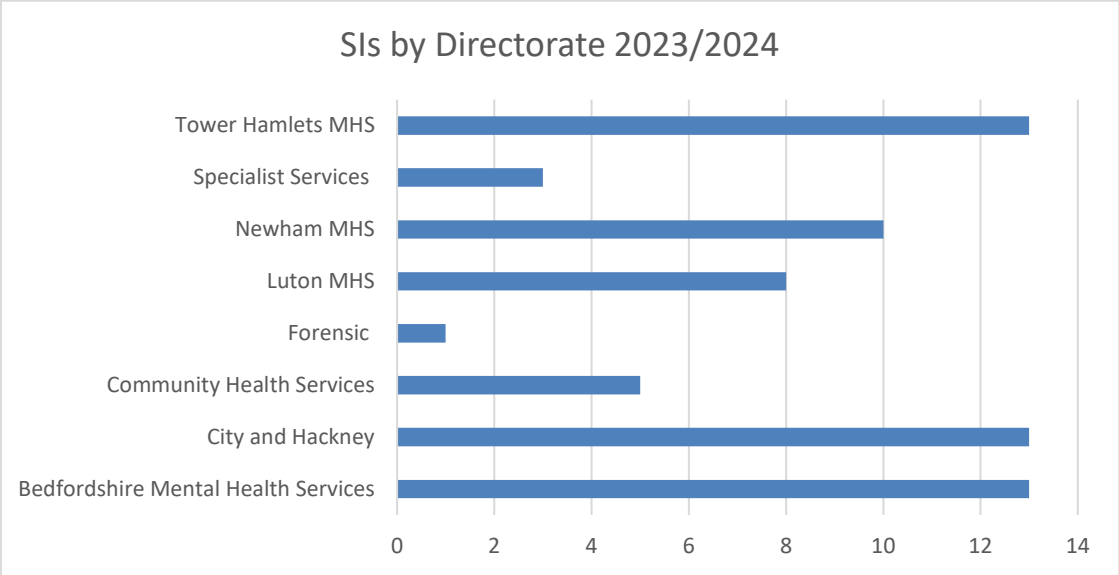
Trend Analysis: Downward Trajectory in SI/PSII Reporting

An examination of the graph above, which combines both (SI) and (PSII) historical reports from September 2019, reveals a consistent decrease in the number of SIs declared. Notably, since 2023, the number of incidents reported has remained below the median range. From June to July 2023, the average number of incidents reported each month has stabilised around eight, with some variations but no significant dips. Moving forward, with the adoption of new learning responses, we anticipate a further downward trajectory in the number of PSII declared as the other learning responses provide more efficiencies. It is important to note that PSIRF learning responses are not solely about declaring incidents when things go wrong; it also involves recognising situations where care was appropriately provided, thereby understanding and reinforcing positive system learning to make impactful improvements.

Graph 3: Number of incident completed/closed per month in 2023/2024



Graph 4: Number of PSII/SI reported by Directorate



Analysis: Summary for Financial Year 2023-2024: Insights and Learning Opportunities
In the past financial year, we completed 94 investigations, a 2% increase from the previous year's 92. 65 incidents of these were recorded as SI/PSII, and 22 were completed using Care Review Tools (CRTs). Additionally, we utilised 72-hour reports for 5 cases that required coroner's court documentation but did not meet the threshold for PSII classification.

Of the 65 PSII/SI reviews, 15 identified no omissions in care that contributed to the index incident. This finding highlights that while the number of incidents declared for investigation may seem high, it does not indicate poor care quality or high-risk areas. In line with PSIRF, many of our investigations were initiated for their potential to yield learning and improvements, rather than solely due to omissions in care.

Category on incident reported: The highest reported/declared incident reviewed using SI or PSII framework is 'Death of Adult Service User' at 59. Bedford Mental Health and Tower Hamlets Mental Health services were the area with the highest number of reported deaths, reporting 16 and 12 cases respectively. Previous analysis has compared directorates relative to patient population size, and has found no significant difference in rates between directorates. Other incidents included 1 homicide in Newham, three pressure sores (Trust Acquired Grade 3 and or more), 4 cases of physical attacks, 1 AWOL, one complication or unexpected deterioration, and the death of a child.

Notable Practices

The Patient Safety and Learning Committee identified several areas of good practice in the last financial year:

1. Exceptional inter-organisational and inter-specialism communication and collaboration (10 cases)
2. Strong patient engagement (6 cases)
3. Holistic approach to mental health care and supportive, responsive care (4 cases each)
4. Compassionate involvement of patients' families (4 cases)

5. Timely access to treatment and thorough assessment and record-keeping (2 cases each)
6. Proactive patient follow-up, with four cases demonstrating excellent outreach to other ELFT services, GPs, and acute hospitals. High-quality care coordination was evident through senior oversight and effective clinical care management.

Analysis of Deaths Data

During the reporting period, the Trust reported a total of 2,862 patient deaths, of which 2,426 (84.7%) were classified as expected and 438 (15.3%) as unexpected. Following an initial review, 20 deaths were re-categorised, resulting in 418 unexpected deaths. In comparison, during the previous reporting period (2022/2023), the Trust recorded 2,863 deaths, with a similar distribution of expected versus unexpected deaths.

Review and Investigation of Deaths

In this period, 1,268 (44.3%) of all reported deaths were reviewed for learning purposes. The breakdown of these reviews is as follows:

- 761 investigations (26.6%) were conducted using the Trust's Structured Judgement Review/Care Review Tool processes (SJR/CRT).

- 418 investigations (14.6%) were carried out through the Trust's internal Patient Safety Investigation process, including 48-hour and 72-hour reports and CRTs.

- 57 investigations (2.0%) employed various learning response methods, including Serious Incident Reviews (SIR), Patient Safety Incident Investigations (PSII), and Concise Reviews.

This detailed breakdown, illustrated in Chart 4, demonstrates the Trust's systematic and thorough approach to incident review, aimed at extracting valuable learning and implementing improvements.

Specific Reviews

There were 32 Learning Disabilities Mortality Reviews (LeDeR) conducted, highlighting our commitment to understanding and improving care for this vulnerable population.

Analysis of Learning and Impact

The analysis of reviewed deaths shows the Trust has a robust framework for learning and improvement. The significant number of expected deaths suggests that end-of-life care pathways are generally well-managed, but the focus on unexpected deaths is crucial for identifying areas where patient outcomes can be improved. The re-categorisation of 20 deaths shows the fluid nature of classification and the importance of continuous review.

Chart 4 – Safety Investigations undertaken for deaths in 2023/2024

Period	Reported deaths	Investigation Type				Total Investigatio (%)
		SJR/CRT expected deaths	48hr 72 hr reports and CRTs unexpecte deaths	Enhanced Concise SIR/PSII unexpected death	LeDeR	
Quarter 1	790	208	116	18	4	346 (43.70%)
Quarter 2	597	192	107	14	10	323 (54.01%)
Quarter 3	711	150	73	8	4	235 (33.05%)
Quarter 4	764	211	122	17	14	364 (47.64%)
Totals	2862	**761**	**418**	**57**	**32**	**1268 (44.30%)**

Expected Deaths

During the reporting period, the Trust reported 2,426 expected deaths, reflecting a 3.73% decrease (94 fewer deaths) compared to the previous year, which recorded 2,520 expected deaths. This drop aligns with the normal fluctuations observed in national death rates. The Office for National Statistics (ONS) uses a five-year average to benchmark expected deaths, which accounts for typical variations over time. Our decrease falls within this expected range, indicating that it is part of the usual yearly variation.

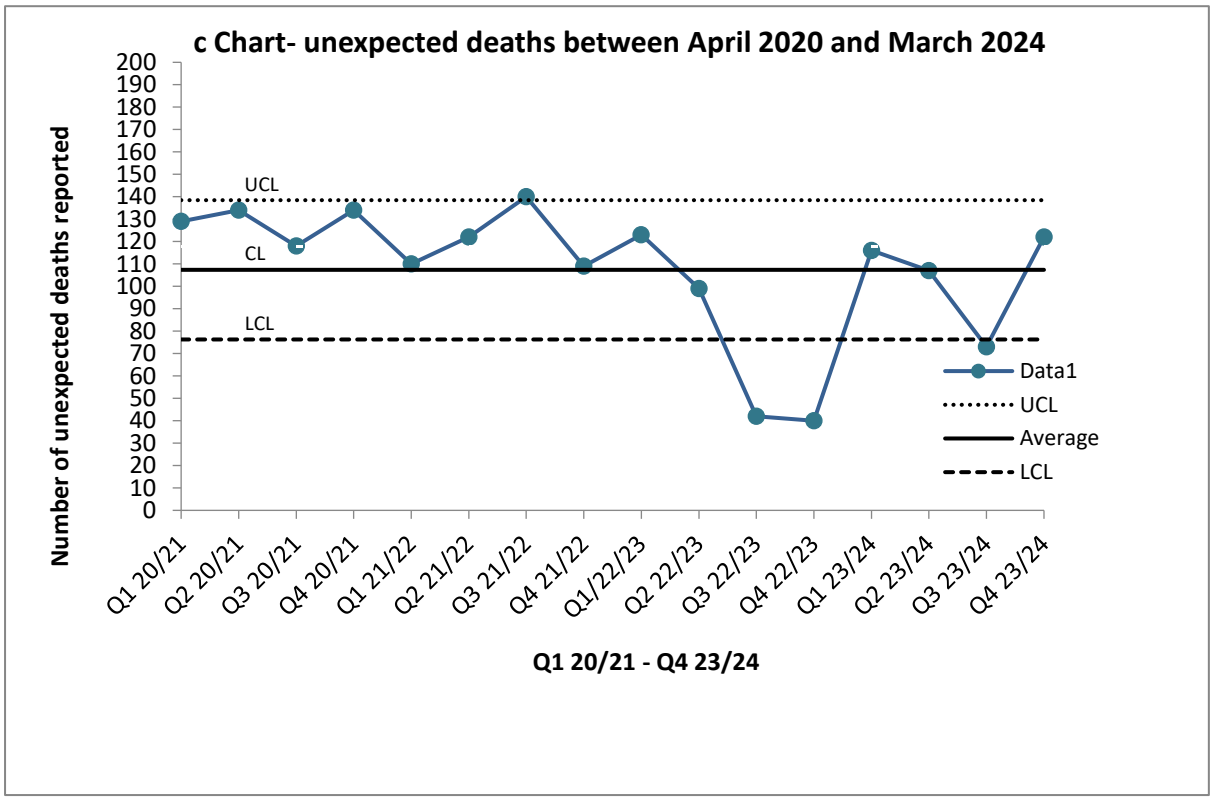
A detailed analysis of the 761 Structured Judgement Reviews (SJR) and Care Review Tool (CRT) investigations revealed that the highest number of deaths occurred in the 76 to 100-year-old age group. Importantly, none of the 761 SJR or CRT investigations identified any contributory patient safety factors in the expected deaths. This indicates that the deaths were in line with anticipated clinical outcomes and highlights the Trust's effective management of end-of-life care pathways.

Nationally, the leading underlying causes of death in England for 2023 were influenza and pneumonia, chronic lower respiratory diseases, and dementia, with cancer being the primary underlying cause among those who died from cancer (ONS Mortality within England 2023). The Trust's data on expected deaths aligns with these national trends, with pneumonia being a significant cause, although influenza was reported less frequently.

Unexpected Deaths

In the period under review, 418 unexpected deaths were reported, representing a 21.86% increase (75 more deaths) from last year when 343 unexpected deaths were reported.

Chart 5 - Unexpected deaths between April 2020 and March 2024



C chart

Of the initial 418 unexpected deaths that were reported 361 were closed after 48 or 72 hour reports. Further investigation was required for the remaining 57, which were subject to concise reviews, SIR/PSII and CRTs. The review methodology was consistent with the transition into PSIRF.

Chart 6, below, shows the pattern of deaths reviewed as a Serious Incident Review (SIR) and Patient Safety Incident Investigations (PSII's). The most recent trend is evident and shows a reduction in the number of unexpected deaths being reviewed as a full SIR/PSII. This continued to reflect the changes in our approach to incidents with our continued Quality Improvement work on Serious Incidents and the transition over to PSIRF. New methods of review such as the 72 hour report and CRT gives a more thorough scrutiny of the incident than a 48 hour report.

Chart 6 - Unexpected Deaths Raised to SI or PSII (including enhanced concise reviews) from April 2020 to March 2024

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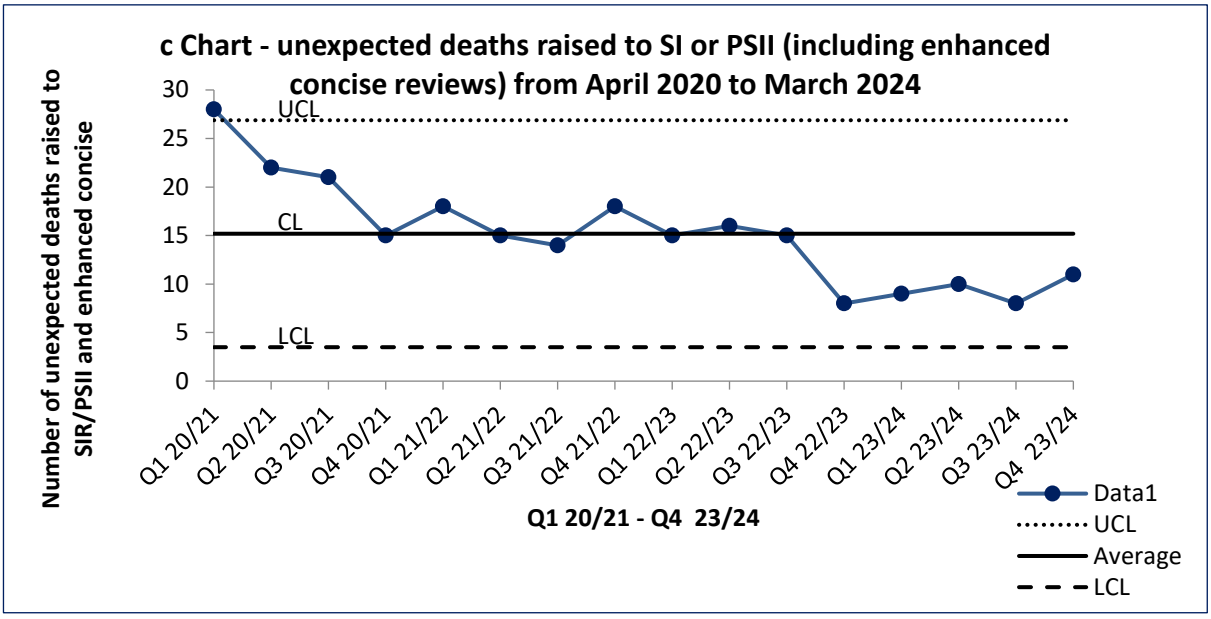
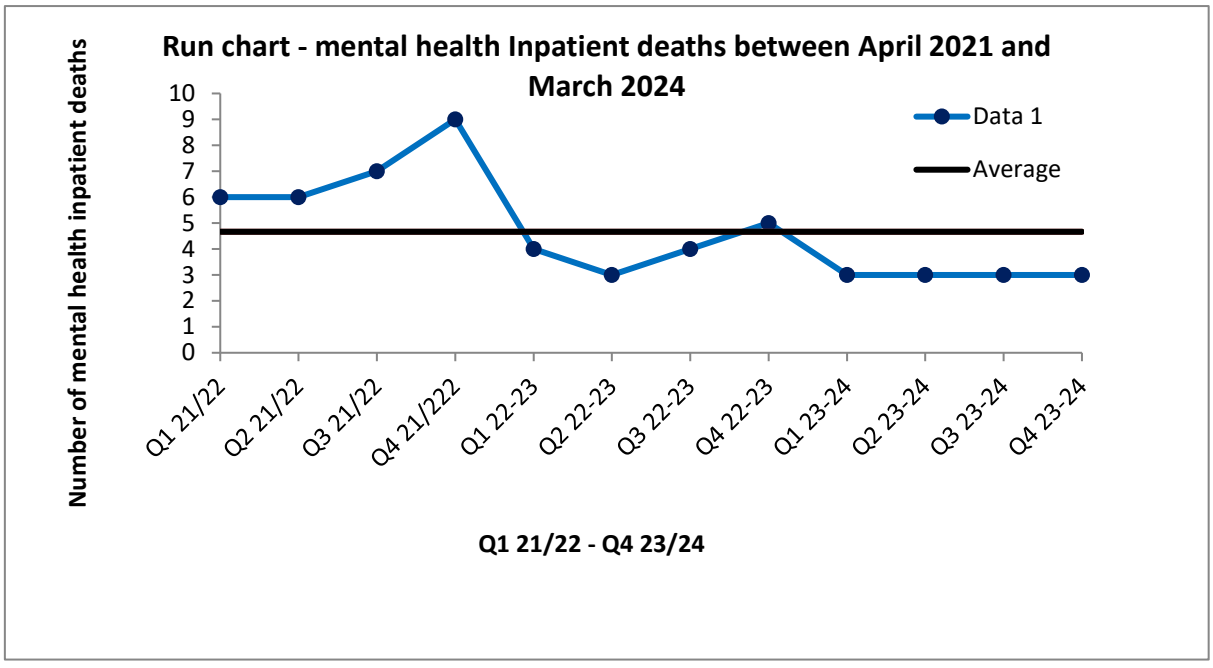


In-patient Deaths: 12 mental health inpatient deaths occurred between April 2023 and March 2024. This was fewer than the 16 reported between April 2022 and March 2023.

Chart 7. Run chart - In-patient deaths in mental health service between April 2021 and March 2024

Run chart



Mortality Review and Inquests

We closely monitor and analyse mortality data and inquest outcomes. This section highlights key findings from the 2023-2024 financial year:

- **Deaths in People with Learning Disabilities and Autism**: The Trust reported 32 deaths of individuals with learning disabilities or autism between April 2023 and March 2024. In line with our commitment to transparency and learning, all cases were promptly notified to the Learning from Deaths Review (LeDeR) programme.

- **Inquest Outcomes:** During this period, 91 inquests into deaths of ELFT patients/service users were concluded at Coroners Court. Notably, suicide was determined as the cause in 29 cases, representing the highest cause of death Trust-wide. This finding underscores the critical importance of our ongoing suicide prevention initiatives.

Prevention of Future Deaths (PFD) overview

The Trust received four PFD notices in the last financial year. These were addressed and discussed in the QAC reports for each respective quarter.

In response to the Trust's PFDs, we initiated a comprehensive thematic review of all PFDs received since 2017. This ongoing analysis aims to identify recurring themes and patterns related to patient safety. The thematic review of PFDs is still in progress. We anticipate reporting on this in the first quarter of this year. Once the review is signed off by the panel, we will share the outcomes, learnings, and next steps at the Patient Safety Forum.

We have also updated our policy to include the integration of a flowchart for handling PFD and also monitor the completion of actions from PFDs. By ensuring that actions from PFDs are completed, we aim to reduce the recurrence of these incidents, embed these actions in practice, and ultimately enhance patient experience of care and population health.

In the learning section of this report, there is a summary of the areas for improvement identified from inquest cases, along with the actions taken to address them. This summary includes the steps we have implemented since identifying these areas for improvement.

Independent Reviews overview

Three independent reviews were commissioned in the last 24 months, which are essential for maintaining quality assurance and driving continuous improvement within our trust.

1. **SI 169552 – In Patient Death**

The independent review of the above case has been completed, and the key themes identified include

- The suicide of detained patients either on or off the ward,
- management of AWOL incidents from the ward including the use of Section 17,
- crisis management and community response from the trust,
- involvement of carers and family in care planning and risk management,
- Clinical oversight and changes in consultants.

Following these findings, the ICB is organising a niche-led learning session to facilitate system-level learning. Additionally, the Trust will conduct its own internal learning sessions to ensure comprehensive understanding and application of these findings within the trust.

2. **SI 182797 – In-Patient death on Rosebank Ward**

The independent review has been completed, and the report has been shared with the Trust. Currently, it is being reviewed by all stakeholders involved. Specific themes and insights are still under discussion, and we will continue to monitor and implement any necessary actions as these are finalised.

3. **SI 199283 - Inpatient homicide Case on Topaz Ward**

The review of this homicide was commissioned during the last quarter. The trust has completed a robust internal investigation, which identified several actions and recommendations that are actively being taking forward. The independent review will focus on identifying additional learnings and augmenting the findings of our internal investigation. Any additional findings from the independent review will be duly discussed at the patient safety forum and integrated into our processes to ensure thorough and effective responses.

We plan to continue commissioning independent and thematic reviews to uphold high standards of patient safety and care. Ongoing updates and findings will be shared in future QAC reports to maintain transparency and commitment to excellence.

Thematic and Cluster review Updates

During the last financial year, we commissioned five thematic reviews and one cluster review. These reviews are designed to address specific areas of concern and enhance overall patient safety and service quality.

The TABI review has been completed, with the findings and learning identified from this review shared at the June 2024 patient safety forum. The remaining thematic reviews are ongoing, with expected completion within the next one to three months. These reviews are being conducted alongside the transition to a new system, presenting some challenges in balancing workloads. The cluster review is also ongoing and is a priority due to its overdue status. We aim to complete this review within the next two months.

The table below provides and overview of the thematic and cluster review ongoing.

Table 3: List of Thematic and Cluster Reviews and progress

Date Commissio	Directorate/ Service	Description	Progress
10/05/2023	Multiple Services	Cluster review of cases with delays in	Ongoing

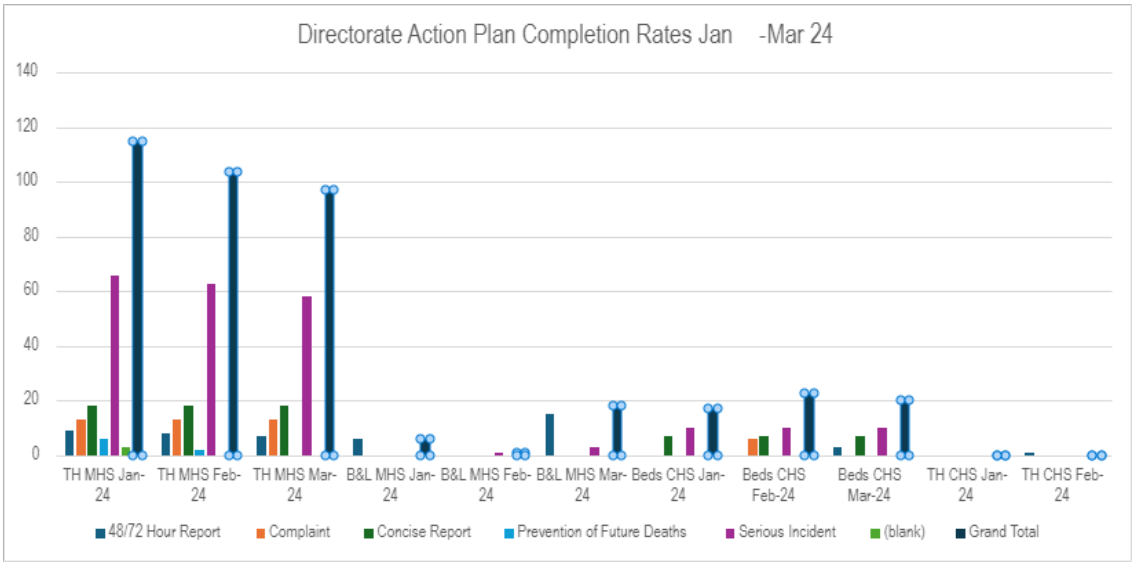
		locating patients who died in the community.	
10/05/2023	TABI – Luton & Beds	Thematic review	Closed, and learning has been shared at the Patient Safety Forum.
23/02/2024	Multiple Services	Thematic Review for falsified documents/observations.	Ongoing
23/02/2024	Multiple Services	Thematic Review for PFDs received by the Trust since 2017.	Ongoing
10/04/2024	Multiple/Poplar Ward	Thematic review of incidents to mitigate recurring issues	Ongoing.
20/04/2023	Neighbourhood Teams and City and Hackney	Thematic Review of NT service delivery	Ongoing

Patient Safety Investigations Action Plan Completions

The Trust's Action Plan Management processes continue to demonstrate steady progress and increasing maturity. Directorates have shared their processes for the management, completion and assurance of Action Plans. Overall, the number of overall outstanding actions for completion is reducing, reflecting the concerted efforts of our Directorates to enhance their local oversight, management, and closure of action plans arising from various learning responses.

Actions outstanding for completion from incidents reported on Datix have reduced from 865 in November 2023 with the move from Datix to InPhase to 115 as at the end of March 2024 an 87% reduction in the number of outstanding legacy actions for completion.

Graph 8: Action Plan completion rate by Directorates



Duty of candour update

Duty of Candour (DoC) Compliance

In the last financial year, the Trust has observed improving completion rates for both legacy and current Duty of Candour (DoC) incidents. Legacy DoC incidents refer to those reported on Datix before the transition to the new InPhase system in November 2023, while current DoC incidents are logged on the InPhase platform. The data on DoC completion rates is directly sourced from the InPhase platform, providing robust evidence of compliance and completion.

The Trust is effectively managing both DoC processes concurrently to ensure comprehensive oversight and adherence during the system transition. Efforts are ongoing to ensure that any DoC actions not completed within the stipulated 10 working days are addressed retrospectively. The importance of completing DoC for all notifiable incidents is consistently highlighted during oversight panel discussions and throughout the investigation processes. These measures reflect our commitment to transparency, accountability, and continuous improvement in patient safety and communication standards.

With the support of a Quality Improvement project on DoC completion, Directorates have made considerable efforts to ensure that DoC is completed appropriately with rationales provided, within patient's records and on InPhase, indicating why it has not been possible to complete DoC in cases where DoC has not been completed.

In November 2023, with the move from Datix to InPhase, there were a total of 1130 outstanding DoC cases for completion. Legacy DoC incidents for completion were at 207 in March 2024, showing a 82% increase in the number of legacy DoC managed and appropriately closed by services.

Table 3: DoC Legacy Completion Rates

	Jan-24	Feb-24	Mar-24
Directorate	Move to InPhase Jan - 24	Feb-24	Mar-24
Bedfordshire Mental Health Services	30	29	1
City and Hackney	86	86	86
Community Health Newham	80	80	8
Community Health Services	628	549	26
Forensic Services	30	28	1
Luton Mental Health Services	14	14	2
MHCOP - TH Mental Health	57	57	0
MHCOP - CHN			43
MHCOP - C&H Mental Health (Cedar Lodge)			0
MHCOP - Demention Team and Urgent Care Centre			2
Newham (Mental Health)	44	43	7
Primary Care Services	3	2	1
Specialist Services and CHN Children's Services	74	72	4
Tower Hamlets (Mental Health)	54	54	10
Tower Hamlets Community Health Services (TH CHS)	30	27	16
Grand Total	**1130**	**1041**	**207**

As at April 2024 the Trust had 47 DoC cases outstanding for completion, against a total of 204 DoC applicable incidents for DoC management, indicating an average 71% completion rate across the months of March and April 2024.

		Mar-24		Apr-24
Directorate	Total # DoC Mar -24	Outstanding DoC Mar-24	Total # DoC Apr - 24	Outstanding DoC Apr-24
Bedfordshire Community Health Services	65	26	15	0
Bedfordshire Mental Health Services	13	1	20	7
City & Hackney Mental Health Services	8	13	15	18
Community Health Services - Newham	18	0	27	1
Community Health Services - Tower Hamlets	30	0	21	0
Forensics Services	2	1	4	1
Luton Mental Health Services	9	2	16	5
Newham Mental Health Services	14	7	12	7
Primary Care Services	2	1	0	1
Specialists Services	4	4	8	4
Tower Hamlets Mental Health Services	15	10	11	3
Grand Total	**180**	**65**	**204**	**47**

Learning from Patient Safety Initiatives: Insights and Future Directions

Overview

During the past financial year, our patient safety initiatives have yielded invaluable insights, enabling us to significantly enhance the quality of care we provide. This section highlights key learnings from various work streams and demonstrates how we have leveraged these insights to drive improvements in patient safety and population health. Through rigorous investigation and analysis, we have identified themes and trends that now inform our strategies for achieving quality patient outcomes.

It is noteworthy that not all patient safety investigations, particularly Patient Safety Incident Investigations (PSIIs), are initiated due to care omissions or gaps. Our review of PSIIs this financial year revealed 10 cases without such omissions. Similarly, Care Review Tools (CRTs) indicated approximately seven cases without care gaps, whilst several 72-hour reports required no escalation. These findings underscore our commitment to thorough investigation and continuous improvement, even in scenarios where care standards were met.

Our primary objective has shifted from merely investigating incidents to intelligently applying the knowledge gained from these ‘Learning Reviews’. By harnessing data analytics, we aim to cultivate a culture of continuous improvement throughout the Trust.

A major step towards this goal is the implementation of the Action Planning Module on the In-Phase platform, which went live recently. Although in its early stages, this tool will enable us to track, manage, and act upon incident-related insights more effectively.

Summary of areas of Improvement Identified during This Period and actions implemented

1. **AWOL Policy:** The Trust's Absent Without Leave (AWOL) policy was deemed insufficiently descriptive and robust in outlining necessary actions for staff when patients go missing in public areas. Issues were identified in managing patients who were AWOL from the ward, including inadequate risk assessments prior to patient departure and delays in police involvement.

    Key Updates

    The Trust updated its AWOL policy with specific guidance on preventing and managing patient absconding during escorted leave, emphasising staff safety, non-physical interventions, and appropriate escalation procedures. Additionally, the Trust implemented measures to enhance staff training, including the incorporation of AWOL scenarios into induction programmes for new staff and the introduction of a biennial refresher course on Section 17 and Escort training, with plans to fully establish these training initiatives within 3-6 months.

2. **Support for Vulnerable Adults**: Concerns were raised about insufficient support for vulnerable adults at risk of accidental or intentional prescription drug overdose and potentially experiencing mental health crises, despite being under the care of secondary mental health services.

   Key Update:

   The Trust initiated a comprehensive review of its risk assessment policies, aligning them with the latest NICE guidance that emphasised supporting immediate and long-term safety over traditional risk stratification methods for suicide and self-harm.

3. **Safeguarding:** A need was identified for teams to review their approach to escalating safeguarding concerns, particularly when external bodies conclude investigations without addressing underlying issues. There was a gap in persistently pursuing unresolved issues and seeking guidance from in-house safeguarding specialists.

4. **Capacity Assessment:** A gap was highlighted in documenting capacity assessments, emphasising the need for more rigorous standards in recording these evaluations.

5. **Carer Assessments**: A gap was identified in conducting carer assessments, indicating a need to better recognise and support the role of carers in patient care.

6. **Therapeutic engagement and observation**: This has been identified in some of the cases and the Trust committed to a quality improvement project to improve practice.

   Key updates:
   This work completed in March 2023 and is being incorporated into standard practice and policy. A system for collecting and reporting on compliance with prescribed observation has also been developed and is available on Power BI. Staff training resource have been developed and move to the learning Academy with plans to move this to mandatory training.

7. **Policy and Training Enhancements:** Over the past financial year, we have markedly improved our clinical policies and training programmes, incorporating key lessons from Prevention of Future Deaths (PFDs).

   Key updates include:

   - Implementation of the VTE Risk Assessment Policy
   - Introduction of comprehensive two-day physical health training across all services
   - Deployment of physical health lead nurses in all inpatient services to:
     - Spearhead training initiatives
     - Enhance staff competency in mental health

    - Support care planning for service users with physical health conditions
- Substantial investment in the Forensic Service to support on-site physical health care, reducing reliance on external referrals. Relaunch of the Safety Bundles to reduce incidents of Violence and Aggression.

- The Trust launched a six-month programme to overhaul its policies, which included seeking external expert opinions on proposed changes and reviewing the Grab Pack's alignment with local policies within a three-month timeframe.

8. **Technological Advancements and Quality Assurance:** We utilise technology to enhance our monitoring and auditing capabilities:

    - Promotion of Power BI to help teams track physical health interventions
    - Comprehensive review of all policies to ensure currency and effectiveness
    - Improved communication with nursing staff regarding incidents and PFDs
    - Development of local induction programmes
    - Enhancement of training materials available through the Trust Learning Academy
    - Forthcoming launch of the Triialog system to support clinical supervision and identify areas needing additional support.

Looking Ahead: Future Directions and Assurance

1. **Annual PSIRF Plan Review**: We shall conduct annual reviews of our Patient Safety Incident Response Framework (PSIRF) plan for continuous evaluation of our safety profile and identify emerging themes or areas of concern.

2. **Enhanced Thematic Review Capacity**: In the coming financial year, we aim to evolve our thematic review capabilities, utilising objective data-driven incident theming to conduct comprehensive analyses.

3. **Data Triangulation**: By integrating insights from various sources, including complaints and patient feedback, we shall ensure a holistic approach to patient safety.

4. **Actionable Quality Improvement**: Our focus will be on translating insights into targeted quality improvement initiatives aligned with PSIRF improvement categories.

5. **Action Plans**: The Action Planning Module will play a crucial role in this process, enabling us to systematically categorise actions and strategically allocate our resources to the most critical areas. This data-driven approach ensures that our responses are not only targeted and effective but also contribute to measurable improvements in patient care and outcomes.

6. **Learning Systems**: To enhance our learning systems, we plan to revitalise our learning lesson seminars and introduce a strategic annual work plan with themed

focuses. We will review completed SI/PSII investigations from the past three years to identify and understand recurring themes, informing our work plan.

By targeting key areas identified from these reviews, we can focus resources on significant recurring issues and develop specific improvement initiatives. Additionally, we will explore why some identified issues persist despite previous actions, assessing whether different strategies or smarter actions are needed.

Appendix A; Annual Safety Plan Progress Report

ELFT Patient Safety
Plan Update and Prog

See below

REPORT TO THE Quality Assurance Committee
18 July 2024

Title	Patient Safety Plan Annual Report
Author	Dr Deborah Dover, Director of Patient Safety
Accountable Executive Director	Dr David Bridle, Interim Chief Medical Officer

Purpose of the report

To provide a year one progress report on our Patient Safety Plan along with outline of objectives and work plan for year two.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Key messages

In this report we outline progress over the first year of our ELFT Safety Plan, with particular attention to our year one objectives. We go on to outline our proposed year two objectives and revised plan for years two to five.

Our **year one 2023-2024 objectives** included:

- Transition from the Serious Incident Framework to the new Patient Safety Incident Response Framework (PSIRF).
- Transition to the new NHSE national learning from Safety system (Learn from Patient Safety Events (LFPSE).
- Development of ELFT Staff skills and expertise in Patient Safety, including engagement with the National Patient Safety Syllabus
- Greater involvement of Service users and carers, including recruitment of Patient Safety Partners.

Positive progress has been made on all of these objectives, along with additional areas of progress and achievement including (but not limited to):

- Safety culture improvement work
- Work on Safety Improvement Priorities
- Sharing of Learning from Safety
- Application of our QI methodology to our Safety Priorities

Areas of challenge have been:

- The negative impact of the national LFPSE system on safety incident reporting
- Engagement with safety syllabus via e-learning modules & upskilling of workforce in absence of national resources.

In year two and beyond, we plan to build on the work commenced in year 1 and go further in our journey to continuously improve our Safety Cultures and systems.
In year two we will continue to focus on some key enablers of the changes we are seeking including:

- a continued focus on our new Patient Safety Incident Response Framework Approach (PSIRF) and ongoing transition and development of our InPhase quality management system.
- Strengthening of the involvement of Service users and carers as part of our Safety System
- Supporting our People Plan Workforce Safety areas in priority safety areas including safer staffing, staff well-being, support after incidents & sexual safety.
- Further workforce safety skills development, through embedding of safety and systems training within existing QI and leadership development and training programmes.
- Ongoing improvements in our digital safety across the trust

Strategic priorities this paper supports

Improved population health outcomes	x	This is one of the primary drivers within the strategy and will have focus in years 3 onwards.
Improved experience of care	x	Safety and experience are strongly linked. Patient experience of safety is a key outcome for this plan.
Improved staff experience	x	Staff experience of safety is a key outcome for this plan.
Improved value	x	Safer care can bring significant reduction in costs to the organisation and individuals, which can be redirected to provide enhanced care for all.

Implications

Equality Analysis	
Risk and Assurance	Enhanced focus on proactive risk identification, monitoring and response.
Service User/ Carer/Staff	Positive implications for staff and patients in delivering safer systems, services and culture of safety.
Financial	As above – significant cost savings by providing safer care.
Quality	Aims to improve quality by sustained and enhanced focus on safer care.

ELFT Safety Plan Year One Progress Report

Introduction

Patient safety science has evolved over the last 20 years and there is now a clear evidence base regarding the elements that support safer care. Key elements include strong safety culture(s), leadership, systems for learning & continuous improvement, application of reliability & systems thinking, just culture principles and the application of human factors understanding.

Continuously improving safety is a central element of providing excellent patient care at ELFT and underpins delivery of our trust strategy. Since 2013, the Chief Quality Officer at ELFT has led on the adoption of a systematic approach to understanding and solving complex safety issues, supported through our partnership with the Institute of Healthcare Improvement (IHI). This work has led to greater involvement of staff, service users, carers and stakeholders in the identification of safety issues and application on Quality Improvement (QI) methodology to improvement. Almost 5000 people have learnt skills in understanding and improving complex systems since 2014, and this programme continues to equip everyone with the skills and competencies to improve safety and quality. Safety improvement work has taken place in many high priority areas including violence reduction, pressure ulcer reduction and medicines safety. Teams are now applying their improvement knowledge to other key areas such as improving therapeutic engagement, observation and physical health of those within in-patient settings.

Over 2018-2020 Internal and external reviews of ELFT patient safety were conducted which, together with the publication on the NHS Patient Safety Strategy in 2019, laid the foundation for development of a Safety Plan for ELFT. To further progress the work, in 2021 ELFT appointed to two patient safety specialist roles and in 2022 the trust appointed a dedicated Director of Patient Safety.

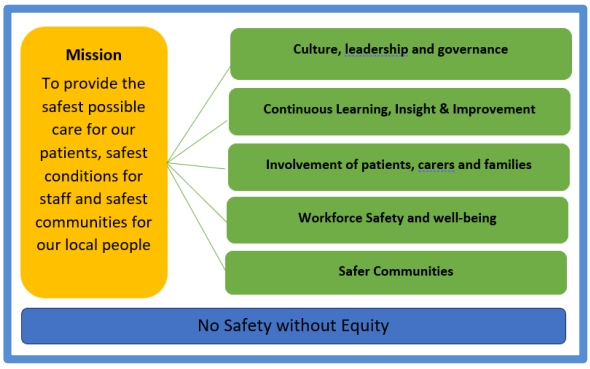
Developing the Plan

Over the course of 2022 we consulted with a wide range of staff, stakeholders and service users to understand what safety meant to our people. We also undertook co-design and foundation work to identify the status of safety, gaps in our safety profile and the improvements needed. This led to an ambitious implementation plan to deliver on the expectations of the NHS Patient Safety Strategy, and to take the trust further, to include evidence-based areas for improvement that are not included in the strategy. The plan was agreed at board in November 2022.

A Vision for Safer Care, Safer People and Safer Communities

The Safety Plan vision is for ELFT to be an organisation which provides the safest possible care for all our people, with a positive and equitable safety culture and where safety is everyone's primary concern, underpinned by strong leadership, people participation and proactive learning, monitoring and improvement. The mission is to provide the safest possible care for our patients, safest conditions for our staff and safest lives for those communities we serve, as we know these three factors are interlinked and mutually dependent.

We also identified five key drivers to achieve this mission, namely culture, leadership and governance, continuous learning, insight and improvement, involvement of service users and carers, workforce safety and well-being and community safety. We included the concept of "no safe care without equitable safe care" as a foundational principle.



In April 2023, the Safety Plan was launched at a shared learning event led by a collaboration of service users, safety experts, our Director of Safety and Assistant Director for Quality Improvement. Since this time work has progressed rapidly on all of our year one objectives, along with many other aspects of the plan. We have also seen a changing national and local landscape since the launch, which has shaped our priorities and focus on the year. For example, we have needed to proactively plan for, and respond rapidly to industrial action that has taken place over the year, and we have taken learning from reviews of "closed cultures" across the NHS and from the homicides at Countess of Chester Hospital to shape the way we lead for safer care.

Progress on our Year One Objectives

Progress Summary

Primary Driver	Idea	Status	Impact
Leadership, Governance & Culture	**Develop & Share Vision & Principles**	Commenced, ongoing work	Positive
	Improve Safety Reporting Quality	Ongoing. Making progress.	Positive
	Appoint, train & support Directorate Safety Specialists	Seven new PSSes	Positive
	Develop Safety expertise, safety skills and capacity	Started, more work needed	Partial
	Define Safety Priorities	Complete for year 1	Uncertain
	Introduce & Implement Just Culture Policy	Discussions stage	N/A
Learning, Insight & Improvement	**Move from RCA to Systems approach to learning from incidents**	Commenced	Positive
	Create trust safety shared learning network & link these with local, national and international networks.	Good progress	Positive
	Introduce suite of new learning from safety methods	Commenced	Positive
	Establish system for cascading & sharing safety learning	Progress made	Positive
	Introduce Safety education and training for all staff, including NHS Safety Syllabus	Commenced. Needs more resource/support	Varied
	Transition to new National Incident Reporting System (LFPSE)	Complete	Concerning impact on reporting culture
	Develop Safety intranet platform & learning library	Commenced – needs further development	Partial
	Continue to apply QI methodology and work with system partners to support improvement in key safety priority areas	In progress	Ongoing
	Apply QI to Incident Review work and actions	Commenced	Not yet
	Safety Action teams with use of QI to address specific priority areas/issues	Commenced	Not yet
Involvement of patients, carers and families	**Involve patients/carers in codesign of safety mission, principles & strategy**	Complete	Positive
	Establish competencies, principles, expectations and training for all staff in engagement of patients, carers and families in safety	Commenced. Needs more work	Not yet
	Introduce dedicated people participation roles within core safety team and for each directorate.	Partial	Early stage – positive so far
	Include patients and carers in all safety governance and improvement forums.	Commenced	Positive
Workforce Safety & well-being	**Continue to apply a QI approach to improving overall workforce safety co-created with workforce with clear aims and priorities**	Ongoing	See people plan
	Continue to address burnout and well-being via Joy in Work approach, incorporating a trauma-informed approach to well-being	Ongoing	
	Safer Staffing QI work focused on retention, reduction of temporary staff and safe staffing levels for all areas	Established & ongoing	
	Support the ELFT People plan with focus on looking after our people, new ways of working, planning for future and belonging	Commenced & ongoing	

To support the above programme of work, we chose four main focus areas for the first year of the plan, based on the expectations of the NHS Patient Safety Strategy, the ELFT internal Safety review and our own assessment of progress to date. These objectives were chosen as potential enablers and catalysts for the changes in culture and systems that we see as fundamental to safety improvement, as per the driver diagram above. The year one objectives were:

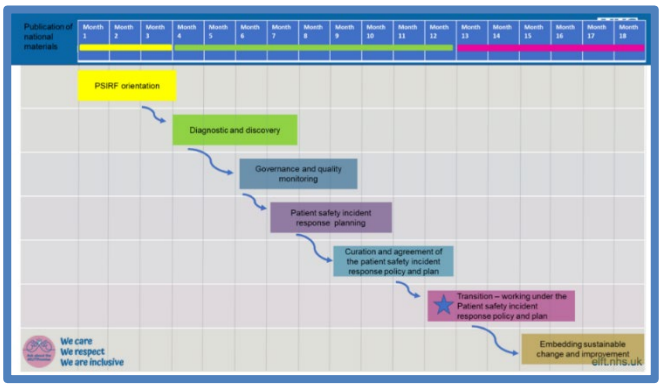
- Transition from the Serious Incident Framework to the new Patient Safety Incident Response Framework (PSIRF):
- Transition to a new incident Reporting System, InPhase, and incorporating the new NHSE national learning from Safety Events system (LFPSE):
- Embedding of the NHS Patient Safety Syllabus.
- Greater involvement of Service users and carers.

Transition to the NHS Patient Safety Incident Response Framework (PSIRF)

PSIRF is the new NHS approach to responding to patient safety incidents, for the purpose of learning and improving patient safety. It was published in 2022 and replaces the Serious Incident Framework and makes no distinction between "patients safety incidents" and "serious incidents". Whilst there is no strict deadline, PSIRF is a contractual requirement for NHS acute, mental health, community healthcare providers, and secondary care NHS services have been encouraged to transition to PSIRF by the end of 2023. It is not yet a requirement for primary care, but primary care is invited to adopt the approach if they wish.

PSIRF is a significant transformation towards a data-driven and coordinated approach to patient safety. Advocating for compassionate engagement with those affected and also embedding incident response within a systems and improvement focussed approach.

Figure 1 – NHSE PSIRF Implementation Timeline



Over the course of the year the trust have progressed well through the preparation stages of PSIRF (as recommended by NHSE and shown within figure 1), under the leadership of our Chief Medical Officer, Director of Safety and Director of Nursing (London MH). A PSIRF implementation lead was appointed and helped us progress through orientation, diagnosis and discovery, creation of a governance and quality monitoring structure and curation of the PSIRF policy and plan. During this period we have worked closely with system partners in both ICBs, NHSE and our local staff and service users to identify the most effective way to tailor PSIRF to our local setting. We have also gained learning from early adopters and from trusts who have applied PRISF to similar services, and we have taken advice from our legal team and local coroners regarding application of PSIRF to our unexpected deaths.

Work undertaken to progress towards PSIRF has included:

- Initiatives to clear Serious Incident Backlog and imporve SI action completion, to free up capacity to focus on PSIRF;
- Oversight by PSIRF Implementation Steering Team;
- Codesign work to engage colleagues, service users and carers at all levels via trust PSIRF visioning event, CEO discussion forum, Safety Forum workshops surveys of staff and regular PSIRF open forums with ELFT and with external partners.
- Coroners' engagement process commenced, led by our Chief Medical Officer.
- Training (see section below)
- Subgroup work on key areas including:
    - alignment of safety review with Quality Improvement
    - Just Culture improvement work
    - incident pathway development
    - involvement and support of those affected inlucding service users, carers and staff.
    - Work to develop our PSIRF Intranet resources.

We are now in the transition phase, having gone live with a soft launch in December, where we introduced:

- A new incident management pathway with strengthened local and senior involvement in a new decision-making panel whose aim is to support proportionate learning response and effective use of new learning methods.
- After Action Review as an additional learning method after safety incidents.

- Patient Safety Incident Investigations, in place of Serious Incident Reviews, using a systems approach rather than traditional Root Cause Analysis.

The full draft ELFT PSIRF implementation plan and progress can be seen in Appendix 3.

Transition to new Incident Reporting System, InPhase, and engagement with the NHS National Learning from Patient Safety Events System (LFPSE)

Historically the trust has used the Datix system for incident reporting and exported all patient safety incidents to the NRLS (in line with the national NHS Contract). From 30th September 2023, all Trusts were required to implement NHSEs' replacement system LFPSE. The new LFPSE system includes a predefined list of mandatory questions included within the Trust's Incident Reporting Form. The mandated questions apply to all healthcare providers including the acute sector and independent contractors providing a national data set aiming to introduce improved capabilities for the analysis of patient safety events occurring across healthcare, using the latest technology, to offer a greater depth of insight and learning that are more relevant to the current NHS environment. In order to support this requirement and to support further improvement in our systems more widely, the trust chose to transition from Datix to InPhase over the course of 2023.

Alongside incident reporting, the system includes multiple modules forming a combined quality management system. This also enabled the trust to embed NHS England's mandated Learn From Patient Safety Events (LFPSE) question bank within our incident reporting system, enabling patient safety incidents to be automatically submitted to NHS England's Learn From Patient Safety Events (LFPSE) system for the purpose of national sharing of learning.

Legacy actions are being uploaded onto the new system and the Feedback, CAS and Legal applications are now live, and other modules due to be introduced in a phased way over the next three months. The project is overseen by an Implementation Group with additional short life working groups established to review risk register form and management processes and to to review actions application, format, quality and governance. A risk register relating to the transition is in place, in recognition of the potential for the transition to impact on our safety reporting culture, practice and systems. Huddle meetings also continue with a number of Trusts already live with INPHASE to ensure learning is identified from their experiences.

Staff support in managing the transition has been provided via the ELFT Learning Academy page where the latest training materials are uploaded and there is a weekly on line drop-in clinic available to all staff to raise any questions or queries. A weekly online drop-in clinic is also available to staff who require assistance with report building. To date over 100 training sessions have also been delivered, attended by over 1000 staff, further sessions are scheduled for reporters and managers. InPhase information has been added to the Trusts Induction Pack for Corporate Induction for new starters.

Incident reporting data has been monitored in detail over the transition, and there is a recognition that there has been an impact on the number of incidents being reported. Staff feedback is being sought via training sessions and enquiries received into the INPHASE support email box. Responses received to date remain positive in respect of the system and accessibility. However staff do report challenges particularly in relation to the clarity, tone and length of the mandated LFPSE question bank and also in relation to the ease of report building.

Development of ELFT Staff skills in Patient Safety, including engagement with the National Patient Safety Syllabus

During the year, ELFT launched **five safety related e-modules** on the learning academy platform to support implementation of the NHS Safety strategy and to develop the baseline skills of our workforce. Module one is aimed at all staff (with a supplementary module aimed at boards and senior leaders) and module two is for those staff in roles where more in-depth knowledge is required. Other modules are available for staff to extend their human factors knowledge and digital safety awareness.

In order to prioritise positive engagement with the learning material at this early stage of our safety plan, the core modules have not become mandated, either nationally or locally. We have also been mindful of the need to prioritise the engagement with PSIRF trainings (below) in the last year, which arguably provide a stronger safety grounding and impact. This has meant, however, that e-module uptake has been relatively slow with 243 staff having now completed at least one of these modules since their launch. Additional modules added in recent months include e-modules focussed on human factors and a further module introducing the basics of digital safety.

We also have provided a programme of **F2F and remote internal and external PSIRF staff training**, in line with NHSE requirements, to prepare for the transition, including modules on oversight, engaging and involving those affected, applying systems approaches to safety and conducting After Action Reviews. 240 staff in key roles have completed PSIRF trainings, and over 175 have had either formal or introductory training in conducting After Action Reviews, with a new ELFT internal AAR facilitator training launched in January.

Our six Patient Safety Specialists have also commenced the one-year NHSE Level 3-4 One Year Specialist Patient Safety training with Loughborough University.

We have also started upskilling the ELFT workforce in patient safety, with human factors content now embedded in a number of our leadership development modules and our Quality Improvement Leaders Programme.

Other patient safety training provided to our staff during the year include:

- an externally provided bespoke one-day human factors training for our QI, QA and performance teams
- PSIRF introduction for Infection, Prevention and Control team
- Inclusion of a patient safety module within our aspiring band 6 leaders and ward manager development programmes.
- External Point of Care Foundation training of 8 ELFT Schwarz Round facilitators, with 5 more booked to complete within months ahead.

Involvement of Service Users, Carers and families

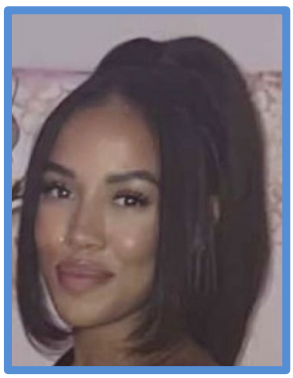
Involvement of service users and carers is a key aspect of our safety plan work with an emphasis on supporting service users to lead on their own safety and amplifying the service user and carer voice both within our safety systems and safety culture. For example, during the year actions have been taken to add in a prompt in safety huddles to consider carer concerns, and we have added a question on safety culture to our ELFT patient survey to give us the service user and carer perspective on our safety cultures.

Our PSIRF training has included a module on involving and supporting those affected by safety incidents, and as part of our safety plan, EFLT have also agreed to be a pilot site for “Making Families Count” training. The content is provided by making families count and co-produced with Oxleas staff and service users and their families and the training will involve 5 e-learning modules that will be completed by around 70-80 staff members.

We have now established a working group, with support from colleagues in QI, to develop and test a range of ideas to improve our involvement of service users and carers to improve safety. This will be an objective within year 2 of the plan and will be reported on thereafter.

Patient Safety Partners

Within the year we have successfully recruited our first two Patient Safety Partners, who have now been in post for three months and are actively involved in our Safety walkarounds, safety forums, PSIRF transformation work and improvement work, bringing further emphasis and support for involving service users and carers for safety. Our PSPs are also involved in Carer Strategy working group and the ELFT patient experience forum, to ensure safety is a focus in both these areas of parallel work.



Our first Patient Safety Partners:
Irum Rela and Rachel Williams

Progress on our Longer-Term Ambitions

Culture, leadership & Governance

Over the year, ELFT has maintained a strong structure for safety leadership, governance & oversight both at a board and executive team level, within directorates and with the support of our dedicated governance & risk team. The well-embedded and robust Trust wide safety huddle structures, local safety leadership and forums & executive walkaround programme have been ongoing.

Relevant safety information has been presented to the Trust Board regularly within the Integrated Performance Report, the Quality Report, the People Plan Report, and the Safer Staffing Report. The Quality Assurance Committee also are sighted on the Directorate Quality & Safety Reports and the Quality Assurance Dashboard. The Quality Committee and Patient Safety Forum have continued to oversee reports on all key safety areas. Safety reporting has been strengthened this year, with the introduction of the QAC integrated safety report, a new Patient Safety Forum exception report to the Quality Committee and embedding of QAC Safety material into the board Quality Report.

This year, the trust has gone further in developing safety leadership, with the commencement of the first Director of Safety, who sits on our trust board and has been leading on developing the new Safety Plan, and also with the introduction of a new head of incidents role and a PSIRF Lead role.

In February we will hold our first meeting of our new Safety Plan Oversight Group, led jointly by our executive lead for Safety, and key safety leaders in the organisation with external input from patient safety expert, Suzette Woodward. The group will continue to meet regularly to provide strategic oversight, assurance, and support for the Safety Plan.

Governance has also been strengthened in a number of ways including:

- Strengthening of our safety incident decision-making and review processes, to enhance quality, reliability, and transparency, including a new daily incident review huddle and PSIRF decision-making panel.
- Transformation of the trust Serious Incident Grading panel into our new PSIRF Sign-Off Panel, with new inclusion of co-reviewers, report authors, Patient Safety Partners and directorate colleagues.
- Introduction of a new executive-led system for Prevention of Future Deaths review and sign-off
- Expanded membership of Patient Safety Forum to include FTSU guardian, directorate quality governance leads, QI colleagues, subject matter leads/experts, and performance team colleagues.
- Representation of ELFT safety leadership at ICB-level safety specialist, safety and PSIRF forums.

The monthly Trust **Patient Safety Forum** has met monthly over the course of this year and continues to oversee work to embed our Patient Safety Plan alongside Trust wide Safety improvement priority

work which is identified by triangulating themes from triangulated safety data alongside soft intelligence from staff and service users, huddle system, operational forums & walkarounds.

This year the Safety forum also benefitted from a review workshop with the input of the IHI, which also served as an opportunity for further co-design of the Safety Plan with trust clinical leaders and colleagues in safety roles.

Standing items at the forum this year have include updates and progress on the Safety Plan, involvement of services users & carers, Updates on PSIRF and LFPSE, learning from CQC themes and PFD reports, Directorate improvement work.

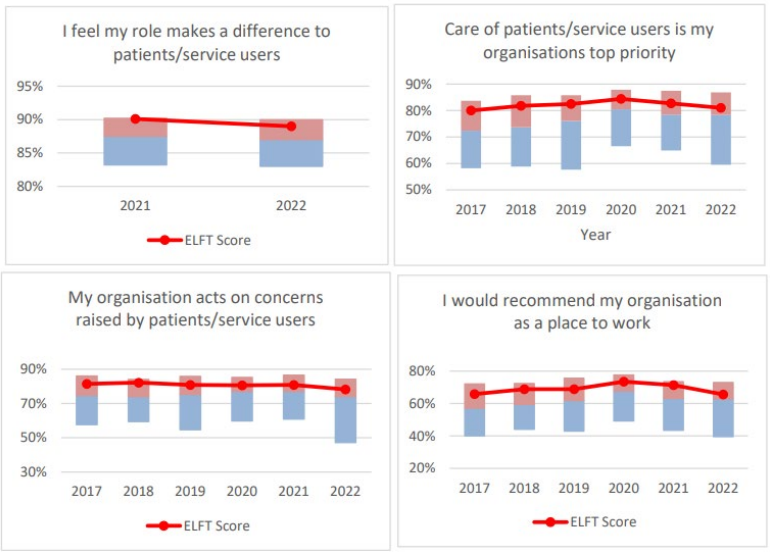
Trustwide safety improvement work on a wide range of priority topics have also been supported by the forum this year such as Violence & aggression, Transitions, therapeutic engagement and observation, suicide prevention, physical health, medicines safety and resuscitation.

The forum has also introduced a section dedicated to cascading sharing of learning, which this year has included learning from inquests, FTSU, Care Opinions, LEDER, safeguarding, thematic reviews and serious incidents.

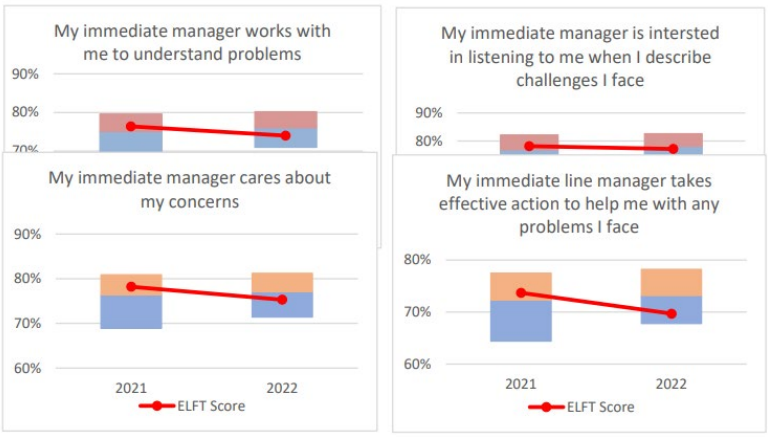
In the year ahead, we will be inviting our complaints team to also contribute relevant safety data and learning to the forum and we will be including learning from our new learning methods, such as cluster reviews and After Action Reviews.

Strengthening Leadership at ELFT:

Staff feedback via the annual NHS Staff Survey paints a reasonably positive picture of leadership and culture at ELFT.



The questions that relate to immediate line managers are less positive, and offer an opportunity for improvement. These questions were only introduced in 2021, so there are only two data points for us to learn from:



Whilst further work is required to fully understand the survey results set out above, and the range of factors that have caused the shift in experience they illustrate, there is work ongoing by the People & Culture department to promote a compassionate leadership culture, and enable leaders to hear and respond to the needs of their staff. The ELFT Learning Academy has a range of training courses for leaders and managers, current and aspiring. Some focus on practical things such as HR process (eg. respectful resolution: managing grievances and complaints) and others are more wide ranging and developmental such as ELFT Lead (for Band 5-7 staff), and ELFT Senior Leaders Programme (for those aspiring to Associate Director roles). By including modules on values and strengths, emotional agility, team dynamics and trauma informed care, these courses foster the compassionate leadership culture that promotes psychological safety, the ability to raise concerns and a willingness to act on them.

Psychological safety, in particular, is a key element in the safety module of our leadership development programmes, and across all our quality improvement training. A series of conversations is planned with our senior leaders across the Trust, to explore this further and consider how we can best support our clinical and team supervisors to be able to create safe spaces, encourage people to share concerns and issues, and to then be able to take effective action on what they hear. Where there is conflict, or unhealthy team dynamics, support is available for teams and leaders through the People & Culture department.

Over the year, the Trust's senior OD consultant has facilitated team conversations around the Trust aimed at resolving conflict and improving team dynamics. We know that whilst we have built some belief and understanding around aspects of leadership that we value at ELFT, there remains variation in the extent to which this is applied in practice.

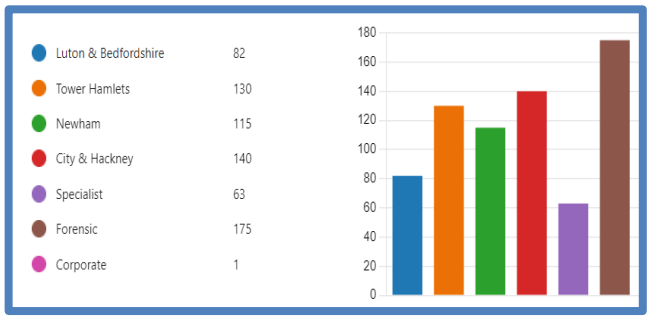
Over the past nine months, extensive work has also been undertaken, led by the interim Chief Executive and Chief Quality Officer, to co-design a common understanding of leadership at ELFT, clarifying the leadership behaviours that link to this, and creating a way for us to measure and improve our leadership across the organisation. This was presented to the Board in May, and work is now being undertaken to develop and implement the plan to embed this across the organisation. The implementation plan is already aiming to address some of the gaps and weaknesses in current systems – for example, structured approaches to ensuring local clinical and service leaders are visible and can hear directly from teams (directorate-level walkarounds), supporting every team to adopt the six practices of healthy, happy teams (supportive supervision using the Trialog tool, regular away days, huddles, use of data, people participation, quality improvement), developing bespoke leadership support for first-line managers, creating ways for leaders to routinely reflect on behaviours based on feedback from a range of sources.

Safety Culture Improvement Work:

A programme of dedicated work to improve safety cultures across the trust has been taking place during 2023. This year's progress includes development and introduction of a Safety Culture In-Patient Team Staff Self-Assessment tool which is now embedded within our annual QCQ readiness programme for all in-patient wards, with the aim of improving awareness, triggering Safety Culture

conversations and improvement work. She charts below for response levels from directorates in this first round of tool use. See figure 1 below, which demonstrates engagement from directorates in the first round of the process. The results for this first year will form the baseline of an ongoing measure for teams to track, to support improvement work.

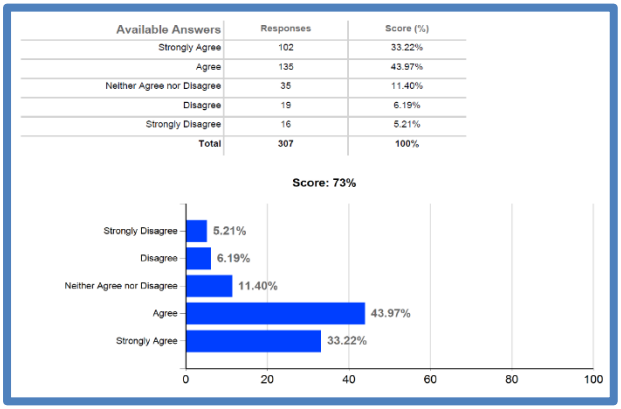
Figure 2 - Safety Culture Tool – Responses from Directorates since launch

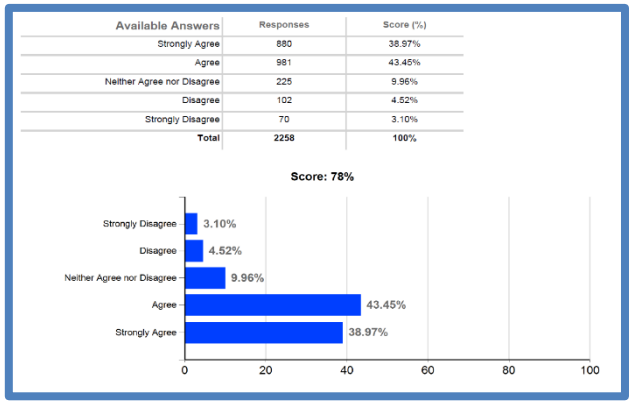


We are currently in the process of evaluating the impact of the tool, to inform further development, codesign and potential application more widely within the trust e.g., within community teams. We also intend to work towards incorporation of our service-user reported measures of safety culture (e.g., using new patient survey safety culture question) to provide services with a more triangulated picture of their safety culture.

We are working on improved triangulation of service user experience data with our staff reported measures, and to support this have added a question into our patient survey specifically relating to safety culture. Initial results (figure 4a and b below) so far indicate strong culture in terms of service user feeling safe to speak up. Our intention is to share this data in an ongoing stratified way at a directorate level regularly to support ongoing safety culture improvement work.

Figure 4a (left – in-patients only) and 4b (right – all patients only) – Patient Survey Results 2023 "I feel safe to raise concerns about my care





Maintaining and Developing our Just Culture

The Senior People Relations Team are currently reviewing the disciplinary process and documentation to further incorporate the principles of a Just Culture. We already have a fair treatment process where managers are required to consider a number of aspects before deciding to proceed with a formal process but this is being strengthened to give greater guidance as to when it would be appropriate to proceed to a formal investigation and how many situations can be managed at an informal level and consideration of whether Disciplinary is the correct policy to be following.

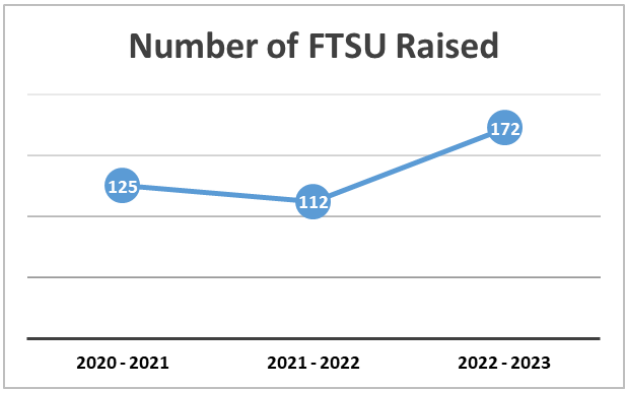
The intention is that this amendment will ensure the fair treatment process is consistently applied in all cases. Once the amendments are finalised, we will update our manager training and the Advisors will work with the senior manager completing the form to ensure consistency and in turn the implementation of a Just Culture. We have recently held two sets of training for managers, one for Investigating Officers and another for Hearing Chairs, to support the quality of investigations. We will be continuing to deliver this training on an ongoing basis.

We have a People Liaison Officer in post who phones staff involved in process to undertake welfare calls. We are currently seeking feedback on the benefits of these calls and looking at how we can monitor the effectiveness going forward. A new Dignity at work policy has been reviewed but is just awaiting a final review before being ratified. This updated policy incorporates our respectful resolution pathway and once ratified we will be updating our manager training to reflect this, although we do already touch on respectful resolution in the training. Respectful Resolution was introduced in the organisation a few years ago but we plan to re-launch it with this policy because until now it has not been formally linked to a policy and therefore has had limited impact. As part of the roll-out of the new policy we will be working with People Business Partners to undertake further adhoc training at directorate levels.

Freedom to Speak Up

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015). These recommendations were made as Sir Robert Francis found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result. The Trust appointed to the FTSUG role in October 2017. The service is run by the Freedom to Speak Up Guardian. There are a number of Freedom to Speak Up Champions across the Trust, who promote 'Speaking Up' and signpost colleagues to the support available if they wish to raise a concern.

Freedom to Speak Guardians are regulated by the National Guardian's Office. The National Guardian's Office is an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The office is not a regulator, but is jointly funded by the CQC, NHS England and Improvement.



Freedom to Speak Up received 172 concerns from 1st April 2022 to 31st March 2023. This is an increase of 53.6% on the previous reporting year. The broad categories (reported to the National Guardian's Office (NGO)) under which these cases fall are:

- Number of cases raised anonymously.
- Patient Safety/Quality of Care
- Worker Safety and/or Worker Wellbeing
- Bullying or Harassment
- Inappropriate attitudes or behaviours
- Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up is indicated.

The NGO also requests data on the numbers of cases brought by professional groups.

The highest number of cases fall under Processes/Organisational Structure/ Other, with such examples being concerns around work areas, HR processes, training/professional development, fraud, service policy, recruitment, disability and impact and on site security.
The second highest number of cases falls under Worker Safety and/or Worker Wellbeing, with such examples being working environment, staffing levels, unresolved issues with staff, management behaviours and impact on staff, safety at work, financial stress, undermining and victimisation.
The highest number of cases from professional groups were Nursing and Midwifery registered (47 cases) and Administrative and Clerical (46 cases).

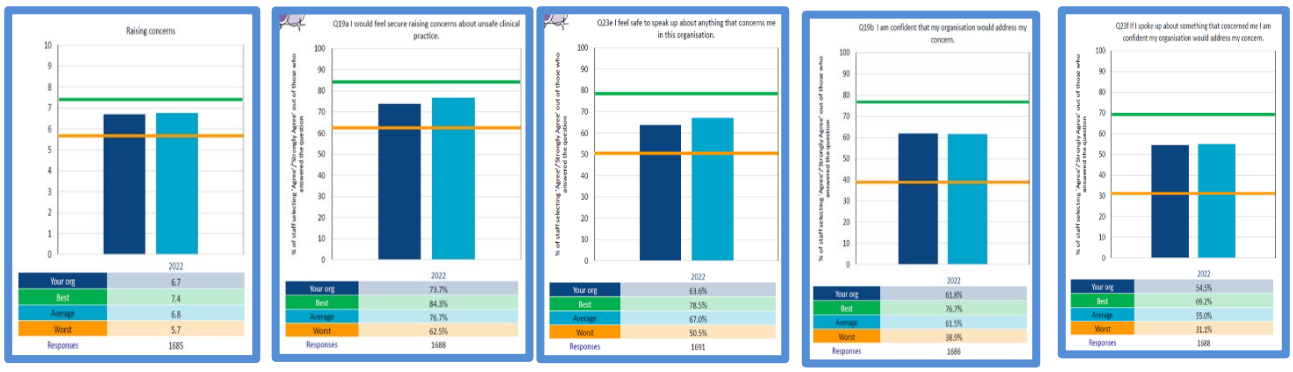
Learning Themes from FTSU

37% of cases raised involved concerns relating to Processes/Organisational Structure/ Other, with such examples being concerns around work areas, People & Culture processes, training/professional development, fraud, service policy, recruitment, disability and impact and on site security. 19.1% of cases raised involved concerns relating to Worker Safety and/or Worker Wellbeing, with such examples being working environment, staffing levels, unresolved issues with staff, management behaviours and impact on staff, safety at work, financial stress, undermining and victimisation. All concerns raised are escalated to Service Directors, senior managers and/or People & Culture, as appropriate to the nature of the concern. The work completed to resolve the concerns are fed back where possible (not always possible when raised anonymously).

We continued to monitor concerns directly related to COVID-19. Those concerns have decreased significantly since the pandemic began in 2020. In this reporting period, 3 of the concerns raised were linked to COVID-19.

NHS Staff Survey 2022 – Raising Concerns

The NHS Staff Survey was complete by 1699 staff, giving a response rate of 33%. ELFT is benchmarked against Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, of which there are 51 organisations in the group. The questions related to raising concerns fall under the People Promise element “We each have a voice that counts”.

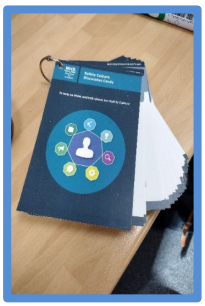


ELFT is just below the overall average of the benchmarking groups for the Promise Element 3 – we each have a voice that counts. In 2021, ELFT was 6.9. Nationally, the sub-score for raising concerns declined from 6.5 in 2021 to 6.4 this year. Further NHS survey data charts from 2022, showing data on our culture of speaking up can be seen above. For questions relating to safety and confidence speaking up, our results show us just below the national average, with more work to be done to address this area. There is also work to be done to gain staff confidence around our response to concerns raised.

FTSU improvement work undertaken during the year:

- The Speaking Up & Whistleblowing Policy was reviewed and updated to reflect the revised national Freedom to Speak Up policy released in 2022 by NHSEI in conjunction with NGO. The updated policy is designed to support staff by showing them the many ways in which concerns can be raised and escalated, and support resolution of concerns by managers wherever possible.
- The Speaking Up & Whistleblowing Policy was ratified by the Joint Staff Committee November 2022.
- A document titled 'Signposting – Where to bring your concern or complaint in ELFT' was created and shared with staff to highlight the many ways in which we can raise/escalate concerns, signposting key contacts and policies as well as the clear parameters of FTSU and People & Culture processes.
- Respectful Resolution was developed by the Trust in response to the number of bullying and harassment cases being raised (directly with People & Culture, managers and FTSU). Respectful Resolution is a toolkit to support with resolving these concerns before they become a formal process (Dignity at Work). The work to embed this across the Trust is ongoing.

ELFT Safety Learning & Safety Plan Launch Event

Safety Culture was also the focus of our annual trust Safety Learning Event, with external speakers on the topic, SWOT analysis using NHS Scotland Safety Culture Discussion Cards, and group work to consider how leaders can support the ongoing improvement around this. A Safety culture is also at the heart of the new ELFT leadership framework, which includes behavioural expectations for leaders at all levels, in support of strong safety cultures. We are also working on embedding a restorative just culture approach, with training led by our human resources team, and elements of a restorative approach being woven into our PSIRF approach to learning from safety.

Safety Culture as a standing item within our safety reporting, our new Safety newsletter and features strongly within our new safety intranet platform. We have also gained external guidance on developing our safety culture from experts in the field, including Professor Jane O'Hara, Derek Feely, Jane Carthey and Suzette Woodward.

Promoting a culture of psychological safety - Embedding Schwarz Rounds

Schwarz Rounds are structured forums where staff (both clinical and non-clinical) come together to regularly discuss the emotional and social aspects of working in healthcare, in a psychologically safe space. They focus on the challenges and rewards intrinsic to care provision, rather than clinical

aspects or problem solving. Rounds can help staff feel more supported in their jobs, and evidence shows that those who attend rounds feel less stressed and isolated with increased insight and appreciation for each others' roles. The also reduce hierarchies between staff and focus attention on relational and compassionate aspects of care. The underlying premise for Rounds is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work.

Schwarz Rounds have now started being held within ELFT community health services. Newham and Tower Hamlets have held their first round, with excellent attendance and engagement of local teams, and Luton and Bedfordshire have their round booked to take place next month. Feedback is being collected from those who attend. For example, from the TH Schwartz Round, 56% of Attendees rated the overall experience as 'Excellent', 36% as 'Exceptional' & 2% as 'Good'.

The rounds are supported by an active steering group with sponsorship by our director of nursing for CHS and Director of Safety with progress and impact reported into our patient safety forum. Once embedded within Community Health Services there is an intention to consider rounds within other directorates and also to introduce rounds bringing together staff from across the trust, to share learning and bring staff together from a wide range of services.

Continuous Learning & Improvement

Sharing of safety learning has been the focus of a key quality improvement initiative, led by our PSIRF implementation lead and our Tower Hamlets governance facilitator, over the first year of our plan (see figure 3 for Driver Diagram). Colleagues have worked together to improve attendance at our learning lessons seminars (see figure 4 below), which has had a substantial impact on the number of staff who learn from our safety reviews. We have also developed new ways of sharing learning from significant safety incidents, such as via learning briefings and cascaded learning points from our Safety Incident Committee (see figures 5a below). We have also launched a Safety Newsletter which has attracted consistently high levels of readership (See figure 5b). These resources have been well-received, and work is ongoing to make them accessible to staff more widely via our new Safety intranet pages.

Figure 3 – Driver Diagram for Safety Learning Improvement QI Project

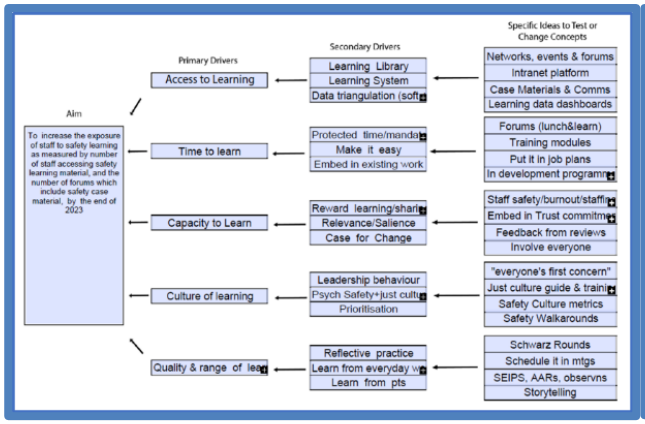


Figure 5 – Attendance at ELFT Safety Learning Lessons Seminars

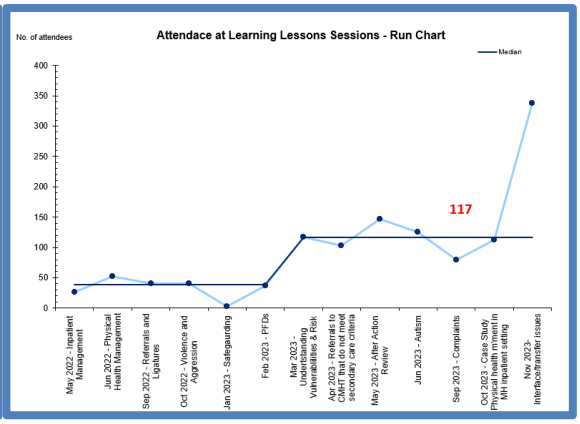
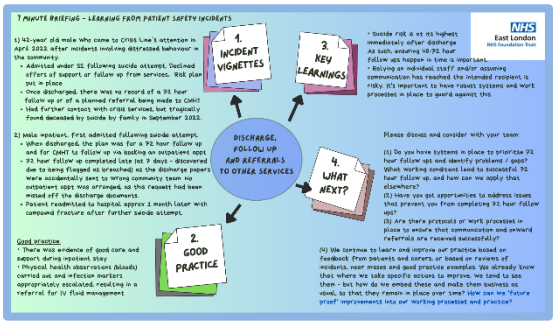


Figure 5a – Examples of Safety Learning Briefings shared across ELFT in 2023



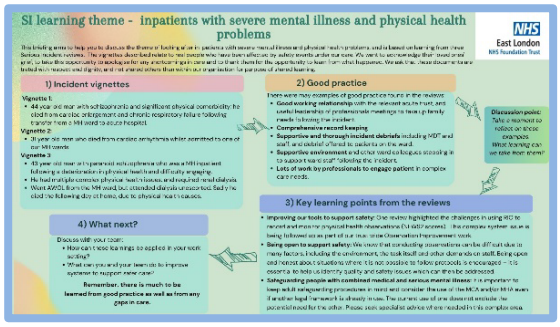
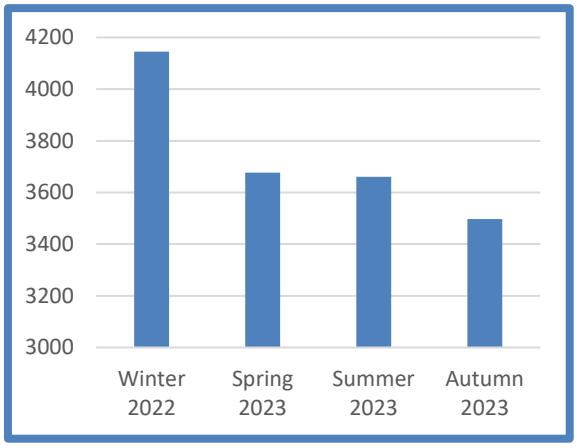


Figure 5b. Safety Newletter Readership



New Safety Learning Methods

Learning has been the focus of much of our PSIRF improvement work, and in particular in the work to develop new methods for learning from safety, in line with NHSE recommendations.

We have introduced After Actions Reviews, with at least 30 being conducted across the organisation within the last three months as part of the pilot stage, and many more planned and/or anticipated as AAR becomes one of our recommended safety responses as part of our new PSIRF plan.

Feedback from staff involved in After Action Reviews is now being collected and initial results show high levels of engagement, satisfaction and learning potential for After Action Review participants (see figure 6 below).

Figure 6 - After Action Review Staff feedback ratings:

Question	Average Rating (likert scale 0-5, where 0 was poor and 5 excellent)
Please rate your overall experience	4.23
Please rate your Learning compared to what they expected	4.08
Please tell us the extent to which whether participating was valuable use of time?	4.31
Please rate the opportunity you had to contribute?	4.38
Please tell us how much what you learnt today will help you with your work in future	4.19

Other safety learning methods are also being piloted, including a number of safety learning reviews making use of frontline observations work to learn better from “Work-as-Done”, using the Systems Engineering Initiative for Patient Safety (SEIPS) framework. In the year ahead we anticipate also bringing in the use of MDT Safety Reviews and Swarm Huddles.

Work is taking place in parallel to enhance our focus on triangulated insight and improved collation, analysis and presentation of safety data via integrated safety reporting and our new safety

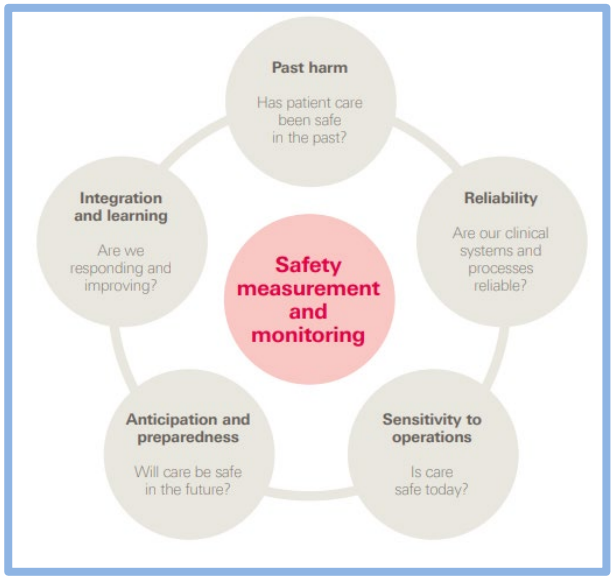
triangulation huddle, where colleagues from our risk and governance, complaints, PALS, FTSU and legal teams review safety data in a regular way to identify new themes and issues, which can then be shared for further action via our safety forum. We are also working with our informatics colleagues to develop dashboards of our key safety metrics to improve ease of monitoring for our safety data.

Over the year our safety staff have worked to improve communication and system working for safety via system safety networks across both our Integrated Care Boards and sharing learning with safety colleagues via NHSE Safety Specialist and other Safety networks at a national level. Our director of safety has also supported board development workshops and governor's meetings on safety topics, and has been active at trust board meetings on a regular basis to ensure dialogue and sharing of emerging themes with executive and non-executive colleagues.

Measurement and Monitoring of Safety

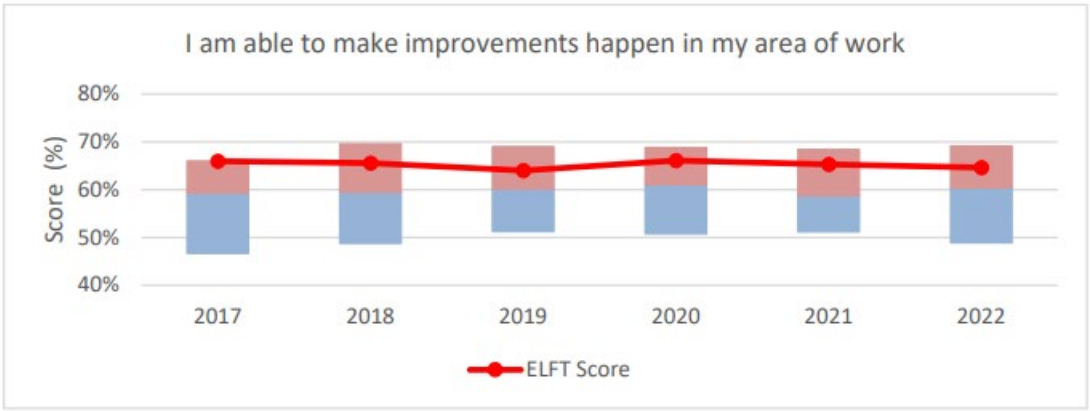
Safety, as a complex dynamic non-entity, is known to be notoriously difficult to measure (Busch et al, 2019) within healthcare. Over the first year of the plan, our team have spent time reviewing our existing safety reporting and monitoring measures, against the five key areas within the Healthcare Foundation framework for measuring and monitoring safety, 2014 (see figure 7) and against what our staff and service users see as meaningful outcomes and measures. This has led to iterative improvements in the data being used to report on our safety work and outcomes, shifting towards more meaningful measures of improvement, learning and reliability of our safety systems. Our Director of Patient Safety has also been contributing to the University of Leeds NIHR Response Study on this topic, as an active panel member, as a means of bringing collective expertise and experience to bear in this complex area and we hope to have access to results to make use of later in 2024.

Figure 7 – Healthcare Foundation framework for measuring and monitoring safety, 2014



Safety Improvement Focus

A commitment to continuous improvement is integral to the culture at ELFT, with a strong sense of agency and autonomy for everyone working together in identifying and addressing problems that arise, as demonstrated by consistently positive NHS Staff Survey results in this area (see below). This confidence in being able to make change happen is supported by having a unified set of improvement tools and a consistent method to tackle complex quality issues, and enabled a more open and curious culture.



This year ELFT undertook an in-depth review of our Safety themes, triangulating three years of data from a range of sources and also staff and service user views, to collaboratively identify our safety improvement priority areas (see figure 8 below). A gap analysis was conducted around existing

safety improvement work, and where appropriate new improvement work has been recommended/commenced.

Figure 8 – Safety Improvement Priority Areas as determined by triangulated safety data.

Triangulated Safety Concerns/Themes	Staff	Service Users	SI Reviews	Complaints	Incident Data	48hr reports
Access/Delays	■		■	■		
Deaths	■		■		■	■
Communication with Sus and carers		■	■	■		
Clinical Care & Mx Issues		■	■	■		
Partnership/transition/discharge	■	■	■			
Physical Health Care	■				■	■
Violence & Aggression	■				■	■
Pressure Ulcers	■				■	■
Staffing Shortages	■	■				
Staff training		■	■			
Staff Safety & Well-being	■					
Self-Harm	■				■	
Medication Issues	■				■	

Figure 9 – Safe Improvement Priorities as ranked by ELFT Safety Leadership Group

Our safety priority areas have been designed into our new PSIRF Plan and progress on each is being tracked via our Safety forum alongside other improvement areas which have emerged as priorities over the year.

Example of Trustwide Safety Improvement Work – ELFT In-Patient Quality and Safety Improvement Programme

The Inpatient Quality and Safety improvement programme began in November 2022, and represents our largest ever quality improvement programme. All inpatient units are engaged in work to reliably implement the safety culture bundle, and test creative ideas to improve the reliability of observations and improve therapeutic engagement.

The safety culture bundle consists of the Broset Violence Checklist (BVC), a dynamic risk assessment tool designed to predict incidents of violence; the Safety Cross, a daily data collection tool to enhance transparency and data ownership across the ward; Safety Huddles, which are structured, safe, and brief meetings to convene, share concerns, and plan action; and finally, Community meetings for service users and staff to discuss safety on the ward. Teams are currently being supported in developing plans to implement these four elements across all inpatient services.

A key component of this work is the use of visual management boards. These are quality control tools that consolidate data on all aspects of the safety culture bundle. Directorates are being supported in developing these boards locally to suit their context. City and Hackney, Tower Hamlets, and East Ham Care Centre all have boards in place (see examples below). Within Forensics, boards have been established, but there is significant variation in their function and appearance, staff are working to standardise these for consistency. All teams across the Trust will also be supported to actively incorporate the boards into regular practice.

Following an initial phase of local innovation, development and testing of a wide range of creative ideas to improve therapeutic engagement and observations, teams are currently being supported to test the three change ideas that have had the greatest impact, under different conditions across the Trust. These include a board relay, where staff hand over a physical board with observation documentation; zonal observations, where nursing staff are assigned a zone to engage with service users; and the use of Life Skills recovery workers on Twilight shifts (2 - 10pm) to conduct therapeutic activities with service users. The team at the original test site has produced standard guidance to assist other wards in testing for scale-up.

Life Skills Recovery Workers on twilight shifts are being tested across most directorates. Feedback from staff and service users has highlighted a positive impact so far. In Luton and Bedford, two wards have seen reductions in the number of incidents of violence and aggression. On Townsend Ward, incidents have reduced by 43%, from 2.62 per week to 1.5. As part of the testing process, some

units have identified a need to consider how staff can travel home safely after a later shift. Some units are now considering how life skills recovery workers can take on some responsibilities of other staff on the ward, with the intention of freeing up nursing staff for therapeutic interventions.

Zonal observations are being tested across nine wards, mainly in Older Adult or Psychiatric Intensive Care Units (PICU). Theories suggest that the layout and higher staffing levels of these wards might provide a context in which this intervention could have most impact. Clerkenwell Ward in Forensics has seen a 72% reduction in incidents of sexual violence from 1.38 a month to 0.38 (below) a month.

The use of a board relay to enhance reliability of completion of observations is currently being tested across all directorates. In some wards, staff have reported challenges in carrying the board, especially when they are required to support service users or colleagues during times of high acuity. Alternatives to the board are being explored in these areas.

Across the Trust, there has been an increase in the reliability with which general observations are carried out, from a baseline of 98.4% to 99.6%

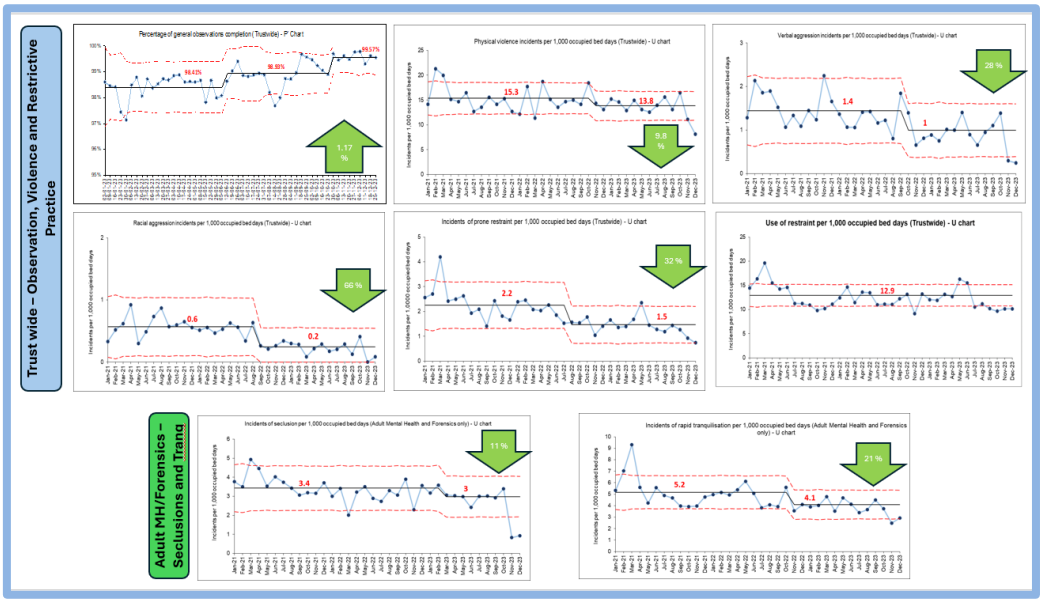
We are also seeing improvement at scale on a range of safety measures, which coincides with the start of this programme. We are seeing Trustwide reductions in the rate of physical violence, verbal aggression, racial aggression, prone restraint, seclusion and use of rapid tranquilisation (see charts below). This impact, at scale, and during a period of heightened acuity and occupancy on our inpatient units, is testament to the deep involvement of service users and staff in coproducing improvements to tackle safety and quality at a local level, through the systematic method of quality improvement.

Until March 2024, the focus of this programme is on testing the three chosen change ideas for therapeutic engagement and observations under different conditions. Subsequently, the work will move into implementation phase, with support to embed the effective change ideas into practice. Additionally, colleagues in informatics and digital teams are developing a longer-term sustainable way to measure and report on reliable completion of observations on our wards. A description of our work and learning will also be written up for peer-review publication, as it is likely to represent the first effort at scale in mental health settings on the topic of observations to achieve these level of results.

Visual Management Board – Shoreditch ward (Forensics)

Visual Management Board – Rosebank ward (Tower Hamlets Mental Health)

Figure 10 – Charts demonstrating impact and outcomes of In-Patient Safety Programme



ELFT Digital is driving Digital Safety

ELFT Digital is delivering an ambitious programme of work to address our organisation's legacy digital needs by transforming digital infrastructure, cybersecurity and implementing our Digital programmes to deliver resilient high-quality systems and services, as the essential prerequisites for safe and effective care. For detail of these programmes of work, please see ELFT Digital's Report to the FBIC in January 2024**.**

ELFT Digital published a new Digital Patient Safety Strategy in 2023 which focuses on the people, processes and governance required to meet DCB0160 Clinical Risk Management standards and to further develop Digital Safety Culture at ELFT, including development of the Clinical Safety Officer role **(Appendix X)**. This work will help ensure that ELFT addresses the increasing complexity of patient safety work in collaboration with our ICS and national partners.

Our Digital PP lead and People Participation Digital Community (PPDC) are working to ensure that service users' voices are at the centre of co-developing our digital systems, increasing service user access and empowerment. This work includes implementation of the Patient Held Record platform 'Patients Know Best'. This innovation is enabled by ELFT's new Trust Integration Engine (TIE) which will also allow us to share structured information more effectively between digital platforms, including with the One London Shared Care Record, to ensure that key clinical information is accessible whenever and wherever needed.

This year ELFT has established the 'Digital 4D Group' to redesign ELFTs model of care planning for Moving Beyond CPA, with patient safety as a design priority. The Digital 4D Group will promote the adoption of Standard Operating Procedures across the organisation, to ensure consistency in care delivery. Our systems redesign will also capitalise on opportunities for clinical decision support and systems feedback to promote safe practice. Close working between ELFT's Informatics and Digital corporate teams will ensure that data is captured efficiently and presented in timely and accessible ways to support safe care delivery.

Workforce Safety

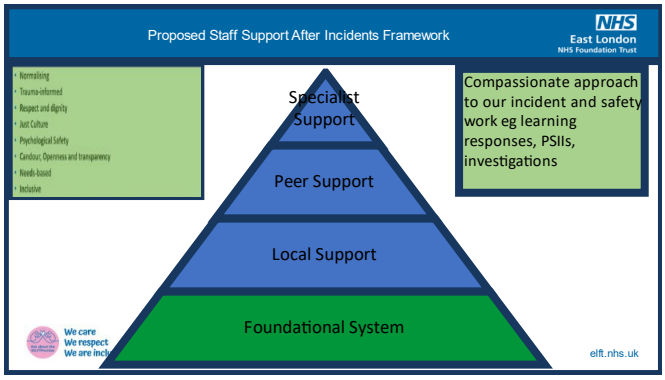
The safety plan is supporting our workforce via our People Plan work, with an increased focus on the physical, mental and sexual safety of the workforceand in key areas such as staff well-being, reducing burnout and work to continuously monitor and improve safer staffing.

Staff Support After Safety Incidents

This year we have launched a staff support after incidents improvement initiative, with codesign of a new "People First" support after safety incident framework and staff support charter (see figure 11 below) which we are working on embedding within our directorate and corporate services.

Work so far has included review of the evidence-base and national guidelines, Consultation with national and local experts, feedback from experience of those affected by incidents and establishment of a Working Group including colleagues with both frontline and subject matter expertise. Work completed in this area includes: improvement of our signposting to support resources, introduction of supportive coroners training, routine use of a feedback tool from staff involved in safety reviews (see figure 12) and inclusion of directorates and co-reviewers in safety review decision-making and sign-off. We now have a QI coach on board and are in the process of designing a measure of staff satisfaction with incident support, which we will use to track improvement as we test out change ideas at both directorate and Trustwide level.

Figure 11 – "People First" Staff Support After Incidents Framework & Charter



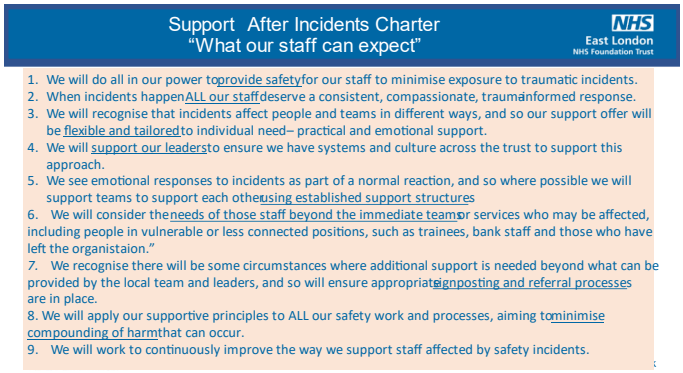
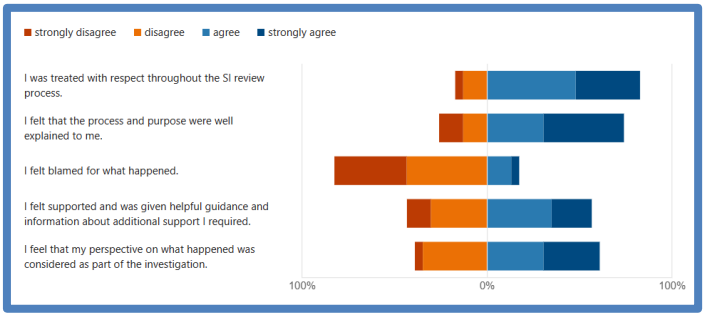


Figure 12 – Initial Staff Feedback from SI Reviews in 2023-24 (n=23)



In parallel, broader work to improve workforce safety has been taking place across the trust in several key areas including:

- violence and aggression reduction work as part of our In-Patient Safety Improvement Programme (as described above)
- New work led by our people and culture team to improve sexual safety of the workforce and including ELFT adoption of the NHSE Sexual Safety Charter
- Ongoing Safer Staffing Work and Trustwide Recruitment and Retention Project

Improving Equity for Safer Care

There is a recognition in our Safety Plan that achieving equity is fundamental to the provision of safer and high-quality care. Over recent years, ELFT quality improvement work has incorporated a strong focus on equity. Phase two of the pursuing equity QI programme

began in September, with 28 teams from across the trust being supported to use QI to tackle a range of inequities. Some examples of the improving equity work are included below.

Hatters Health Primary Care Network are aiming to increase the percentage of individuals with severe mental illness (SMI) from minority ethnic groups in Luton who have had routine physical health checks. The team have tested a range of change ideas including improving communication with service users via text message reminders, sending appointment confirmations and offering appointments in more convenient locations such as at a service users' home or care home.

Tower Hamlets Community Health – The Advanced Care Planning team in Tower Hamlets Community health is aiming to improve end of life care for Bangladeshi patients. The team have identified that only 19% of their caseload are Bangladeshi, despite this group making up 36% of the local population. The team are working with partners from East London Mosque, local funeral services and members of the population to understand their needs and assets, which will help them develop a theory of change. The team have already produced a podcast for local GPs to increase awareness of the service. They are also working with colleagues from services in Cambridge to learn from a pilot which offered drop-in sessions regarding end-of-life care at Cambridge Mosque.

Forensic Services - Building on the success of work on East India ward to tackle racism, a multidisciplinary team from across the Forensic directorate is working to improve staff knowledge, awareness and reporting of racism by 20% by June 2024. The project team undertook a survey to help them understand the problem, identifying that 70% of staff experienced racism at work. 52% of respondents said they reported their experiences to their line manager, but only 41% received any support following the incident. Using the data, the team have created a fishbone diagram to help them understand the causes. The team are now finalising their driver diagram and measurement plan.

Bedfordshire and Luton Community Mental Health - The OCEAN (Offering Compassionate Emotional Support for those Living Through Birth Trauma & Birth Loss) team offers support for tokophobia, which is a profound fear of childbirth. The team identified an underrepresentation of individuals from Black, Asian, and Ethnic minority backgrounds in their referrals, which does not accurately mirror their local demographic. Their aim is to increase referrals from Black, Asian and other minority ethnic backgrounds from the Luton area by 25% by October 2023. They have a project team in place, including a service user from the perinatal families together group, coach, sponsor, and an initial measurement plan. The team are being supported to build their driver diagram and select change ideas to test.

Our Safety Plan includes an ambition to increase the focus on equity and we are working towards:

- measures of equity within our Safety Plan.
- Use of data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics.
- Application of a more flexible approach and intelligent use of data to help identify any disproportionate risk to patients with specific characteristics, and how this information informs patient safety incident response.
- Use of InPhase to allow for analysis of safety data by protected characteristics to give insight into any apparent inequalities.
- Equitable engagement and involvement of patients & families following a patient safety incident with consideration of their different needs, ensuring that we use available tools such as translation and interpretation services and other methods as appropriate to meet

the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

Safer Communities

In line with the trust strategy, we would like to support safer lives and communities actively via prevention work. Over year one of the plan, we have actively engaged with system partners to ensure that system reviews are a priority for both our ICBs and to develop strong working relationships, shared principles and regular communication to support this work. We have also actively worked on supporting community Suicide Prevention groups with renewed focus. Additional population-level safety priority areas are in the process of definition and will have more dedicated focus in years 3-5 of the plan.

3.0 Our Safety Plan Objectives for Year Two and beyond

As part of our annual planning, we have taken the opportunity to revisit the Safety Plan objectives, and update these for year two considering the changing landscape of safety within ELFT and in relation to the broader NHS context. To do this we have engaged with our Safety Oversight group, Patient Safety Specialists and Patient Safety Partners to help us remain focussed on areas which are priorities to the workforce, those we serve and our leadership team.

We recognise that the NHS landscape has become increasingly challenging for both service users and professionals working within the system. Nationally and locally, there continue to be significant pressures with increase demand, complexity and acuity of health and social difficulties, plus reduced access to social care provision, impacting on access to safe care and increased moral distress for our staff. Nationally, there is also a climate of increased societal scrutiny of healthcare, in connection with high profile safety incidents and problems in NHS services. More than ever it seems crucial to focus our safety work on continuously learning from safety with a focus on systems and processes rather than individuals, working to maintain and improve positive safety cultures, and developing our systems to support vigilance and effective improvement to ensure ongoing safety of care. We believe that our existing Safety Plan remains focussed on the right objectives and actions needed to support this direction of travel.

In year two we plan to focus on the following areas, building on work already started in each:

Year Two Focus Area One: Further development of our safety culture, learning and improvement systems, via development of our Patient Safety Incident Response Approach (PSIRF) and InPhase system.

Whilst much progress has been made in our PSIRF transition, we recognise the need to go further to develop our incident response approach in a direction which embraces the core principles of PSIRF, and which we know will continue to develop our just and learning culture with a systems-approach to learning and a focus on impactful safety improvement.

Going forward, we wish to enhance our safety work by increased application of QI methodology. For example, an exciting next step is the initiation of a QI project across Bedfordshire and Luton adult mental health services to improve the incident response process, reduce variation in the quality of incident reports and refine the support offered to staff and families affected by incidents. The intention is to learn deeply in one place, then quickly scale up and spread the lessons to other directorates and as standard practice.

We will also be supporting directorates to move beyond safety actions, to proactively identify their own safety improvement priorities and design safety improvement plans accordingly, including safety actions at the stronger end of the actions hierarchy.

In parallel, we will be going further with skilling up our staff in the new PSIRF learning methods, with a focus on learning from work-as-done and understanding and applying the ingredients of safe care

in the different care settings across the trust. After Action Review, Swarm Huddles, Frontline Observations. SEIPS application and MDT Reviews are some of the tools we will be testing further and adapting for our setting. We will be using the following measures to support us with testing improvements in this area:

- Attendance at learning lessons seminar
- Pareto Chart – Outcome of Incident - AAR, No action, PSII, Swarm Huddles, Improvement

InPhase Development

We remain in the early stages of our InPhase transition, and actions have been identified to address impacts/risks and realise the full potential to support our safety system and cultures.

Next steps include:

- Embedding of methods for collecting feedback are being introduced including a feedback field on the incident form, a Staff survey and a feedback log to record all enquires providing quantative data.
- Work with directorates and individual teams where a reduction in incident reporting has been identified, to understand barriers and support and training will be provided. Attendance will be offered at team meetings, away days and DMTs, both face to face and virtually. A meeting has also been held with all lead nurses offering support. A change management process has also been developed to support the introduction of improvements to the system; suggestions will be presented to the Implementation Group for consultation, discussion and agreement before implementation.
- Development of LFPSE question guidance, enhanced training materials for report building and improved form flow.

Discussions are also being held to consider the introduction of an InPhase steering group, to provide oversight and strategic direction to support the implementation team.

In relation to culture, leadership and governance, we will develop our reporting to support monitoring using the following measures:

- NHS staff survey responses
- Question responses to our In-patient safety culture tool
- Executive walkarounds themes
- Introduction of directorate level safety monitoring dashboards

Year Two Focus Area Two: Involving Service Users and Carers to Improve Safety

The NHS framework for involving service users in Safety supports us to focus our efforts on two areas: firstly, involving service users and carers in improving and maintaining their own safety, and secondly the involvement of service users and carers in developing safety at an organisational level. Our intention for year two is to engage our Patient Safety Partners to help the organisation to prioritise a focus on both these areas.

In terms of developing organisational safety, our PSPs will work and grow our existing service user reference group to codevelop approaches to take, and will continue supporting our Carer Strategy Group, Working Together group, our Patient Experience Forum, and other key forums to support colleagues to apply a safety lens to all we do.

In parallel, our PSPs will help us further develop our service user and carer metrics and feedback within our safety system and as part of our ongoing safety culture work. For example, making use of our Care Opinions system, our new Patient Survey data on raising concerns and working with our incident team to increase inclusion of service users and carers in safety decision-making and to increase the focus on responding to feedback from those affected by incidents. We will be also be

looking to test out new ways that service users and carers can be supported to raise safety concerns in effective and accessible ways.

Examples of the way we hope to support service users and carers to take an active role in improving their own safety, include supporting the work to embed the “Patient Knows Best” patient portal and the work to develop Safety Planning as part of our Dialog+ work.

For this objective, to help monitor progress, we will be tracking the following measures through our reporting:

- % of safety forums with People Participation
- % of safety improvement projects with People Participation
- No. of People Participation safety roles
- % of PSIIs with People Participation in the team

Year Two Focus Area Three: Workforce Safety

We will continue to support key areas of improvement work led within our people plan particularly in the areas of safer staffing, staff well-being, support after incidents and sexual safety.

In terms of measurement, to support progress and testing of improvement ideas around workforce safety, we plan to track the following measures and report these via our people plan:

- Rates of Workforce safety incidents
- Rates of Sexual Safety Incidents affecting staff
- Staff survey wellbeing measure responses
- InPhase feedback measures including staff support after safety incidents
- Number of QI projects that focus on workforce safety

Year Two Focus Area Four – Upskilling and training for our workforce

In the year ahead we will be working with colleagues in learning and development to go further in upskilling the ELFT workforce in key safety areas such as safety and restorative just culture, systems (human factors) approaches, risk management and mitigation and safety learning and improvement methods.

In order to achieve this we will continue to promote and support staff to engage with the NHSE e-modules, and will go further to embed safety training modules and tools within our QI and leadership development programmes. To supplement this, we will continue to develop and deliver our specific PSIRF and new learning method training programmes to teams and for staff in key roles.

In parallel, we will work to make safety learning increasingly accessible, both to our workforce and also to the public, with ongoing work to develop our intranet resources and learning library.

Year Two Focus Area Five – Digital Safety

In the year ahead, ELFT Digital will further develop the ongoing programmes of work described above to deliver on our strategic vision for Patient Safety and will be publishing our Digital People Participation strategy to support this. We will progress our digital systems training offer, to include flexible on-demand e-learning that can accommodate multiple

learning styles. Improved training will ensure safe and effective use of our core Electronic Patient Records, as well as the successful adoption of new functionality which we will be implementing to improve patient safety, including eObs for physical health (NEWS2) monitoring on inpatient wards, 'Order Comms' electronic ordering and communication of blood test results, and ELFT will be the lead Trust for the Pan-London eMHA Programme to implement an electronic Mental Health Act workflow solution with our partner Trusts across London.

5.0 Recommendations

5.1 The success of this plan depends on engagement at all levels and visible sponsorship and support by the board and executive leadership team. The board is asked for feedback including areas for improvement and/or strengthening, and also their active involvement in championing and supporting this plan over the years ahead.

6.0 Action Being Requested

6.1 The Board is asked to:

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

Appendix 1: ELFT Safety Plan Driver Diagram

Appendix 2: ELFT Patient Safety Long-Term Plan

Primary Driver	**Secondary Driver**	Idea	Notes/ Status	Time Frame
Leadership, Gov & Culture	Everybodys Core concern	**Vision & Principles** – develop and share using co-creation workshops	Commenced, ongoing OD work	Y1
	Everybodys Core concern	**Define Safety Priorities** (using systematic review of board papers, incident themes and improvement work) & in co-creation with senior leaders. Review every 2y.	Complete for year 1, needs repeated regularly	Y1
	Everybodys Core concern	**Develop Safety Commitments for each Priority** – what care looks like when goes right. Review, test, revise regularly		Y2
	Leadership & Gov	**Improve safety reporting** to focus on analysis and improvement & reduce information burden	Ongoing. Making progress.	Y1
	Everybodys Core concern	**Core set of "Brilliant Basics" Safety Behaviours** - Develop and publish		Y3
	Leadership & Gov	**Integrated patient safety team** with safety advisors	Under discussion	Y2
	Leadership & Gov	**Board level Safety Role**	Partial - Dir of Safety	Y3
	Leadership & Gov	**Directorate Safety specialists** - linked to core team to create network	7 PSSes identified and commenced	Y2
	Leadership & Gov	**Shift focus to risk monitoring** with dedicated safety risk monitoring work group to develop information escalation framework, make use of information on harms, operations, anticipation and learning, development of risk visualisation and monitoring framework with owners for each risk. Test risks ?Use BARS map	Under discussion	Y2-5
	Leadership & Gov	Introduce **competency-based training** to support all in safety leadership roles	Started	Y2-5
	Leadership & Gov	Independent **Safety Advisory Panel** reporting to Board	Partial – overisght	Y3+

Primary Driver	**Secondary Driver**	Idea	Notes/ Status	Time Frame
			group launched with independent contirbutors?	
	Leadership & Gov	**Develop expertise and capacity** re Human Factors, safety analysis and evaluation methods	Partially complete	Y1+
	Leadership & Gov	Framework for safety escalation	In place, continuous develpement needed	
	Accountability	**Framework of safety skills & responsibilities** defined for every role & support staff to attain these	Started	Y3-4
	Psychological Safety/Just Culture	**Introduce & Implement Just Culture Policy** including separate line management & performance from safety improvement	HR	Y1
	Psychological Safety/Just Culture	**Just Culture Simulation Exercises** led by all managers 6 monthly	HR	Y3
	Psychological Safety/Just Culture	Work with colleagues in quality, diversity and inclusion to ensure alignment to **enhance the restorative just culture approach**	HR	Y3
	Psychological Safety	Introduce **routine monitoring of safety culture** & tools for teams to self-assess and improve	Partially complete (in-patient so far)	Y2+
	Transparency	**Regularly publish/share Key Safety Performance Data**		Y2
	Teamwork & Communication	**Incorporate training on human factors, use of safety communication tools** such as SBAR, critical language teamwork and communication into existing training packages, eg., PocketQI.	Partially complete	Y3+
	Teamwork & communication	Embed **Incivility Toolkit**		Y3+
Learning, Insight & Improvement	Continuous Learning	Move from RCA to **Systems approach to learning from incidents**	Complete	Y1

Primary Driver	**Secondary Driver**	Idea	Notes/ Status	Time Frame
	Continuous Learning	Transition to new **National Learning from Patient Safety Events System** (LFPSE)	Complete	Y1
	Continuous Learning	Create trust **safety shared learning network** and link these with local, national and international learning networks.	Learning lessons network – growing, Safety Learning Committe	Y1
	Continuous Learning	Introduce suite of **new learning from safety methods,** eg., After Action Review, Swarm Huddles, Ward Observations & shift safety resources to include learning from everyday work, and towards the frontline	Commenced	Y1 onwards
	Continuous Learning	Embed **learning from excellence** system	Partial	Y2-3
	Continuous Learning	Introduce **Safety education and training for all staff**, including **NHS Safety Syllabus**	Commenced. Needs national support to drive.	Y1-Y3
	Continuous Learning	Establish **system for cascading & sharing learning** from all safety learning forums	Progress made	Y1 onwards
	Continuous Learning	Develop **Safety intranet platform & learning library**	Complete with ongoing development	Y1
	Continuous Learning	Develop **safety analysis** using SEIPS, HF, Bow Tie methodology		Y3
	Continuous Learning	**Improve the response to new and emerging risks**, supported by the new National Patient Safety Alerts Committee		Y3
	Application of QI	Continue to apply quality improvement methodology and work with system partners to support improvement in key safety priority areas	In progress	Ongoing
	Application of QI	Apply QI to Incident Review work and actions	In progress as part of PSIRF	Y1

Primary Driver	**Secondary Driver**	Idea	Notes/ Status	Time Frame
	Application of QI	Safety Action teams with use of QI to address specific priority areas/issues	In progress as part of PSIRF	Y1
	Application of QI	**Oversight structure** for all Safety Improvement work (Patient Safety Forum) with QI reporting template	Established	
	Application of QI	Dedicated QI lead role for Safety		Y3+
	Application of QI	QI competencies and training for all in Safety leadership roles	Existing QI Programme	Y3+
	Application of QI	Rewards and Celebrations for involvement in Safety Improvement	Via HSJ awards, could do more	
	Measurement	**Work with informatics and analytics to develop system for optimising safety insight,** incoporating all sources of patient safety intelligence	Planned	Y2
	Measurement	Develop Safety Monitoring & Continuous Improvement **Dashboard**	PowerBI	Y2
	Measurement	Use of visual data display at all levels to support safety	Partial	Y2
	Reliability	Promote and enhance **simplification and standardisation of core operational processes**	Ongoing	
	Reliability	Safety leads to participate in all key operational forums (sensitivity to operations)	Commenced	Y3+
Involvement of patients, carers and families		Establish **competencies, principles, expectations and training** for all staff in engagement of patients, carers and families in safety	NHS Strategy. Embed in PocketQI?	
		Introduce **dedicated people participation roles** within core safety team and for each directorate.	Partial	Y1-2
		Involve patients/carers in codesign of safety mission, principles & strategy	Commenced	Y1 onwards
		Include patients and carers in safety reviews	PSIRF	Y2

Primary Driver	**Secondary Driver**	Idea	Notes/ Status	Time Frame
		Include patients and carers in all safety governance and improvement forums.	Commenced	Y1
		Provide **compassionate support** for patients and carers affected by patient safety events	PSIRF	Y2
		Develop **methods for patients & carers to lead safety of own care,** eg., via education, tools, systems	PSPs to support	Y3-4
Workforce Safety & well-being		**Continue to apply a QI approach** to improving holistic workforce safety co-created with workforce with clear aims and priorities	Ongoing	
		Robust support system for staff involved in safety incidents	Framework developed & shared, needs further work and resource	Y2-5
		Compassionate engagement approach to involving staff in incident reviews	Part of PSIRF. Commenced.	Y2
		Continue to address burnout and well-being via Joy in Work approach, incorporating a trauma-informed approach to well-being	Ongoing	
		Safer Staffing QI work focused on retention, reduction of temporary staff and safe staffing levels for all areas	Established	
		Support the ELFT People plan with focus on looking after our people, new ways of working, planning for future and belonging in the NHS	Led by Tanya Carter	
Equity		Equity data in all patient safety monitoring dashboards		Y3-5
		Equity focus and aim for safety reviews	PSIRF will help this	Y2-3
		Equitable patient and carer involvement in own care and organisational safety work		Y3-5
Safer Communities		**Population health focus** for safety priority areas with community partnership work		Y3+

Primary Driver	**Secondary Driver**	Idea	Notes/ Status	Time Frame
		Prevention work on priority areas and social determinants of safe care	Commenced.	Y3+
		System-level safety reviews	PSIRF	Y2
		*Needs more work to define this area in Year 3		Y3+

Appendix 3: ELFT PSIRF Implementation Plan

Phase	Actions	Implementation Status
Orientation	Create Implementation Team	**Complete**
	Allocate Time for reading and Reflection	**Complete**
	Identify knowledge and support needs for getting started	**Complete**
	Create Stakeholder list and plan engagement	**Complete**
	Agree structure and processes for project management	**Complete**
	Set ambition for PSIRF implementation	**Complete**
	Training – source provider and commence training and training log	**Complete**
	Targeted SI backlog clearance work	**Complete**
Diagnostic and Discovery	Assess status of open and transparent reporting	**Complete**
	Assess engagement and involvement of patient safety incidents	**Complete**
	Assess status of developing a Just Culture	**Complete**
	Assess incident response capacity and training needs	**Complete**
	Assess alignment of incident repsonse and improvement	**Complete**
	Identify where improvement is needed based on above assessments	**Complete**
Governance and Quality Monitoring	Develop processes for incident response decision-making	**Complete**
	Define how system effectiveness will be monitored	**In progress**
	Develop processes for reporting cross-system issues	**Complete**
	Define how PSIRF will be monitored	**In progress**
Patient Safety Response Planning	Map our services	**Complete**
	Examine patient safety incident records and safety data	**Complete**
	Describe safety issues revealed by the data	**Complete**
	Identify work underway to address to address contributory factors	**Complete**
	Agree how we intend to respond to issues listed in our patient safety profile	**Complete**
Curation and agreement of policy and plan	Populate policy and plan templates and share these with stakeholders	**Complete/ongoing**
	Respond to stakeholders feedback on the draft policy and plan	**Complete**
	Agree how to manage transition	**Complete**
	Ensure commitment to delivering required improvement	**Complete**

	Seek policy and plan approval/sign-off and agree transition date	**In progress**
Transition	Apply new learning response methods	**Ongoing**
	Reflect on agreed plan with internal and external stakeholders and conside adaptations needed	**Ongoing**
	Continue to develop diagnostic and discovery work	**Ongoing**
	Continue collating insight, collecting data to support quality monitoring and supporting and collaborating with others.	**Ongoing**

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East London
NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE TRUST BOARD IN PUBLIC

18 July 2024

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Purpose of the report

This is a combined adult and children Safeguarding Annual Report that has been adopted in line with the Trust's shared safeguarding strategy. Its purpose is to inform Trust Board members of the progress regarding its responsibilities for safeguarding adults and children's activity as part of its regulated and statutory responsibilities, and to ensure that patients, service users and carers know that safeguarding of children and adults is a Trust priority. The report outlines the work the Trust has done to strengthen safeguarding governance through better alignment of the safeguarding priorities. This report also includes the achievements, primary areas of development and challenges for safeguarding during 2023-2024.

Committees/meetings where this item has been considered

Date	Committee/Meeting
11/08/2023	Safeguarding Committee
10/11/2023	Safeguarding Committee
09/02/2024	Safeguarding Committee
10/05/2024	Safeguarding Committee

Key messages

The Executive team, the Corporate Safeguarding team and all staff across the Trust remain committed to ensuring that the safety and protection of our patients/service users and staff remains a key Trust priority.

The Corporate Safeguarding Team went through restructure with the Associate Director of Safeguarding providing integrated leadership across children and adult safeguarding. She is supported by two Lead Professionals, one for Safeguarding Adults and one for Children. The new Team structure has been successfully implemented since September 2023, and the Corporate Safeguarding team has at its heart the Think Family ethos.

This new safeguarding team structure will ensure that the Trust has strong systems and processes to identify safeguarding issues and to take action to prevent harm. The team has already made

significant improvements in the organisation of work and new processes have increased capacity to support frontline services.

The Trust contributed to the various multi-agency reviews which are commissioned including Local Safeguarding Child Practice Reviews (LSCPR), Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR). Through contributing to these reviews, ELFT are at the forefront of identifying learning which is disseminated to all staff in the trust through quarterly events, training and the Safeguarding Newsletter.

The revision to the Working Together to Safeguard Children was published in December 2023. This edition replaces Working Together to Safeguard Children 2018, which underwent limited factual update in 2020. The revision to the guidance focuses on strengthening multi-agency working across the entire system of help, support and protect children and their families, keeping a child-centred approach while bringing a whole-family focus, and embedding strong, effective and consistent multi-agency child protection practice.

The Safeguarding Committee, which oversee the work of safeguarding across the Trust, refocused its activities to strongly embed the 'Think Family' approach to ensure assurance is received from all Directorates in lie with CQC Regulation 13, contractual safeguarding requirements in accordance with the Children Act (1989/2004) and the Care Act (2014)

Safeguarding is often described as a 'golden thread' that weaves through every service and touches every area of practice and practitioner. The independent Review of Greater Manchester Mental Health NHS Foundation Trust and the Lucy Letby case reinforces the importance of having a well-staffed safeguarding team, about raising safeguarding concerns, the value of data collection and analysis and the culture of the organisation as extremely essential functions in safeguarding people /service users from risk of abuse. It is important to listen to staff and patients to provide safe and high-quality care, furthermore it highlights the fact that information is only effective if the data is joined together and effectively analysed to identify patterns and trends.

Strategic priorities this paper supports

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

Implications

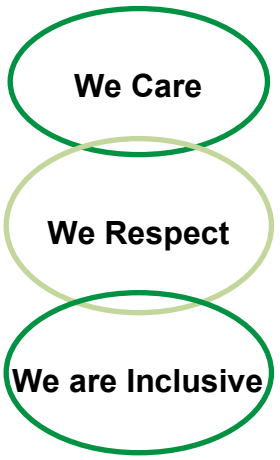
Equality Analysis	This report provides an overview of actions the safeguarding team have taken to identify inequalities that can contribute to vulnerabilities of service users and strategies to address these.
Risk and Assurance	The report provides assurance of the monitoring and understanding the occurrence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

1.0 Introduction and background

1.1 The annual report summarises safeguarding work undertaken across the Trust and demonstrates to the Trust Board and external agencies how ELFT discharges its statutory duties and responsibilities in relation to Section 11 of the Children Act 2004, Working Together to Safeguard Children 2023, the Mental Capacity Act 2005 and the Care Act 2014.

1.2 The report outlines safeguarding activity across the Trust and highlights the achievements, challenges and priorities during the year. This is in accordance with the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (V3, 21st July 2022). The framework provides an assurance that service users and their families are effectively protected.

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



Everyone is entitled to the highest quality care.

Everyone should be treated with kindness and respect.

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

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

1.5 The Trust operates from the following Boroughs:

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

1.6 The Trust employs 7888 permanent staff. The mixed demographic profile of the trust results in a range of adult and children safeguarding issues that require an individual response based on local partnership arrangements.

2.0 Quality Assurance

2.1 All health providers are required to have effective arrangements in place to safeguard children and adults at risk of abuse or neglect and to assure themselves, regulators and their commissioners that these are working (Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework. NHSEI, 2022).

This includes:

- Safe recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable children as appropriate.
- A suite of safeguarding policies and procedures that support local multi-agency safeguarding procedures.
- Effective training of all staff commensurate with their role and in accordance with the intercollegiate competences for Safeguarding children and adults.
- Effective supervision arrangements for staff working with children / families or adults at risk of abuse or neglect.
- Effective arrangements for engaging and working in partnership with other agencies.
- Developing and promoting a learning culture to ensure continuous improvement.
- Identification of named safeguarding professionals.
- Developing an organisational culture where all staff are aware of their personal responsibilities for safeguarding and information sharing.

3.0 Governance and Accountability arrangements for Safeguarding

3.1 The Chief Nurse is the Executive Director for safeguarding who provides leadership and oversight of safeguarding arrangements across the Trust.

3.2 The Director of Nursing has delegated responsibility for safeguarding strategy and leadership across the Trust. It is important to note that the requirement for Associate Director of Safeguarding to have direct access to the Trust Board is maintained through the links via the Director of Nursing and Chief Nurse who has the Executive function and responsibility for safeguarding.

3.3 The Associate Director for Safeguarding has operational and strategic responsibility and provides leadership for the corporate safeguarding adults and children teams, supported by two Lead Professionals, one for Safeguarding Adults and one for Safeguarding Children.

3.4 The Lead Professionals for Safeguarding Adults and Children provide operational leadership and co-ordination for the Corporate Safeguarding teams.

3.5 Named Safeguarding Professionals provide the Trust with operational advice, support and training. The professionals are committed to supporting embedding safeguarding into 'everyday business' and improving outcomes for service users.

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

4.0 External Safeguarding Governance and working with Partners

4.1 The Trust is committed to working in collaboration with all partners seeking to protect adults and children at risk from harm caused by abuse or neglect, regardless of their circumstances. As part of these arrangements the Trust is represented at six Safeguarding Adult Boards and seven Safeguarding Children Partnerships covering the local authority areas where ELFT has a presence. The local safeguarding partnerships look at areas of concern for their local populations. Our services work in collaboration with system partners to address these identified areas. These partnerships also have an assurance function that ELFT reports into.

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

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

4.4 There have been safeguarding adult reviews, child safeguarding practice reviews, domestic homicide reviews, channel panel, Domestic Abuse Steering and strategic leaders' group, and

PREVENT/CONTEST boards, which ELFT has been representing in the reporting year.

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

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

5.0 **Reporting of Safeguarding activity**

5.1.1 The Trust Safeguarding Committee meets quarterly and provides challenge and assurance with regards to the safeguarding arrangements within the Trust and monitors compliance. Reports are submitted on a quarterly basis which provides assurance against our responsibilities as outlined in CQC Regulation 13, Contractual Safeguarding requirements and in line with The Children Act (1989/2004) and Care Act 2014.

5.1.2 Key Performance indicators monitored quarterly are:

- Safeguarding Training compliance
- Safeguarding Supervision compliance
- Safeguarding adults and children's audits including Section11 audits, multi-agency audits and other audits as requested by services, partnerships and boards.
- Safeguarding adults and children's reviews including learnings from Section 42 and Patient Safety Incident Investigations.
- Safeguarding Dashboards
- Policies
- Domestic Abuse activities and Domestic Homicide Review leanings.
- Prevent quarterly returns and training compliance
- Risk Register

5.1.3 Quarterly Safeguarding Committee minutes and exception reports are shared with the Quality and Assurance Committee, which is a sub-committee of the Trust Board. These assurance reports are also provided to the Integrated Care Boards (ICB's) in line with the reporting arrangements.

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

5.2 **Risk Register**

5.2.1 There were twelve safeguarding risks identified on the Risk Register at the beginning of the year. These have been reported to the Trust Safeguarding Committee where the actions to address them were monitored and updated regularly. Five of the risks have been resolved and closed during the year.

The remaining risks include:

- Low compliance at level three adults and children safeguarding trainings.
- Inconsistencies in reporting of safeguarding incidents on Datix.
- Staff incorrectly mapped to safeguarding children's training levels.
- Impact of changes to the safeguarding team structure.
- Inconsistent Routine Enquiry and Professional Curiosity across the Trust
- Inconsistencies of recording of safeguarding data in Rio.
- Use of Local Authority recording systems to record safeguarding activity- This has been partially resolved

The following five risks have been closed and removed from the risk register:

- Safeguarding children's team were unable to identify all the children and family members known to ELFT services due to lack to access of the patient electronic record systems -
- Low safeguarding supervision compliance across the Trust
- Staffing within children's safeguarding team
- Inconsistent understanding and application of Mental Capacity Act- This risk has transferred to the MHA team
- Low DBS compliance

5.3 **Section 42 Responsibilities (Care Act, 2014)**

5.3.1 The Section 42 duty on the local authority exists from the point at which a concern is received (ASASS 2019). Section 42 duty:

Section 42(1)

Once a referral expressing concern is made, the local authority decision maker needs to gather enough information in order to ascertain whether there is:

Reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)-

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. (Care Act 014,S42(1))

Section 42(2)
If there is reasonable cause to suspect that the concern relates to an adult whose circumstances meet the criteria we have set out, the next decision is about whether an enquiry, or some other course of action, is needed.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part [of the Act] or otherwise) and, if so, what and by whom. (Care Act 2014, S42 (2))

5.3.2 ELFT has a Section 75 agreement made under Section 75 of National Health Services Act

2006. Section 75 arrangements can include arrangements for pooling resources and delegating certain NHS and local authority functions to other partners if it would lead to an improvement in the way those functions are exercised. One of such responsibility is the delegation of Section 42 enquiries under Care Act 2014, by the Local Authorities to ELFT Adults and Older Peoples services in five of its directorates.

5.3.3 The section 75 agreements in Tower Hamlets and Hackney delegates the Trust with the responsibility to screen safeguarding concerns, while in Luton, Bedford and in Central Bedfordshire they are screened by the Local Authority safeguarding team. During this reporting period, the Hackney directorate screened 588 safeguarding concerns and Tower hamlets directorate screened 356 safeguarding concerns. The Trust saw an increase in safeguarding concerns and the national picture shows that there was a 9 %increase in safeguarding concerns.

The Trust completed 485 section 42 enquiries in 2023-24 compared to 318 section 42 enquiries in 2022-23. This is a 52.5% increased request for enquires compared to 2022-23. The Trust has seen a much higher increase in section 42 enquiries compared to 7% increase nationally. One of the reasons for increase in volume of section 42 enquiries is because of the changes adopted by Central Bedfordshire council due to their low conversion rate. Central Bedfordshire Council now operate a three level framework of Section 42 enquiry as follows (whenever the three S42(1) criteria are met) –

1. S.42 Safeguarding initial enquiries (Level 1) - handled and closed by the adult safeguarding team without the need for further safeguarding enquiries, because no further enquires were considered ‘necessary’ to identify safeguarding actions.
2. S.42 Safeguarding other actions (Level 2) is identified by the safeguarding team as necessary and assigned to the appropriate team or partner. The three-stage test is met but a more formal plan using the complete set of safeguarding paperwork/activity is **not considered necessary**. Proportionate recommendations are provided by the safeguarding leads as a s42(2) enquiry.
3. S42 Safeguarding full enquiry (Level 3) is identified by the safeguarding team as necessary and assigned to the appropriate team or partner. The three-stage test is met a more formal plan using the complete set of safeguarding S42 paperwork/activity **is considered necessary.** Proportionate recommendations are provided by the safeguarding leads as a s42(2) enquiry in the DMT.

Section 42 Concerns

Year	Bedford	Central Bedfordshire	Luton	C&H	Forensics	Tower Hamlets	Total
2022-23	50	69	82	77	1	39	318
2023-24	90	137	51	102	28	77	485

5.3.4 The emerging trends of the section 42 enquiries completed by the Trust do not reflect the

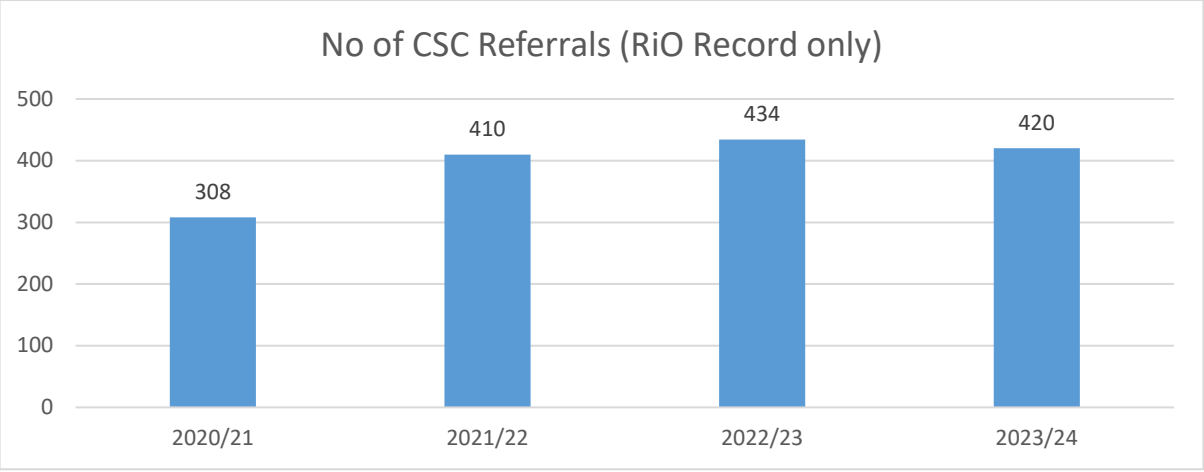
national picture where Neglect and acts of omission has been reported as the most reported category of risk. The Trust trends show self-neglect, domestic abuse and Emotional abuse being the predominant types of risk. These were similar trends found in the Trust in the previous year.

5.3.5 The location of risk remains consistent with the national picture which is at home for most of our cases. In substantial number of the enquiries that the Trust carried out, the risk was removed or reduced as reflective of the national picture. In cases where the risk remained, the staff have appropriately escalated the concerns to the safeguarding team or made a referral to the complex/ high risk panel.

5.3.6 As required of the delegated responsibility, all safeguarding activity is recorded and uploaded on the Local Authority system and on the Trust recording system Rio. Last year in view of the assurance the Local Authorities has gained with the Trust over the safeguarding activity in recording and reporting, it was agreed in four out of the five local authority areas to record safeguarding activity in the Trust system and only outcomes of the section 42 enquiries to be updated on the Local Authority system. This has cut down on duplicate recording of safeguarding information.

5.3.7 The operational Directors of the Trust hold bi-monthly Section 75 meetings with the Local Authorities to provide updates of the safeguarding and social care activities delegated to the Trust which is attended by the Trust safeguarding team.

5.4 **Children's Social Care Referrals (CSC)**



5.4.1 The Children's Social Care referrals are completed by staff on Rio in line with the Trust's recording policy, once a safeguarding children's referral is made to the local authority for safeguarding children's issues.

5.4.2 In 2023-24 the Trust staff made 420 children's social care referrals compared to 434 in 2022-23 which is a 3.2% drop in the reporting of CSC referral. The most recorded category of abuse remains Neglect, which is consistent with the previous year.

5.4.3 The safeguarding team is working with the local partnerships to obtain the data of safeguarding children's referrals done by the Trust to have a better understanding of the themes, trends and risks across the organization.

5.4.4 The safeguarding team meets with the ICBs and the partnerships on a quarterly basis to update them about the safeguarding activities of the Trust. The Trust has a safeguarding dashboard that captures all the safeguarding activity including CSC information.

5.5 **Safeguarding Audit**

5.5.1 During 2023/24 several multi- agency and Trust wide audits were undertaken with findings, learnings and recommendations reported to individual staff members, managers and Trust Safeguarding Committee. The audits were in response to learning from local and/or national case reviews or internal reviews. Audits are presented to the Safeguarding Committee for assurance purposes and to ensure that the relevant learning is disseminated across directorates to improve or change practice.

5.5.2 The table below shows the audits undertaken in 2023/24 by the safeguarding team:

Safeguarding Adults	Safeguarding Children
• Domestic Abuse case file audit • ADHD referral audit for Bedfordshire • Police Referral audit for Bedfordshire • Multi-agency Self-Neglect Audit Luton • Safeguarding Concerns audit Trust wide	• Level three training • Professional Practice • Case file audit focusing Tower Hamlets directorate • Trust wide case file audit • Pan beds Sections 11- Neglect

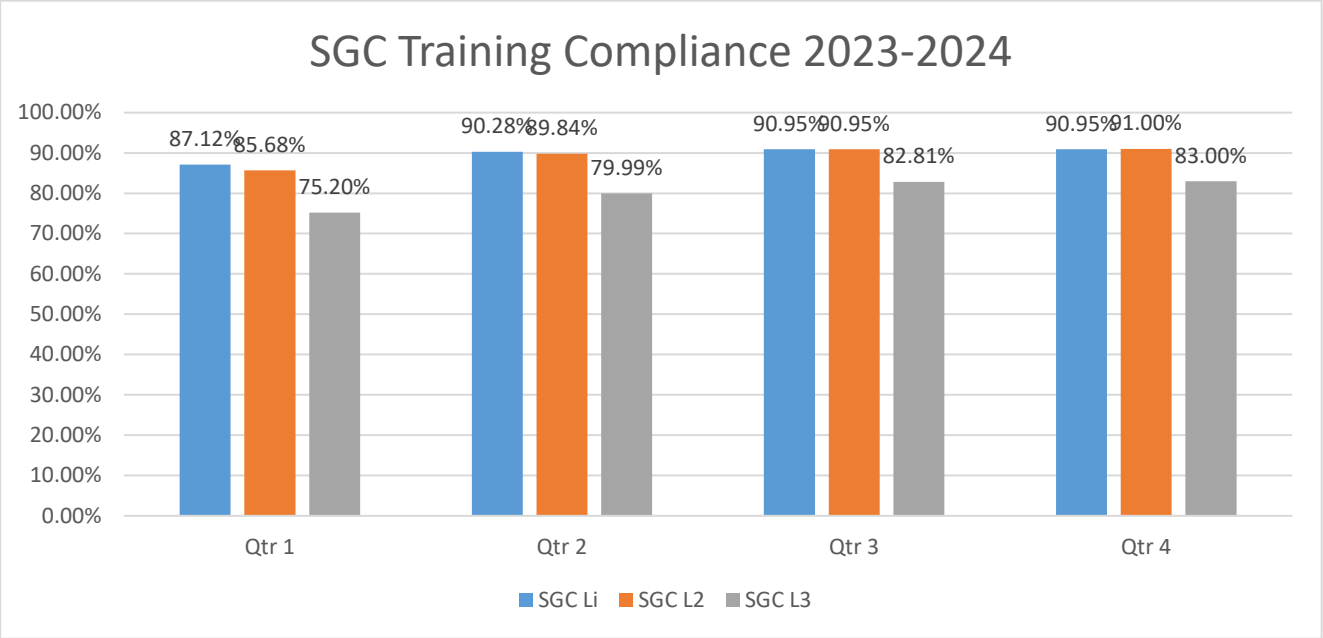
5.6 **Safeguarding Training Compliance**

5.6.1 The Trust has a Safeguarding Training Strategy and Training Needs Analysis in place, based on the Intercollegiate Document, Safeguarding Children and Young People: Roles and Competencies for Health Care Staff. Fourth edition (2019) and Adult Safeguarding: Roles and Competencies for Health care Staff. First edition: August 2018**.**

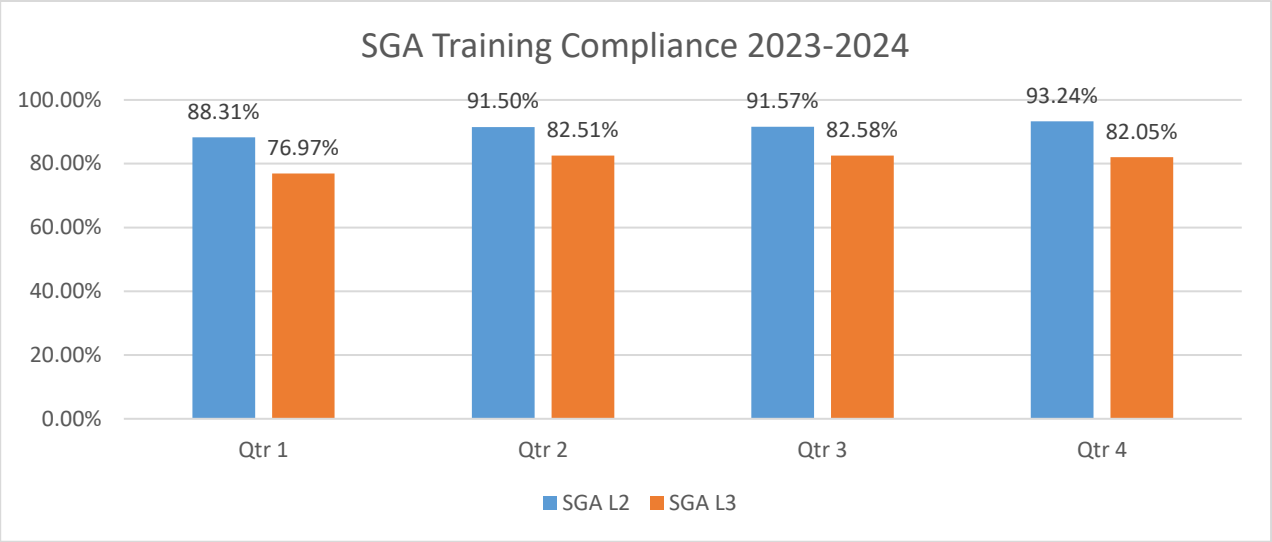
5.6.2 The training plan incorporates safeguarding children, adults, domestic abuse and PREVENT training. The aim is to provide high quality training which will improve practice and service provision.

5.6.3 During the majority of 2022-2023 there was a lack of training compliance data due to the trust moving to a new learning academy and the data not being available. At the start of the year when the training compliance report was received by the safeguarding committee, the compliance for safeguarding training had significantly dropped due to more staff being mapped and new staff members joining the Trust.

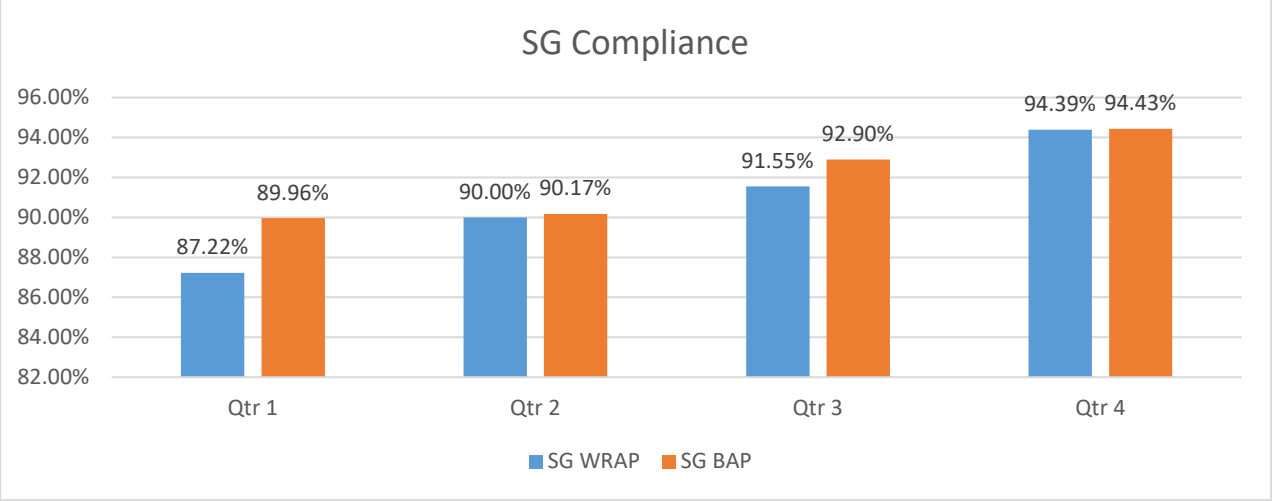
5.6.4 Level 1 and level 2 safeguarding children training, and level 2 adult safeguarding training are completed via an online package. There is a significant increase in compliance for Level 1 and 2 trainings across the Trust. The safeguarding team worked closely with the Trust training department to remap staff to the correct level of training, in line with the intercollegiate guidance.



5.6.5 The level 3 safeguarding training continues to be delivered by virtual platform, facilitated by the named professionals for safeguarding. The compliance for level 3 safeguarding children is at 83% compared to 68.23% in 2022-23, its 15% increase compared to last financial year. Adult Safeguarding level 3 training compliance has also increased by 20%since the last reporting period from 62.32% to 82.05%.



5.6.6 The Trust compliance with WRAP (Workshop to Raise Awareness of Prevent) training is at 94.93% compared to 82.43% in the previous year. The compliance for Basic Prevent Awareness is at 94.43% compared to 83.37% in 2022-23. The Trust is complaint with WRAP and BAP as it's over 90%.



5.6.7 The safeguarding team delivered 68 level 3 adult and children's Safeguarding training sessions and trained 3485 staff in 2023-24 compared to 2650 staff members in 2022-23. This is a 32% increase in training attendance.

5.6.8 Further to the statutory trainings the safeguarding team offered several "Think Family" themed training and bespoke training to the trust staff where areas of practice improvements and gaps were identified in the audits and supervisions.

5.6.9 The training covered the following topics:

- Working with families with that have multiple Needs
- Adultification and Intersectionality
- Forced Marriage
- 16 days of Action
- No Recourse to public funds
- Managing Disclosure
- Contextual Safeguarding
- Perplexing presentations
- Autism and LD focus in Safeguarding
- Learning from Child Q CSPR
- Learning from safeguarding children practice reviews
- Learning From Safeguarding Adult Reviews and Domestic Homicide Reviews
- Self-Neglect
- Neglect of children
- Domestic Abuse and its impact

5.6.10 The feedback received from delegates who attended the BSMHFT safeguarding training was positive, with some comments below:

"This will improve my practice in relation to safeguarding as it has shown the realities of how much effect we can have on cases like the ones discussed. We need to prepare, document and notify correctly any concerns to help with children."

"Feel empowered and more confident in managing safeguarding cases. The learnings from Domestic Homicide Review were an eye opener."

"This is the best training I have attended, the information that I learnt today will be helpful in my day-to-day practice"

"The trainers are passionate and knowledgeable, and it makes the session even more effective"

5.7 **Safeguarding Supervision**

5.7.1 Safeguarding supervision for adults and children is provided in line with the respective supervision policy in place.

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

5.7.3 Safeguarding supervision gained momentum and some services have achieved 100% compliance for safeguarding supervision. The safeguarding supervision platform is used by Named Professionals to deliver bespoke training, for sharing learning from local and national reviews and to provide outcomes of audits completed.

5.7.4 The safeguarding team offers advice to staff across the trust on safeguarding and non-safeguarding cases with varying degree of complexity. The Named Professionals have attended high risk panels, complex case panel, MARAC and MAPPA to support staff with the management of such cases.

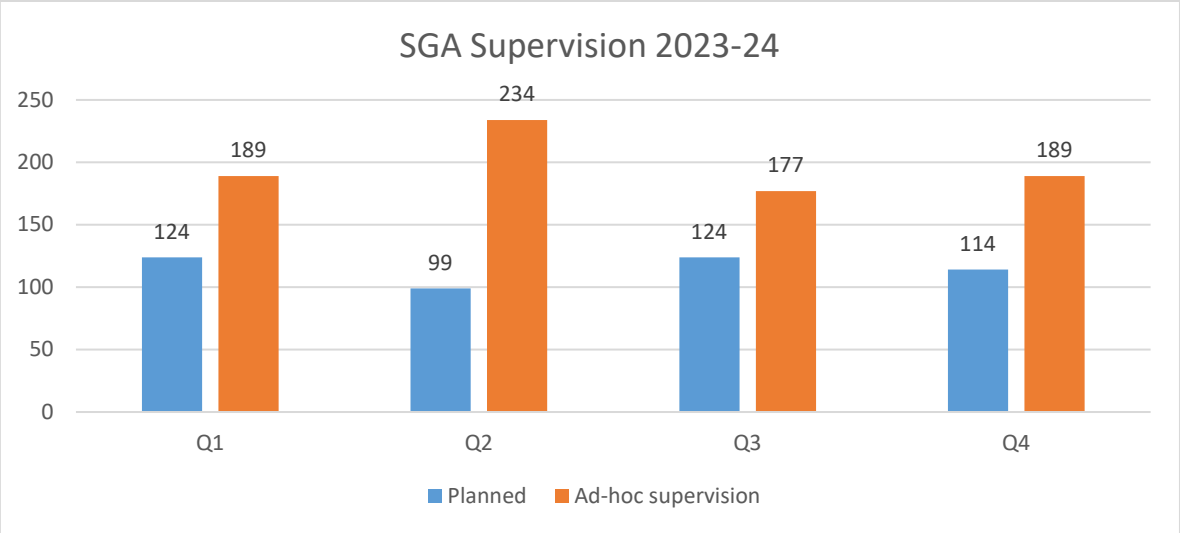
5.7.5 The most common themes discussed during safeguarding supervision are as follows:

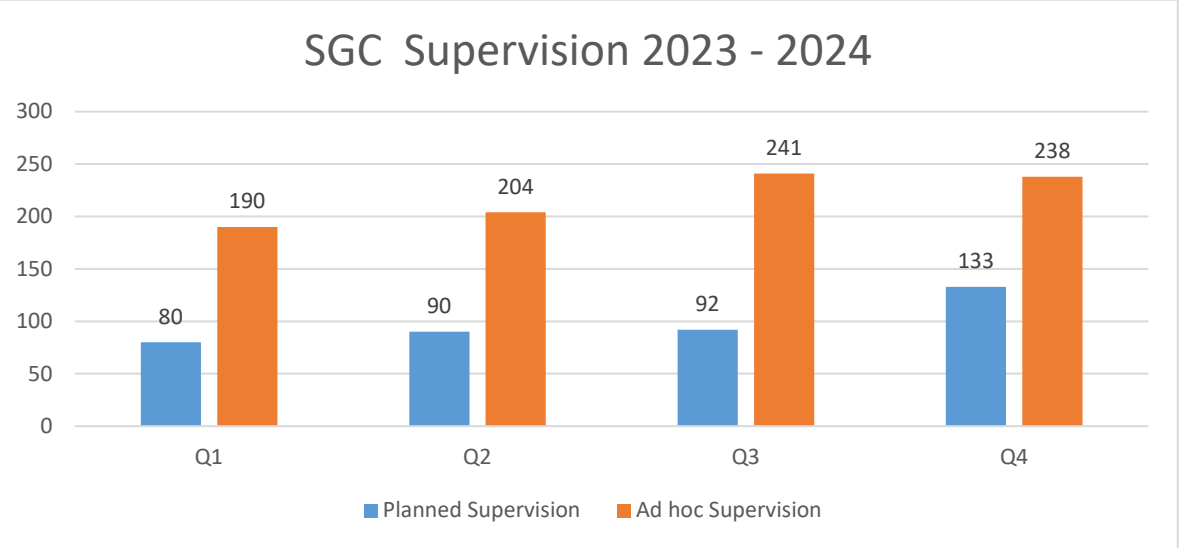
Safeguarding Adults	**Safeguarding Children**
Section 42 cases	Parenting Capacity with mental health issues
Complex cases involving safeguarding, mental capacity and potential criminal allegations.	Domestic Abuse
Domestic Abuse and responding to high level risk.	Neglect
Self-Neglect and hoarding issues	Non-recent abuse
Non-recent abuse and information sharing	Child exploitation risks including criminal, sexual, online grooming, trafficking gangs
Person in position of trust (PiPOT) – how to report and respond	LADO (Local Authority Designated Officer) issues
Mental Capacity and DoL's related practice issues.	Transitions to adult services

5.7.6 The safeguarding team facilitates several joint face to face safeguarding supervision sessions to relevant services across the Trust. This provides staff an objective perspective to help them "think family" and to recognise the impact that parental and family behaviours have on children, young people and vulnerable adults.

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

5.7.8 During 2023-24 the safeguarding team was contacted 1662 times for ad hoc supervision and the team offered 856 planned supervisions to staff across the Trust. The safeguarding team records one advice form per case, which is not a true reflection of the work as one case can generate multiple contacts. The team is reviewing this, and any changes will be reflected in next year's annual report.





5.7.9 The safeguarding children's team were contacted 873 times in 2023-24 for ad hoc advice compared to 711 times in 2022-23, it's a 22% increase in request across the Trust.

5.7.10 The top three reasons practitioners contacted the children's team for ad hoc advice and support were parenting capacity and mental illness, domestic abuse and parenting capacity which remains consistent as the previous year.

5.7.11 The safeguarding children team provided planned supervision to 395 teams in 2023-24 compared 188 teams in 2022-23. The team saw 110% increase in supervision uptake across the Trust. The top three themes discussed in planned supervision across the trust remains consistent with the themes identified in ad hoc advice.

5.7.12 During 2023-24 the safeguarding adult's team was contacted 789 times for ad hoc advice compared to 544 times in 2022 – 2023. This is a 45% increase compared to last year, however this now includes section 42 enquiry advice which was not previously captured.

5.7.13 The safeguarding adult's team provided 461 planned supervisions to staff in 2023-24 compared to 395 sessions in 2022-23. Its 17% increase in the uptake for safeguarding supervision. The team had to cancel supervision sessions owing to staff sickness and vacancy.

5.7.14 The top three themes, Domestic Abuse, Self-neglect and Neglect and Acts of omission remains consistent with the previous year across the adult safeguarding landscape.

5.8 **Safeguarding Reviews**

5.8.1 The safeguarding team have contributed to several statutory reviews within the time frame of the annual report. This includes providing reports based on agreed terms of reference regarding children and adults in the family home and their contact with Trust services. There is also a requirement to attend panel meetings, practitioner learning events, provide feedback to draft reports, sign off panel to agree final reports and meetings about publication and publicity arrangements.

5.8.2 In addition to writing reports, there is a requirement to meet staff and managers who have provided services to the child, adult and family. The safeguarding team also have to follow up and update the partnerships and boards about the progress of the action plans and recommendations.

5.9 **Safeguarding Adults Review**

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

- understand what has happened and why
- learn lessons from the way professionals and agencies worked together
- identify what the agencies and individuals might have done differently that could have prevented harm or death
- prevent similar harm occurring again in future
- improve future practice by acting on the learning
- review and improve the safeguarding adults procedure
- identify good practice as well as poor.

5.9.2 During 2023-24 ELFT was involved in 11 SAR's. The SAR's are at different stages of progress. Where any immediate learning been identified this is actioned at the time. Learning from published reviews is included within level 3 training. For example, a section on transitional safeguarding has been added to the level 3 training following the publication of the Max SAR. Learning is also disseminated to staff groups via the named professional, included in the safeguarding quarterly newsletter and through targeted work with specific teams.
The following reviews were published in 2023-24:

Identifier	Type of Review	Overview	Area

JH	Safeguarding Adults Review (SAR)	Death of an adult service user who had physical and mental health issues along with self-neglect, Domestic abuse and substance abuse. 7 minute briefing - Click here for the report	City and Hackney
Lillian	Safeguarding Adults Review (SAR)	Death of an adult service user. The SAR focused on intersectionality of gender, ethnicity and age. Report and action plan- Click here for the report .	Newham
Adult C	Safeguarding Adults Review (SAR)	Neglect of an adult service user by multiple agencies. Report- Click here for the report	Luton

5.10 **Rapid Reviews and Safeguarding Children Practice Reviews (CSPRs)**

5.10.1 Rapid Reviews and Child Safeguarding Practice Reviews are held after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future. The new arrangements categories reviews into those at which there is learning to be disseminated at a national level, and learning which is more suitable to a local area.

5.10.2 During 2023-2024 the ELFT Safeguarding Children Team contributed to 30 new and ongoing reviews involving. The case reviews included:

- 8 rapid reviews
- 11 child safeguarding practice reviews
- 1 learning reviews
- 1thematic review
- 2 joint reviews
- 7 serious incident notifications

5.10.3 Where any immediate learning has been identified this has been actioned at the time. Learning from published reviews is included within level 3 training, for example, domestic abuse awareness was a common theme from CSPRs, this is now an integral part of the training, to ensure that staff are able to identify signs of this and provide appropriate support to families. Learning is also disseminated to staff groups via the named professional, included in the safeguarding quarterly newsletter and through targeted work with specific teams. The following reviews were published in 2023-24:

Identifier	Type of Review	Overview	Area
Child Q Update	Published CSPR	Concerns of adultification and intersectionality Report- Click here for the report	Hackney
Lena	Published CSPR	Concerns about criminal activity, child pregnancy, Child Sexual Exploitation, management of	Luton

		vulnerability and family engagement. Report- Click here for the report	
Thematic Review of serious youth violence	Published CSPR	Serious youth violence Report- Click here for the report	Luton

5.11 **Domestic Homicide Reviews (DHR)**

5.11.1 A DHR is convened by the Community Safety Partnership under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act):

The Act states: (1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) to establish, or to participate in, a domestic homicide review.

(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.

5.11.2 There have been 8 DHRs within the timeframe of this report. These reports have not yet been completed or published

6.0 PREVENT Duty

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

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

6.3 The trust submits a quarterly return to the Regional Prevent Co-Coordinator and NHS England. The staff achieved 94.93% compliance with WRAP training and 94.43% compliance with the Basic Prevent Awareness training against an expected target of 90%.

6.4 The Trust achieved 94.93% compliance with WRAP training and 94.43% compliance with the Basic Prevent Awareness training against an expected target of 90%.

6.5 In total the Trust responded to 20 Prevent related concerns in 2023-24 compared to 78 PREVENT related concerns in 2022-23. These range from general enquiries to request by Channel Panel from assessments of people's mental health.

6.6 Since 2021, the Trust has seen a decrease in reporting of Prevent referrals and this is consistent with the national picture. In 2023-24 the Trust made three Prevent referrals.

6.7 Channel Panel across the country has reported a drop in adult referrals and an increase in children's referrals, one of the major reasons in the decrease of adult's referral is because Mixed, Unclear, Unstable (MUU) Prevent referrals are increasing and very few present a genuine CT threat or risk or are escalated to Channel. The main risk gravitates around the vulnerability traits these individuals display.

6.8 PREVENT team consistently identify around a third of cases, where mental health is an apparent factor, and they are not known to health services. Many of the trends we see appear to reflect the national conversation in mainstream media about young people and declining mental health.

6.9 Teenagers and people with autism and mental health issues make up an increasing proportion of suspects prosecuted for terror offences, with police attributing this variously to the ease of accessing terrorist propaganda online.

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

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

6.12 The Trust continues to attend and participate in Prevent workshops and events in East of England and London.

6.13 The Associate Director of Safeguarding and the Lead Professionals for Safeguarding attend the PREVENT and CONTEST boards to update them of the work done by the trust and provide inputs to their work plan

7.0 Domestic Abuse

7.1 "Sections 1 to 3 of the Domestic Abuse Act 2021 outline a statutory definition of domestic abuse, which is set out below:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if— (a) A and B are each aged 16 or over and are "personally connected" to each other, and (b) the behaviour is abusive. A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child). Behaviour is "abusive" if it consists of any of the following—

a) physical or sexual abuse;
b) violent or threatening behaviour;
c) controlling or coercive behaviour;
d) economic abuse;
e) psychological, emotional or other abuse; and it does not matter whether the behaviour consists of a single incident or a course of conduct.

Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to acquire, use or maintain money or other property, or obtain goods or services. Two people are "personally connected" to each other if any of the following applies —

a) they are, or have been, married to each other;
b) they are, or have been, civil partners of each other;
c) they have agreed to marry one another (whether or not the agreement has been terminated);
d) they have entered into a civil partnership agreement (whether or not the agreement has been terminated);
e) they are, or have been, in an intimate personal relationship with each other;
f) they each have, or there has been a time when they each have had, a parental relationship in relation to the same child (see subsection (2));
g) they are relatives.

A child is considered a victim of domestic abuse if they see or hear, or experiences the effects of, the abuse, and they are related to A or B".

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

7.3 There continues to be Trust representation at the local Multi Agency Risk Assessment Conference meetings (MARAC), at the respective Community Safety Partnerships and at the Domestic Abuse Strategic Leaders group.

7.4 The Trust has seen a sharp increase in the number of Domestic Homicide Reviews (DHR) and the Safeguarding team have been involved in about seven ongoing DHRs across the trust.

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

7.6 The Trust has reviewed its Domestic Abuse and Harmful Practices Policy and updated it in line with the new Domestic Abuse Act 2021.

7.7 The Trust "Domestic Abuse Steering" group meets twice a year to plan and identify areas of work that needs strengthening within the organisation to appropriately respond to concerns of domestic abuse. The meeting is chaired by the Associate Director of Safeguarding and has representatives from various services within the trust and survivors of domestic abuse.

7.8 The safeguarding team organised 16 days of action to raise awareness of Domestic Abuse and also shared learnings from published DHRs.

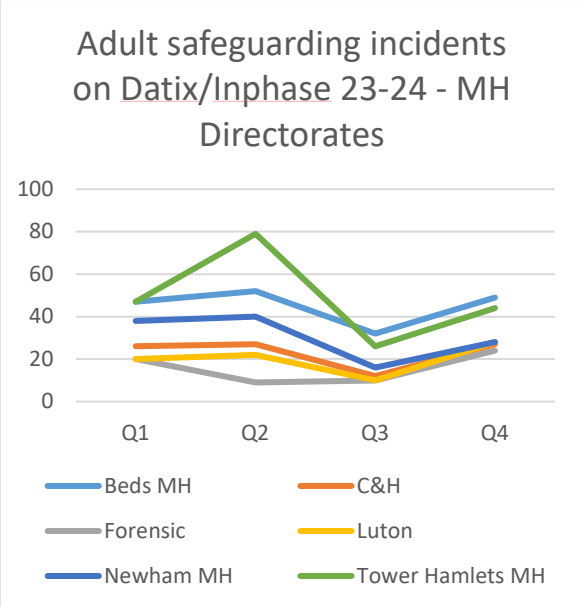
7.9 To support the victims of Domestic Abuse, Trust has acquired organisational membership with Respect, a Domestic Abuse charity.

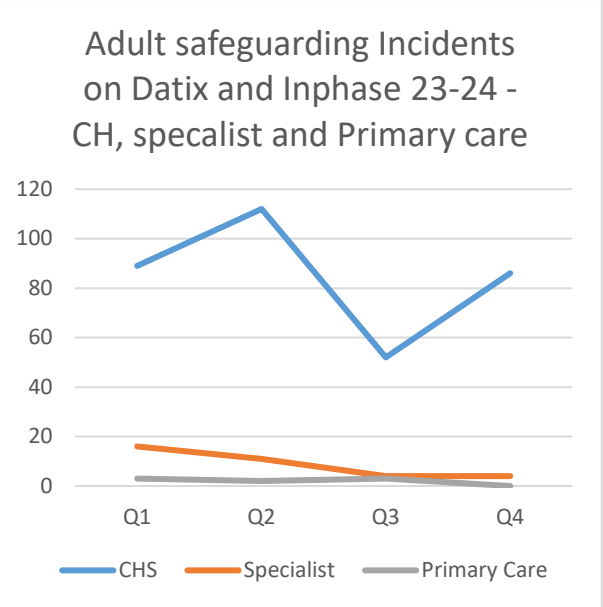
8.0 DATIX and InPhase reported incidents (2023-24)

8.1 In the reporting period the Trust incident reporting system moved from Datix to In Phase, which is the new incident reporting platform during the quarter three of the financial year. The change caused a drop in reporting of incidents in quarter three.

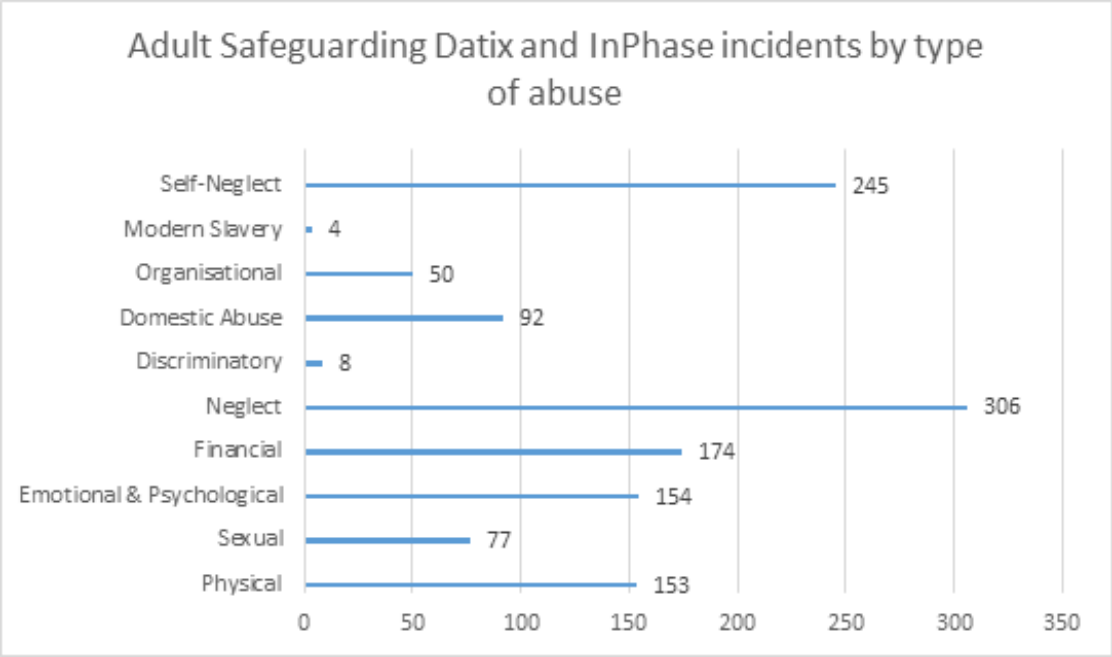
8.2 All patient safety incidents reported on the Datix/InPhase incident reporting system are monitored, assessed and screened for cases where abuse or neglect or poor care are indicated. This process supports staff in their decision making to consider and identify safeguarding concerns. The information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

8.3 There were 1115 safeguarding adult incidents raised by the trust staff in 2023-24 compared to 1845 incidents raised in 2022 -23 and 1072 in 2021-22. The Trust has seen a 39.56% drop in incident reporting in 2023-24.





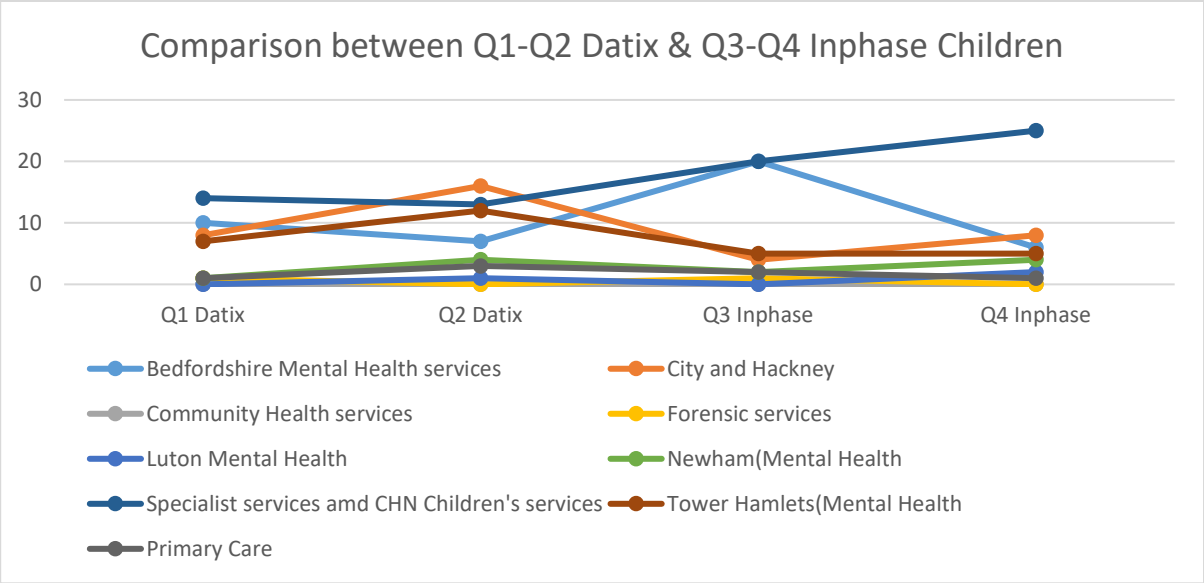
8.4 In 2023-24 Mental Health services raised 760 safeguarding incidents followed by Community Health services reporting 322 incidents. Tower hamlets Mental Health services raised the highest number of safeguarding incidents (190) followed by Bedfordshire Mental Health services (180) and Newham Mental Health services (120). Bedfordshire CHS raised the highest number of incidents followed by Tower hamlets CHS.



8.5 The most reported category of abuse was Neglect and acts of omission followed by self-neglect. Community Health Services across the Trust raised the highest number of abuses relating to Neglect and Acts of Omission and the Community Mental Health Teams raised the highest number of Self-Neglect cases.

8.6 Ninety-two incidents of Domestic Abuse incidents were reported in 2023-24. This excludes the concerns that have been separately reported under the categories of Financial Abuse, Emotional Abuse, Physical Abuse and Sexual abuse. If more than one category of abuse could be ticked the Trust would have seen higher number of Domestic Abuse concerns.

9.0 Safeguarding Children's Incidents



9.1 In the reporting period 190 safeguarding children's incidents were reported where children were directly affected or indirectly involved compared to 185 incidents in 2022-23. This is a 2.7% increase in reporting compared to the previous year.

9.2 Specialist Children's services raised the highest number (72) of children's safeguarding incidents followed by City and Hackney reporting 36 incidents followed by Tower hamlets reporting 29 incidents.

9.3 Neglect remains the most reported category of abuse followed by emotional abuse and physical abuse. This remains consistent with the previous year's reporting.

9.4 The Safeguarding team is working closely with services to improve incident reporting as there is inconsistency in reporting and recording of incidents on the Trust recording system. The safeguarding team will be updating the operational policies and providing guidance to staff regarding reporting and recording of safeguarding children's incidents.

10.0 Modern Slavery Declaration

10.1 The Trust is compliant with the responsibilities to have a statement regarding its commitment to ending Modern Slavery, through its support and oversight of the Modern Slavery Act 2015. This is available on the Trust website - modern-slavery-and-human-trafficking-statement-2023.

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

11.0 Allegations against staff

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

11.2 Within the reporting period, a total of twenty-one cases of staff allegation were managed by the Human Resources team which remains consistent with the previous year. Seven of the cases were closed and did not require any further escalations or DBS referrals. Only one case met the Local Authority Designated Officer (LADO) threshold, however was closed after the review meeting with no further action.

12.0 Workforce

12.1 Statutory guidance requires the Trust to have robust arrangements for safe recruitment practices including identity and DBS checks for all new and existing every three years. At the end of the financial year the percentage of staff with a valid Disclosure and Barring Scheme (DBS) check was 98%. This was due to a number of staffs members being off sick, on maternity leave and career break.

13.0 Children in Care

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

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

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

3.4 The total number of children looked after by Newham as of March 2024, was 512 an increase of 21% from March 2022. (Source: unpublished ELFT caseload data from RIO). For those living outside of the Borough, care is provided by the host Local Authority and health provider.

3.5 In the financial year 2023-2024 - 236 children entered newly into care in Newham. (Source: unpublished ELFT caseload data from RIO). This is an increase of 29 children from 2021-2022.

3.6 50.5 % of Initial health assessments were completed in the 20 working days’ time frame in 2023-2024. The expected national average per annual % of IHAs completed is 88%.

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

3.8 The main reasons for breaches are Child’s paperwork was received from Social worker on or after breach date, no slot available in clinic to book earlier and carer’s request for later

appointment. There was also a reduced capacity of the medical workforce in the 2023-2024 financial year due to changes in the department.

3.9 Under 5yr Review Health Assessments:

- Under 2yrs are reviewed by the Community Pediatricians and age 2-5yr by the Specialist Nurses. For this report they are calculated.

- 67.1% of under 5's Review Health Assessments (RHA) were completed in the set time frame in 2023-2024, a decrease of 11% from 2022-2023.

3.10 5yr- 18yr Review Health Assessments:

68.2% of over 5's was completed in the set time frame. This is a decrease of 12% from 2022-2023. The national average is 88%. The main reason why reviews have not been completed are:

- Child's appointment cancelled by carer
- Young Person refusing
- No consent received for child from social worker
- All cases of reviews not being completed are fed back to the child / young person's social worker.

3.11 ELFT CIC ensure that all Children and young people leaving care aged 18 years have a completed Care Leaver's health summary

- 97% of children and young people leaving care have a completed Care Leavers health summary in 2023-2023

3.12 Unaccompanied Asylum-Seeking young people (UASC):

- 34 UASC have been seen in a novel integrated health care pathway in 2023-2024 from Newham and other local authorities. This includes a joint assessment with a senior CAMHS practitioner and support from a Health Improvement Practitioner who facilitates access to healthcare and improved health outcomes.

3.13 Children from other Local Authorities

- By March 2024 215 children were seen for other local authorities for IHAs and RHAs but the Newham Children in Care Health Team.

3.14 Adoption Medicals

- Our medical advisor for adoption and fostering has seen 17 children in 2023-2024 for a medical assessment prior to a proposed adoption.

3.15 CIC Governance and reporting arrangements:

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

14.0 Key achievements and challenges

14.1 In 2023-24 the safeguarding team has achieved:

- integrated leadership to promote Think Family approach.
- developed joint team SOP (Standard Operating Procedures) and house style guide for safeguarding reports.
- achieved over 80% compliance for level three adult and children safeguarding training.
- participated and contributed to partnerships, boards and sub-groups across the Trust.
- improved team data collection methods which have provided more accurate data on trends, themes and risks across the Trust.
- participated in a project with Local Authority safeguarding partners across the Trust to reduce duplication of safeguarding information across IT systems.
- supported the Trust to deliver the actions identified in the SARs, CSPRs, DHRs and other learning reviews.
- hosted 16 Days of Action and a few safeguarding training events.
- offered face to face Think Family supervision to teams across the Trust.
- supported CMHT's with performance issues by providing intensive safeguarding support at MDTs and increased supervision to ensure that the Trust delivers safe services.
- acts as subject matter experts and co-reviewed multiple safety incident investigations, ensuring that Safeguarding Adults and Children is fully considered.

14.2 **Service User Involvement and Co-Production** – service users were involved in the interview panels for recruitment of new staff members within the safeguarding team. There is service user representation at the safeguarding committee and the domestic abuse steering group. The Named Professionals continue to engage with the people participation leads across the directorates. For example, in Tower Hamlets the Named Professional attended service user forums to present and answer questions related to how ELFT safeguards its patients.

14.3 **Challenges:**

- Domestic Abuse remains an ongoing risk as Routine Enquiry is not embedded in staff's practice. Therefore, this forms part of the key priorities for 2024/25.
- The impact of pandemic and the socio-economic crisis continues to be reflected in the increased number of adult and children's safeguarding reviews (Rapid Reviews, Child Safeguarding Practice Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews).
- The ongoing increase and complexity of safeguarding cases related to e.g. mental health, perplexing presentations, domestic abuse, serious youth violence, self-neglect and neglect often requires ongoing and longer-term input from the safeguarding teams.
- Due to the multiple electronic patient record systems in use across the Trust and lack of clear guidance on how children's safeguarding incidents are recorded on InPhase, the safeguarding team is unable to accurately capture the number of the children social care referrals and safeguarding children related incidents.
- Being a safeguarding lead is a demanding and specialist role. The team deals with complex cases and access to high quality and up to date training is essential to support

staff and services effectively. The nature of the job impacts on staffs mental and physical well-being and recruiting skilled staff to such roles is a challenge. The team receives monthly restorative supervision to address some of these issues. This includes a time and space provided for reflection.

14.4 **Key Priorities for 2024-25:**

Priorities	**Actions**
Domestic Abuse	• Trial implementation of Routine Enquiry in services embedding a trauma informed approach to responding to domestic abuse.
Developing Level three refresher trainings	• Self-Neglect and hoarding • Intergenerational and Intersectional training • Legal Framework • Responding to Allegations • LADO/Pipot • Neglect • Domestic Abuse and Think Family
Co-production	• Developing training package and leaflets with support from experts by experience
Learning from reviews	• Offering staff bi-annual training to cascade learnings from reviews.
Improving the quality and specificity of safeguarding data	• Improved recording of children's social care referrals and safeguarding information on Rio • Improved recording of child safeguarding incidents on the Trust incident reporting system. • Development of safeguarding teams' dashboard on PowerBi

15.0 Conclusion:

- During 2023-24, the safeguarding team made progress with the safeguarding strategic objectives and work plan underpinned by the Trust's core values.
- The work plan has achieved most of its objectives. Areas such as training, reporting, auditing has improved and embedded in staffs practice and evidenced in this report.
- A new work plan for the next 3 years has been developed which incorporates some of the ongoing work of the existing work plan and will be reviewed by the Safeguarding Committee on a bi-monthly basis.

- Finally, this report needs to acknowledge and provide focus to the numerous excellent safeguarding achievements which have occurred in this reporting period. There are a great number of committed staff who work impeccably to support and serve our service users and their families, and the Safeguarding team would like to acknowledge them all.

15.1 The Board/Committee is asked to:

a) **RECEIVE** and **NOTE** the report
b) **NOTE** the assurance provided and **CONSIDER** if further sources of assurance are required

NHS
East London
NHS Foundation Trust

Appendix 1 - Safeguarding Work Plan (2022-25)

No	Improved Population Health Outcomes	Action Required	Lead	Timescale	Evidence/ Progress/Success Measures	Rag Rating
1	The Corporate Safeguarding team will focus on Preventative and Early Intervention safeguarding practice to support staff to have knowledge, skills and confidence to protect all ELFT service users, regardless of age.	Seek assurance that Safeguarding Policy and associated practice guidance is effectively embedded.	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	• Good practice case studies shared with staff. • Providing advice and InPhase new responses • Action Plans from audits completed • Reviewed and updated policies and protocols. • Trial implementation of Routine Enquiry in services embedding a trauma informed approach to responding to domestic abuse.	
		Support staff with areas of practice that needs strengthening to reduce repeat safeguarding referrals.	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	Delivered training to raise the awareness of Safeguarding Provided safeguarding and complex case supervision to staff members. Reviewed and updated policies and protocols. Trial implementation of Routine Enquiry in services embedding a	

					trauma informed approach to responding to domestic abuse. Develop modular training packages for the following areas of practice: Self-Neglect and hoarding Intergenerational and Intersectional training Legal Framework Responding to Allegations LADO/Pipot Neglect Domestic Abuse and Think Family	
		Produce guidance for staff around Homelessness, Domestic Abuse, Self-Neglect Substance Misuse, Harmful Gambling.	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	Delivered training and good practice workshops to raise the awareness of Safeguarding issues. Learnings from the SAR/DHR/PFDs is shared with staff and drives improvement in practice through quarterly learning events. Trial implementation of Routine Enquiry in services embedding a trauma informed approach to responding to domestic abuse.	

					Develop modular training packages for the following areas of practice: Self-Neglect and hoarding Intergenerational and Intersectional training Legal Framework Responding to Allegations LADO/Pipot Neglect Domestic Abuse and Think Family	
		SG team to work with the Trust Transition Lead to develop and review the policy and procedures around transition to ensure a more integrated approach	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	• Guidance produced; feedback from transitional lead - Completed • Reviewed and updated policies and protocols.	
		Review current practice guidance regarding the interface between poor quality care and safeguarding	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All	• Revised guidance in place- Updated in 2022-23 • Survey feedback demonstrating good understanding of the interface- Completed in 2022-23.	

				actions to be continued		
No	**Improved staff experience**	**Action Required**	**Lead**	**Timescale**	**Evidence/ Progress**	**Rag Rating**
2a	The Corporate Safeguarding team will ensure that its expertise is shared within and outside the organisation and the team engages in the dissemination of lessons learnt from safeguarding enquiries, Safeguarding Adult Reviews, Child Safeguarding Practice reviews, Domestic Homicide Reviews, PFD's LeDeR reviews and other relevant enquiries.	IMRs and chronologies when requested to be prepared jointly by NP and Assistant Directors / Deputy directors / Directors	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	• Named Professional's attend and actively participate in the SARS, DHRs, CSPRs and other statutory panels. Actively engaging and participating with its various partners and safeguarding sub groups to support and deliver the effective safeguarding service.	
		Disseminating learnings from the reviews, through training, supervisions and newsletters.	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	• Quarterly trainings –Discontinued in 2023 and replaced with bi-annual conference. • Safeguarding Supervisions • Six monthly news letters • Disseminate seven minute briefings	

		Monitoring how much impact learning lessons are having on changing practice and embedding learning	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	• Undertaking regular safeguarding audits • Monitoring staff attendance at training and supervision • Periodical review of Trust wide and local policies and procedures • Utilising the safeguarding database to understand what the themes, trends and risks are within services.	
		Maintain an awareness of both national and regional learning to ensure this is disseminated.	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	▪ Rolling programme of dissemination of learning as it is published via training, supervision or newsletter.	
2b	The Corporate safeguarding team will continue to engage and collaboratively work between services to ensure that the voice of the child/vulnerable adult is heard, and their circumstances safeguarded.Shared	Deliver good practice training on self –neglect	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	▪ Invite all partners to quarterly events / training being offered by ELFT ▪ Disseminate partner agency training to ELFT staff	

	information must lead to shared understanding and thinking.	Deliver training on hidden harm which includes; Drug and alcohol Misuse Domestic Abuse Harmful Gambling Mental ill health in the household.	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	▪ Quarterly refresher trainings. Joined up safeguarding Supervisions- Completed in 2022-23 ▪ Feedback obtained from staff to be disseminated and used to influence changes in practice and communication through the Safeguarding committee.	
No	**Improved staff experience**	**Action Required**	**Lead**	**Timescale**	**Evidence/ Progress**	**Rag Rating**
2c	The Corporate safeguarding team will ensure that their practice recognises and focuses on trauma informed care/practice across all the services as it is crucial to good integrated practice and effective support for staff and service users.	• NPs to attend Trauma Informed Care (TIC) training offered by the trust. • NP's to incorporate the principles of TIC into training, supervision and advice offered.	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	• Updating trainings with the principles of TIC- Completed in 2022-23 • Advice and supervision offered to include TIC – Started in 2022-23 and ongoing	
No	**Improved Experience of care**	**Action Required**	**Lead**	**Timescale**	**Evidence/progress**	**Rag Rating**
3	The Corporate Safeguarding team will ensure that the ethos of Making Safeguarding Personal and Voice of the Child is totally embedded within the practice of all trust staff.	Consultation and coproduction with service users to understand peoples lived experience of safeguarding to raise the profile of safeguarding.	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	▪ Undertake regular audits to seek evidence that the views and wishes of service users are at the heart of the safeguarding process ▪ Deliver training and supervision to staff to equip them with the knowledge and skills required to ▪ Developing forms/assessments that help to evidence MSP and Voice of the child.	

					▪ Link with People Participation Leads to develop task and finish group to strengthen MSP – Work in progress	
3a	The Corporate Safeguarding Team to ensure that proactive support is provided to carers to prevent carer breakdown and occurrences of abuse or neglect.	▪ Engage carers, and people's participation services to understand their perspective on the challenges they face and support needed. Develop recommendations for system improvement and action plan.	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	• Feedback from training sessions and the content of material provided • Reviewing, developing, co-producing and designing training packages, leaflets etc- Work in progress	
		▪ Seek carer's views and feedback and incorporate learnings into practice through co-production.	SGA/SGC NPs and ADs	Ongoing Reviewed progress in Q1, Q2, Q3 and Q4 reported to safeguarding committee. All actions to be continued	▪ Integrate service users experience of Safeguarding into training packages – Work in progress	

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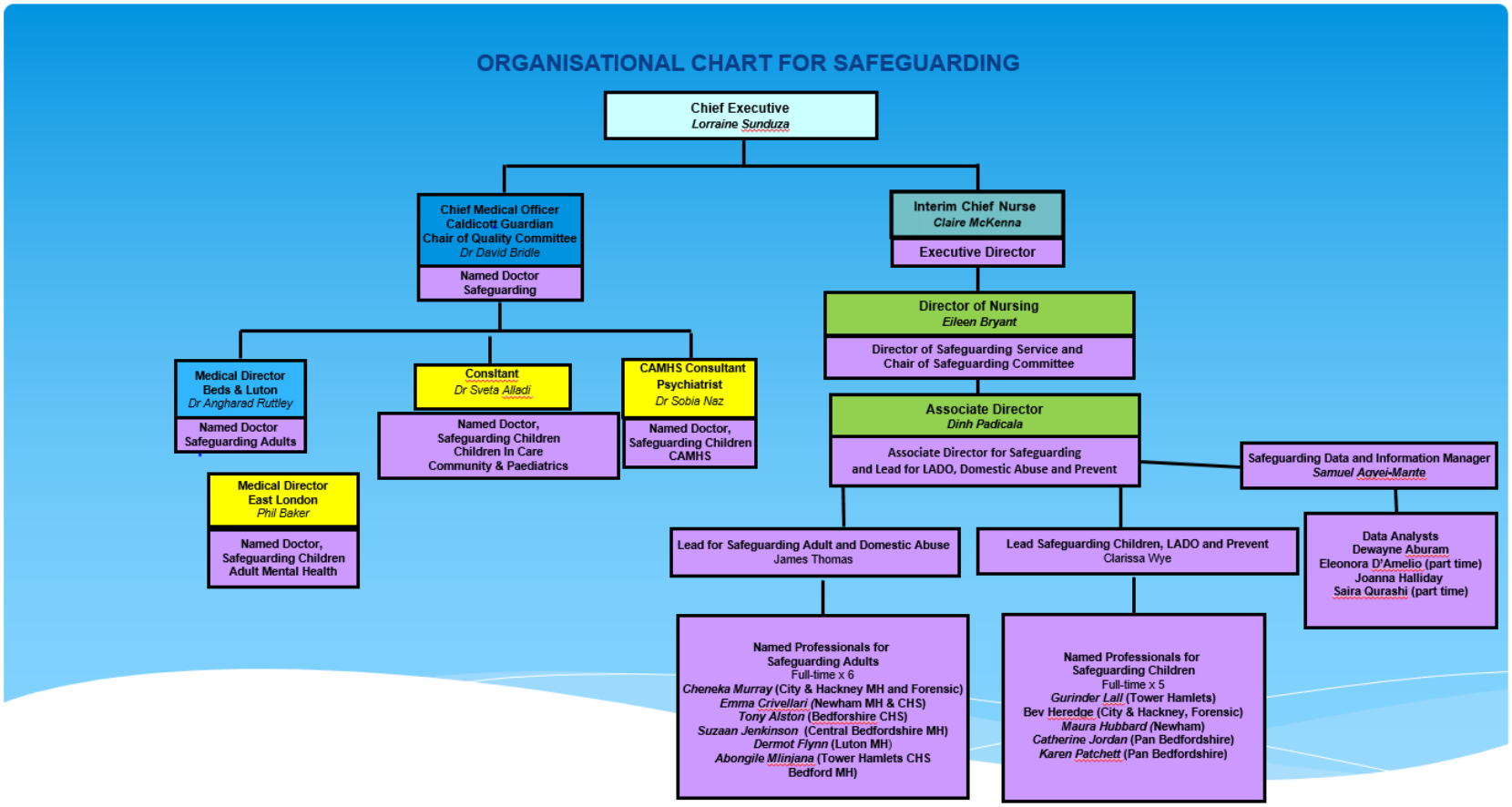
Appendix- 2 Organisational Chart



Appendix - 3 Governance

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INFECTION PREVENTION AND CONTROL ANNUAL REPORT - TO THE QUALITY COMMITTEE

July 2024

Title	Infection Prevention and Control (IPC) Annual Report.
Authors	Rana Begum – Trust-wide Lead Infection Prevention & Control Nurse
	• The author would like to thank the following individuals and department in developing the annual report: • Claire McKenna- Interim Chief Nurse/ Director of Infection Prevention & Control • Ruth Bradley- Director of Nursing –London Community Services • Bernadette Kinsella –Deputy Director of IPC/Physical Health Lead Nurse • Dr Giovanni Satta – Consultant Microbiologist / Infection Control Doctor • Harriet Ddungu – Trust-wide Deputy Lead Infection Prevention & Control Nurse • Valrie Burgess – Senior IPC Nurse • Serakoule Traore – Senior IPC Nurse • Nichole Reid – Senior IPC Nurse • Inez Monteith – IPC Nurse • Melanie Charles – IPC Nurse • Monsur Gabr – Infection Prevention & Control Team & Contracts Administrator • Rakib Ali– Infection Prevention & Control Administrator • Estates and Facilities Department • Occupational Health Department • People and Culture Department • Health & Safety Department • Pharmacy Department • Medical Devices Department • Fit Testing Department • Vaccinations Department
Accountable Executive Director	Clare McKenna – Interim Chief Nurse / Director of Infection Prevention and Control

Purpose of the Report

This report aims to:

1. Update the Trust Board on Infection Prevention and Control (IPC) standards maintained in the past year to ensure continual delivery of care in clean and safe environments for patients, staff, and visitors.
2. Meet The Health and Social Care Act (2008) *code of practice on the prevention and control of infections* requirements, demonstrating governance and public accountability in IPC systems at ELFT aligned with quality care metrics.

Committees/Meetings where this item has been considered:

Date	Committee/Meeting
June 2024	Infection Prevention and Control Committee
July 2024	Quality Committee

Key Messages:

Key Achievements for 2023-24:

The Infection Prevention & Control Team (IPCT) continue to maintain high awareness and engagement among Trust staff through proactive use of social media, national campaigns, and regular sharing of best practices, audit findings, Root Cause Analysis , and Post Infection Reviews across Integrated Care Boards (ICB) in North East London (NEL) and Bedfordshire. Key initiatives include successful awareness campaigns of World Hand Hygiene Day and National Infection Prevention and Control Week. Adoption of ELFT IPC Nurse induction programme by NEL ICB for wider NHS implementation. Ongoing quality improvement projects on Gram Negative Blood Stream Infections and sustainability projects. Other keys achievements for the IPCT include advancing IPC training for IPC nurses, and collaborative research with Cambridge University Hospital on Air Cleaning Study at Fountains Court. Furthermore the Trust-wide Lead Infection Prevention & Control Nurse completed an NHS England Pan-London IPC Fellowship during 2023-24. The IPC team achieved the 2023-24 annual workplan.

Healthcare Associated Infection Surveillance:

In 2023-24, there were no reported cases of MRSA bacteraemia, C. diff toxin-positive infections, or Gram-negative rod bloodstream infections. COVID-19 cases decreased to 105 from 508 the previous year, with 92 healthcare-onset infections. The IPC team responded to 903 general inquiries, this is an increase from 633 the previous year, while COVID-19 enquiries decreased to 281 from 767. Additionally, one case of invasive group A Streptococcal (iGAS) was reported at the Foot Health Clinic in Newham. Further details are in Section 8.5 of the report.

Coronavirus (COVID-19) Pandemic:

Daily COVID-19 surveillance data and dashboards are regularly submitted to NHS England, with Outbreak Management meetings conducted across the Trust to adhere to Trust policy and UKHSA guidelines. Communications are continuously updated to reflect emerging evidence on COVID-19 and IPC issues for both staff and patients. IPC Policy Manual and Respiratory Policy have been updated are accessible on the intranet for staff. Routine testing ceased in April 2023, shifting to symptomatic testing as per national guidance. On 5th May 2023, the World Health Organization declared the end of the COVID-19 Pandemic.

Outbreaks & Incidents:

During 2023-2024, there were 23 COVID-19 outbreaks reported to UKSHA, down from 99 the previous year. One Influenza *A* outbreak was reported affecting 7 patients that were treated successfully. One serious incident involving a Scabies infection which led to a patient's unfortunately passing away. Further information can be found on section 8.1 of the report. The IPC team supported a prolonged bedbug infestation in Forensics services, covered in section 8.4 of the report.

Cleanliness of the Environment:

The Trust's cleaning scores of 95.7% align closely with the national average of 95%; refer to page 31 for further details. Throughout 2023-24, the IPC team facilitated PLACE inspections and efficacy audits

across ELFT, collaborating closely with the Estates department. Overall, the IPC team continues to uphold rigorous cleanliness standards across ELFT, tackling persistent challenges and promoting initiatives to improve environmental cleanliness and pest control measures.

Sharps Injuries:
In 2023-24, Optima Health, ELFT's Occupational Health provider, reported 33 sharps injuries, which increased from 30 incidents the previous year. The IPC Team provides follow-up, education, and training to minimize risks associated with needlestick injuries (NSIs).

Seasonal Influenza campaign:
The campaign achieved a 93.85% offer rate to staff, despite a decrease in frontline staff uptake reported to NHS England from 62.3% last year to 29.76% in 2023-24.

Water Safety:
During 2023-24, 35 positive legionella cases were identified, prompting immediate remedial actions; subsequent resampling confirmed the absence of legionella. Additionally, the IPC team and Estates & Facilities department underwent water hygiene training led by the Trust's Authorised Engineer, focusing on water management, hygiene awareness, & responsibilities. The Trust's Water Safety Plan was also reviewed and revised.

Ventilation Safety:
Ventilation strategies and FFP3 mask usage are emphasized in outbreak meetings to mitigate COVID-19 risks, aligning with the hierarchy of controls. Additionally, ventilation risk assessments continued organisation-wide. During 2023-24, the IPCT, Estates, and Luton and Bedfordshire Mental Health Clinical teams collaborated on the Cambridge University Hospitals Trust-led Addenbrooke's Hospitals Air Disinfection Study at Fountains Court, demonstrating effective removal of COVID-19 and other pathogens from the air. The study commenced on June 2023, & at the time of writing report, plans for expansion at Mile End Hospital are being explored.

IPC risk:
The following items remain on IPC risk register:

- Enabled Living Healthcare Services faces risks from ineffective decontamination of reusable medical devices. They have been advised to implement a recommended action plan to meet essential quality requirements of decontamination. Tower Hamlets Community Health Services is monitoring this risk at local contracts meetings. A re-audit is scheduled for July to assess further improvements.
- A workforce review, benchmarking against NHS Trusts like CNWL and NELFT, led to the removal of one Band 6 specialist nurse due to cost-saving measures. This poses this following risk to the organisation:
    - Compliance with the Health and Social Care Act (2015) to fulfil provider duties.
    - Increased healthcare-associated infections and outbreaks.
    - Failure to maintain a clean and safe environment, affecting patients, staff, & visitors.
    - Lack of assurance to regulatory bodies like CQC, ICB, and UKSHA, possibly resulting in financial penalties.
    - Risk mitigation involves prioritising the annual work program for 2024-2025.

Work Plan 2024-2025:

- Ensure ELFT's compliance with national standards, particularly The Health and Social Care Act (2015) Code of Practice on infection prevention and control, aligning with Trust strategic objectives. Please refer to Appendix 1 for the IPC workplan driver diagram for 2024-2025 (Page 44)

- Strengthen Infection Prevention Control efforts focusing on reducing Gram Negative Rod Blood Stream Infections, community-acquired MRSA and MSSA bacteraemia, and enhancing antimicrobial stewardship.
- Continuing sustainability initiatives and ensure financial viability.
- The annual workplan for 2024-25 will be monitored by the IPC committee on progress and if any amendments are required in delivering the workplan.
- Our key stakeholders in delivering the plan will be all Trust staff, services users and visitors in further developing resilience at local level & collaborative work with Patient participation & ELFT wider departments.

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

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

Implications:

Equality Analysis	Infection control is everybody's business. This work plan has no impact on individual groups. This report has no direct impact on equalities.
Risk and Assurance	Ensuring a safe clean environment for staff and service users is fundamental to good quality care.
Service User/Carer/Staff	The new work plan will support staff to identify areas of concern to staff and service users and empower them to escalate and take action to make improvements.
Financial	There will be financial implications in discharging its duties to keep infections to a minimum in safe clean environments. Some of these costs will be met with Directorate obligations.
Quality	Providing quality care and continuously improving the environment

Infection Prevention and Control Annual Report 2023-2024

Glossary

Abbreviations	
Antimicrobial Stewardship Group	AMS
Blood Borne Virus	BBV
Clostridioides difficile infection	CDI
Care Quality Commission	CQC
Clinical Commissioning Group	CCG
Carbapenem Resistant Organisms	CRO
Central & North West London NHS Foundation Trust	CNWL
Data capture system	DCS
Director of Infection Prevention & Control	DIPC
Deputy Director of Infection Prevention & Control	DDIPC
East Ham Care Centre	EHCC
East London Foundation Trust	ELFT
Gram Negative Rod Blood Stream Infection	GNR BSI
Health Care Associated Infection	HCAI
Human Resources	HR
Infection Prevention & Control	IPC
Infection Prevention & Control Committee	IPCC
Infection Prevention and Control Team	IPCT
Infection Prevention & Control Nurse	IPCN
Methicillin-resistant Staphylococcus aureus	MRSA
Needle stick injury	NSI
North East London Integrated Care Board	NEL ICB
North East London Foundation NHS Trust	NELFT
Patient Led Assessment of Care Environment	PLACE
Quarter 1	Q1
Quarter 2	Q2
Quarter 3	Q3
Quarter 4	Q4
Single Use Devices	SUDS
United Kingdom Security Health Agency	UKSHA

Red, Amber, Green (RAG) Ratings		
Green	85=100%	Compliance
Amber	60-84%	Partial compliance
Red	0-59%	Minimal Compliance

1.0 Executive Summary

This annual report assures that East London NHS Foundation Trust fully complies with CQC regulations under The Health and Social Care Act (2008), particularly regulations 12 and 15, detailing efforts undertaken to meet statutory duties outlined in the *Code of Practice on infection prevention and control* (DH 2015). Figure 1 outlines the ten criteria covered in the code, highlighting the IPC team's efforts alongside clinical and operational staff to mitigate infection-related harm.

Figure 1. *below displays the ten-criterion covered in the code of practice on the prevention and control of infection as detailed in the Health and Social Care Act (2008):*

Criterion	Description
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitate the prevention and control of infections.
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	The provision or ability to secure adequate isolation facilities.
8	The ability to secure adequate access to laboratory support as appropriate.
9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections
10	That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

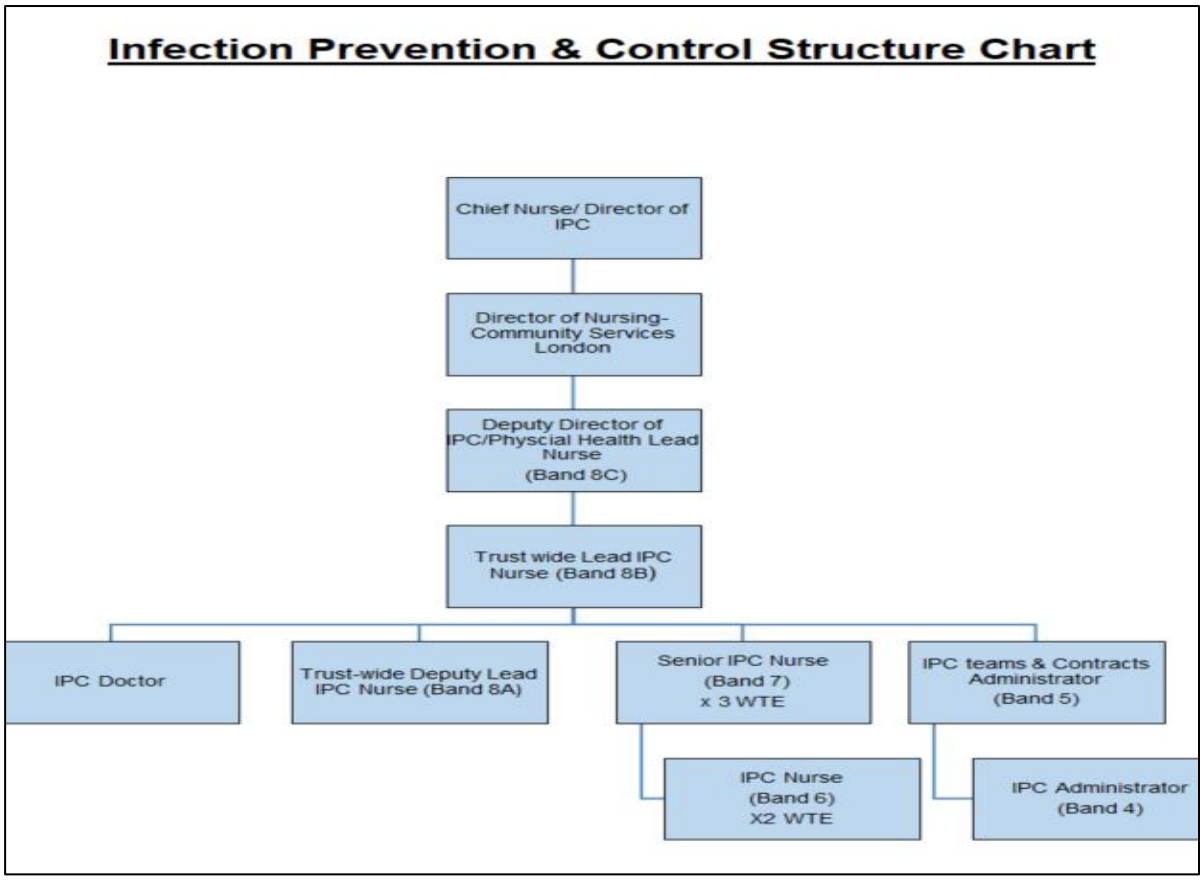
1.1 Background/ Introduction

The annual report from the Director of Infection Prevention and Control (DIPC) demonstrates the Trust's ongoing commitment to IPC, highlighting improvements across all areas of the organisation. It provides assurance to the Trust Board regarding compliance with The Health and Social Care Act's Code of Practice on infection prevention and control and CQC standards. The IPC driver diagram for 2024-25 outlines priorities for the coming year (Appendix 1), supported by audit, surveillance, and IPC reporting mechanisms integrated throughout the organisation. During this year, significant progress has been made to ensure patients are cared for in a safe and clean environment, where the risk of healthcare associated infections are minimised.

1.2 Management and Governance Arrangements for Infection Prevention and Control

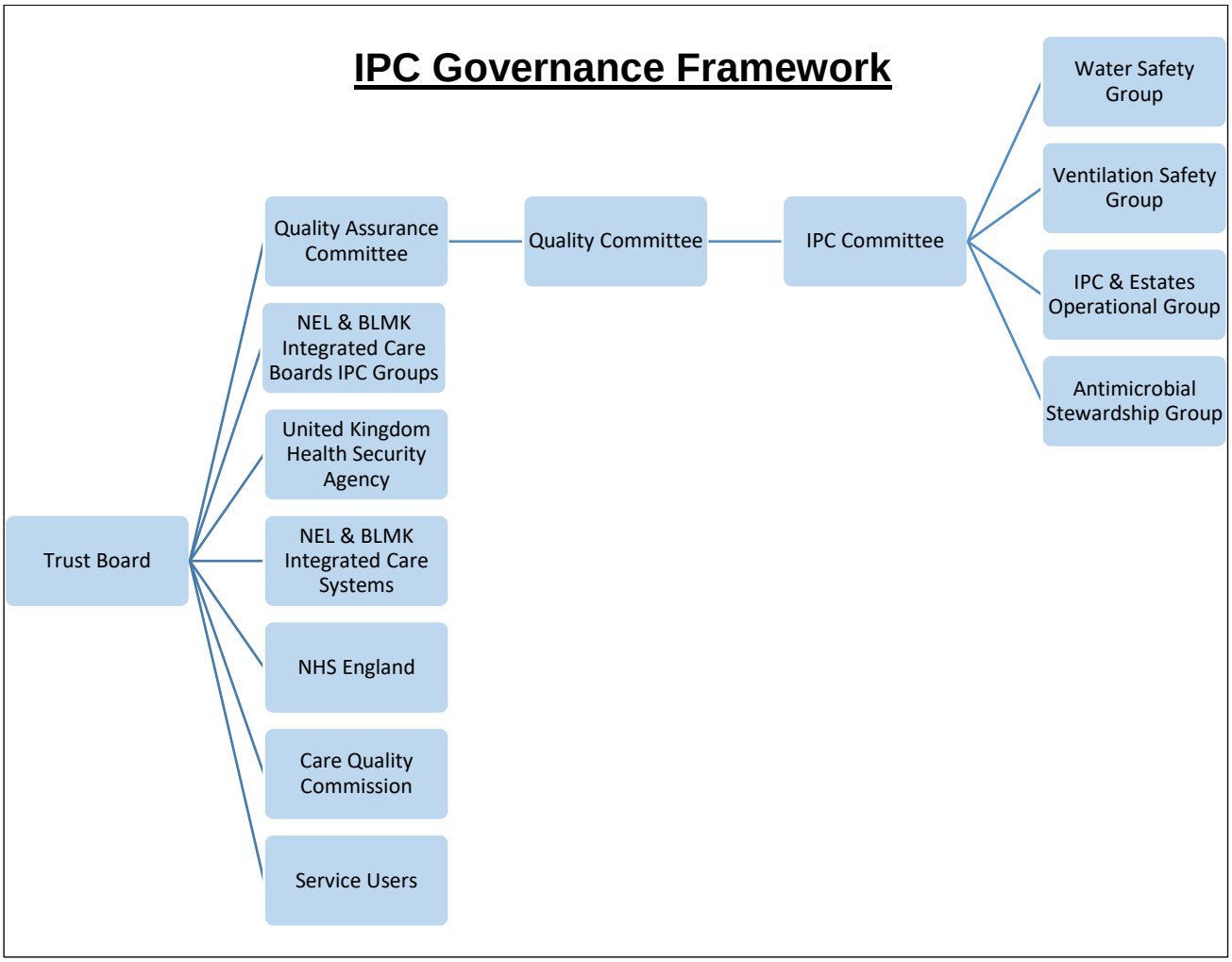
The Trust Board oversees effective IPC arrangements, delegating operational responsibility to the IPC Committee (IPCC), which advises via the Quality Committee in compliance with statutory requirements. The Chief Nurse serves as Director of Infection Prevention and Control (DIPC), reporting directly to the Trust Board and ensuring IPC leadership and continuous improvement within ELFT. The Deputy Director of Infection Prevention and Control (DDIPC) manages day-to-day IPC operations, policy implementation, and external engagements, supporting the DIPC in embedding IPC standards across clinical areas and governance structures.

Figure 2. *below shows the IPC establishment structure:*



1.3 Governance Framework for Infection Prevention & Control Committee

***Figure 3**. below shows the Governance Framework for Infection Prevention and Control:*



1.4 Infection Prevention and Control Committee (IPCC)

The IPCC is a key forum for the development and performance management of the IPC agenda across the organisation. During 2023-24, The IPCC met quarterly and is chaired by the DIPC with key stakeholders from across the organisation. An overview of the IPC agenda and progress throughout the year is discussed at this meeting. A quarterly report is routinely submitted to the IPCC. This enabled capturing HCAI's alert organisms, outbreaks, IPC audit programme and scoring therefore comparable data can be analysed.

The Committee within the Trust's governance framework that have responsibilities/roles in relation to IPC are as follows: Quality Committee:

- The Quality Committee monitors the work of the Infection Prevention and Control Committee.
- The Quality Committee is chaired by the Chief Nurse and is attended by senior corporate staff and all clinical directors.
- The Quality Committee oversees clinical governance activity across the Trust

1.5 Infection Prevention and Control Board Assurance Framework (BAF)

In June 2020, NHS England/NHS Improvement (NHSE/I) introduced an IPC board assurance framework (BAF) to help Trust boards ensure their management of Covid-19 adhered to national IPC guidelines and addressed identified risks. The BAF was revised in October 2022 to include a broader focus on all seasonal respiratory viruses. Currently, the BAF encompasses 95 key lines of enquiry (KLOE) across ten domains.

Of the 95 KLOE, 83 are rated green & 12 is amber. Actions have been implemented to address the amber KLOE, which pertain to staff fit testing on two or more FFP3 masks and aspects of ventilation, and the application of a hierarchy of control model for risk assessment.

1.6 Infection Prevention and Control Service

The Infection Prevention and Control Service aims to maintain a safe environment with minimal infection risks for patients, visitors, and staff. Key responsibilities include providing expert guidance, conducting surveillance of healthcare-associated infections, ensuring legislative compliance, advising the Trust board on IPC matters, implementing infection control strategies, updating policies, educating staff, conducting audits, promoting antimicrobial stewardship, and monitoring infection incidents for continuous improvement. Microbiology services for London-based and Luton/Bedford-based services are provided by Bart's Health NHS Trust and Bedfordshire Hospital NHS Foundation Trust.

2.0 Healthcare on-set Infections (HCOIs)

Healthcare on-set Infections (HCOIs) are infections that are acquired during care in hospitals and other healthcare facilities.

2.1 Surveillance of Healthcare Associated Infection (HCAI's)

The National Mandatory Data Capture System (DCS) was introduced by UK Security Health Agency (UKSHA) to monitor Healthcare associated infection (HCAI's) nationally. In the event of a bacteraemia from MRSA a post infection review (PIR) investigation is undertaken and for *Clostridioides difficile* (C. diff) toxin positive, a root cause analysis (RCA) investigation is undertaken. The rationale for undertaking RCA's is to highlight where lessons can be learnt and to demonstrate best practice in clinical fields.

2.3 Methicillin Resistant Staphylococcus Aureus (MRSA)

Staphylococcus aureus is commonly carried by about one-third of the population without issues, but some strains, known as Methicillin Resistant Staphylococcus aureus (MRSA), have developed antibiotic resistance; routine MRSA screening is performed in community intermediate care units but is not required for mental health services per Department of Health Guidelines.

Figure 4*. below shows zero MRSA Bacteraemia cases reported across the Trust during 2023-2024:*

MRSA bacteraemia infections	Q1	Q2	Q3	Q4
Trust-wide	0	0	0	0

During Q1, the IPCT supported NEL ICB with an MRSA bacteraemia post infection review. A summary is provided below:

2.3.1 Case summary of MRSA Bacteraemia Post Infection Review

A 50-year-old male with neuro-ischemic diabetic ulcers on his left foot, known to community Foot Health services and District Nurses, attended a Foot Health Clinic for wound care. After completing a course of Flucloxacillin prescribed by his GP, his ulcers showed signs of infection, prompting a referral to the Hospital SOS clinic and subsequent wound swabbing. Despite extensive discussions about treatment options, including below-knee amputation, the patient initially opted for alternative therapies like ozone and oxygen therapy. However, following further deterioration and the development of left-foot wet gangrene, he was admitted to the Accident & Emergency department. Blood cultures confirmed MRSA bacteraemia, and despite initial resistance, the patient ultimately underwent a below-knee amputation while being treated with Teicoplanin.

2.3.2 Conclusion of Post Infection Review

The attribution of the MRSA-positive case to ELFT was unsupported due to a lack of communication from the GP, who failed to notify ELFT of the patient's MRSA status in March and April. As a result, ELFT did not administer MRSA treatment. The patient's chronic ulcers would have rendered decolonisation treatment ineffective. When the patient's condition worsened in March and they visited ELFT's Emergency Podiatry Clinic, an MRSA swab was taken, but system issues prevented the team from accessing the result, which was later found to be negative. Patient non-compliance, self-discharge, and personal choices further complicated the situation, and no formal follow-up plan was established, resulting in missed treatment opportunities.

2.4 Methicillin-sensitive Staphylococcus Aureus (MSSA) Bacteraemia cases

Methicillin-sensitive Staphylococcus aureus (MSSA) harmlessly colonises the skin and noses of about one-third of people but can cause septicaemia if it enters the bloodstream.

Figure 5*. below shows zero MSSA Bacteraemia cases were reported across the Trust during 2023-2024:*

MSSA bacteraemia Infections	Q1	Q2	Q3	Q4
Trust-wide	0	0	0	0

2.5 Clostridioides difficile (C. diff)

Clostridium difficile (C. diff) lives harmlessly in the guts of 3-5% of healthy adults but can cause diarrhoea if antibiotics kill the 'good' bacteria that normally control it, particularly affecting the elderly and those on broad-spectrum antibiotics; prevention focuses on maintaining normal gut flora and preventing cross infection.

Figure 6. *below shows zero C.diff cases were reported across the Trust during 2023-2024:*

C.diff Infections	Q1	Q2	Q3	Q4
Trust-wide	0	0	0	0

During 2023-2024 the IPCT have supported BLMK ICB on their C.diff reduction plan & supported meetings across BLMK improving value and population health.

2.6 Carbapenem-resistant Organisms (CRO)

These are groups of bacteria (germs) that produce carbapenemases (chemicals). These chemicals can destroy antibiotics called carbapenems. This makes the bacteria resistant to the antibiotic. Carbapenems are a powerful group of antibiotics that are often relied on for infections where treatment with other antibiotics has failed. CRO can live in the gut of humans and animals and they help us to digest food. In most cases CRO are harmless and cause no ill effects. However, if the bacteria get into the body for example, into the bloodstream or urinary tract it can cause an infection. There have been no cases of CROs recorded across the Trust this year.

***Figure 7**. below shows zero CRO cases were reported across the Trust during 2023-2024:*

CROs Infections	Q1	Q2	Q3	Q4
Trust-wide	0	0	0	0

2.7 Gram-negative Rod Blood Stream Infections (GNRBSIs)

Gram-negative bacteria can be resistant to antibiotics and in some cases will be multi-resistant rendering most available antibiotics useless. Some of the antibiotic resistance mechanisms are on mobile genetic elements, such as plasmids, which allow the genes that encode resistance to spread more easily, and importantly, between different bacterial species. During 2023-2024 the IPCT produced their GNRBSI strategy. This was also presented at the NEL ICB IPC group meeting with positive feedback.

***Figure 8**. below shows zero GNRBSI cases were reported across the Trust during 2023-2024:*

GNRBSIs	Q1	Q2	Q3	Q4
Trust-wide	0	0	0	0

2.8 Surveillance: Other Alert Organism: (all reported in East Ham Care Centre post 48 hours of admission)

***Figure 9**. below shows there were no alert organisms reported across the Trust during 2023-2024:*

Alert Organism Infections	Q1	Q2	Q3	Q4
Fothergill ward – East Ham Care Centre	0	0	0	0

3.0 Coronavirus Disease 2019 (COVID-19)

On December 31, 2019, the World Health Organization (WHO) was notified of a cluster of pneumonia cases in Wuhan City, Hubei Province, China, caused by a novel coronavirus named SARS-CoV-2. In March 2020 WHO declared a global pandemic, because due to its rapid spread and severity. Since then, the IPC service has been actively engaged in supporting teams through regular safety huddles, maintaining daily surveillance on COVID-19, updating communication materials, conducting outbreak management meetings, and ensuring ongoing staff and patient education on IPC issues. The pandemic was declared over by WHO on 5th May 2023.

4.0 COVID-19 Infections

During 2023-24 there were 105 COVID-19 infections reported, this is a decrease from the previous year where 490 COVID-19 cases were reported. This significant in the number of case reported was possibly a correlation to the changes in testing guidance that was introduced in April 2023.

***Figure 10**. below displays the total number of COVID-19 cases during 2023-2024 per quarter:*

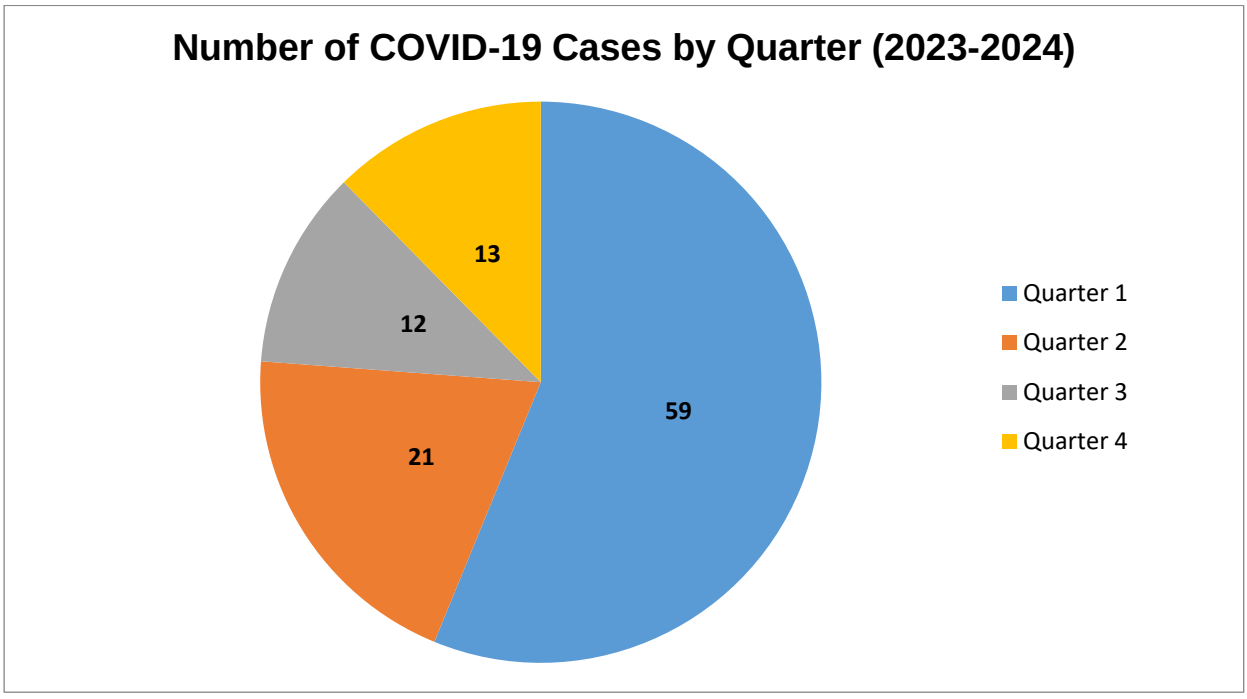
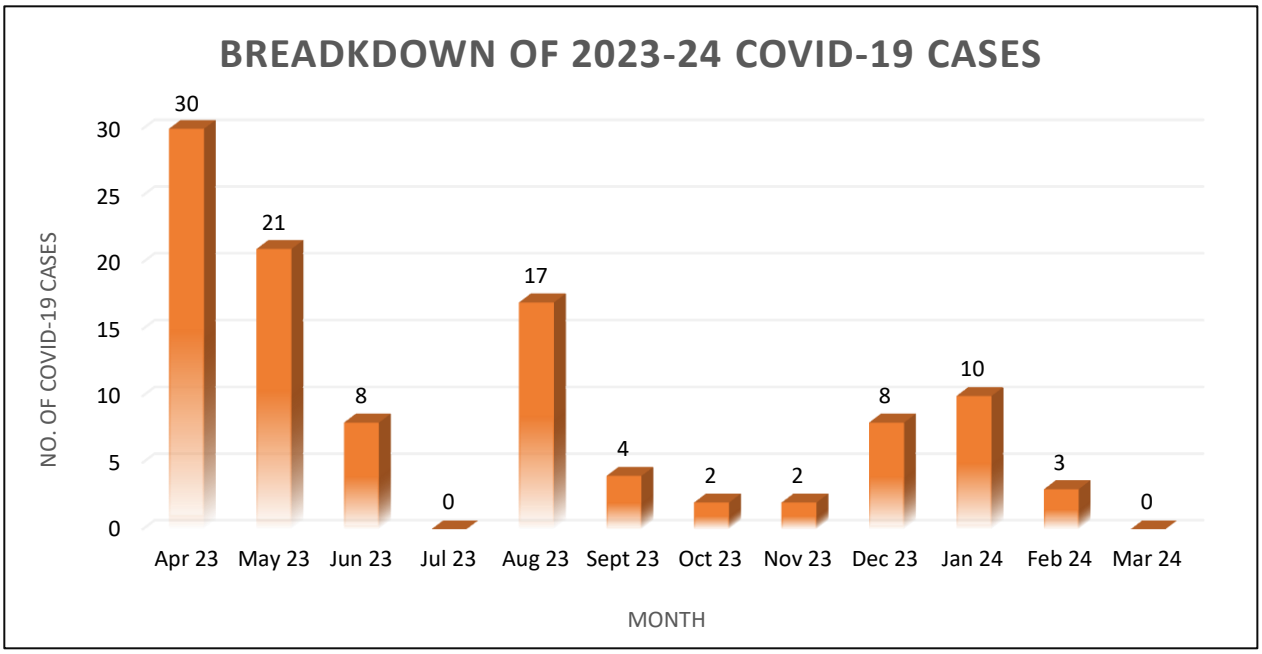
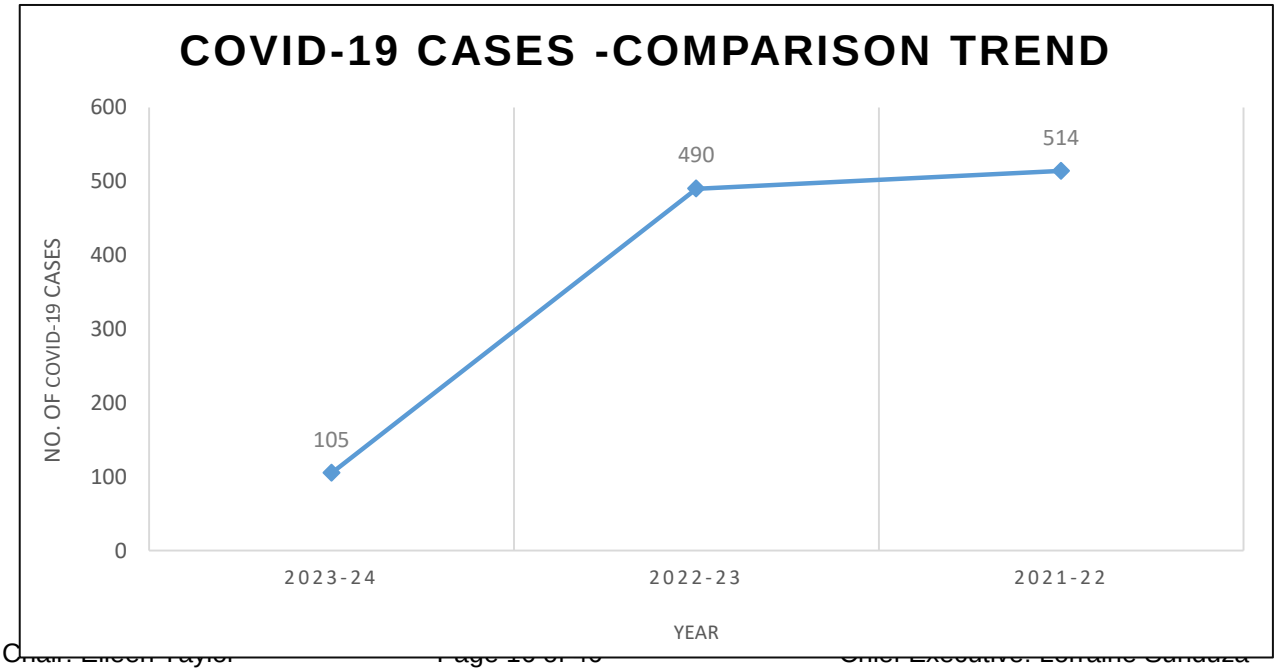


***Figure 11**. below displays a yearly breakdown of COVID-19 cases during 2023-2024:*



The chart above illustrates the number of Covid-19 cases per month in 2023-24. In April 2023, there was a notable surge in the number of confirmed positive COVID-19 cases throughout the Trust. This increase corresponded with the national trend of rising COVID-19 cases across the United Kingdom, primarily attributed to the emergence of the Omicron XBB.1.5 variant. During 2023-24 there was also 2 months whereby no COVID-19 cases were reported.

***Figure 12**. below shows the number of COVID-19 cases in comparison to previous years. In 2023-24 there was 105 cases reported, however the decrease could be due to the guidance changes introduced in April 2023, and vaccination uptake & herd immunity.



5.0 Healthcare-onset COVID-19 Infections (HOCI)

Healthcare onset COVID-19 infections (HOCI), which account for 10-20% of cases, are linked to higher harm and mortality, making their reduction a crucial patient safety issue. Early identification of infection spikes and outbreaks is essential for reducing HOCI, understanding COVID-19 transmission in healthcare, ensuring performance transparency, and fostering a culture of continuous improvement.

5.1 The Definition of Healthcare-onset Infections (HCOIs)

Figure 13. *below displays the types of number of Healthcare-onset Infections:*

Healthcare-onset of Infection Type	Definitions
Community-onset (CO)	Positive specimen date <=2 days after hospital admission or Hospital attendance.
Hospital-onset Indeterminate Healthcare-Associated	Positive specimen date 3-7 days after hospital admission.
Hospital-onset Probable Healthcare-Associated	Positive specimen date 8-14 days after hospital admission.
Hospital-onset Definite Healthcare-Associated	Positive specimen date 15 or more days after hospital admission.

Cases of COVID-19 acquired after 8 days of admission within ELFT services are reviewed. A Root Cause Analysis (RCA) is conducted for HOCIs to attempt to establish a causal link. The IPC Team have updated the RCA Template to include ventilation and levels of harm information as requested by the local Integrated Care Board.

Figure 14*. below shows a breakdown of HOCIs during 2023-24:*

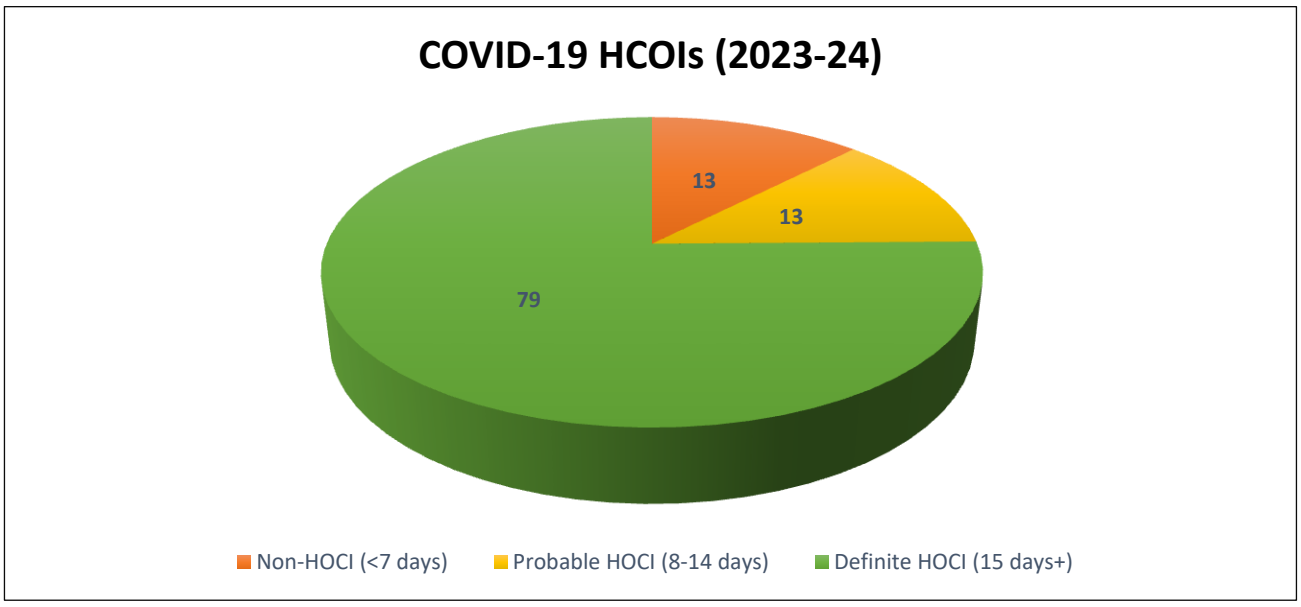
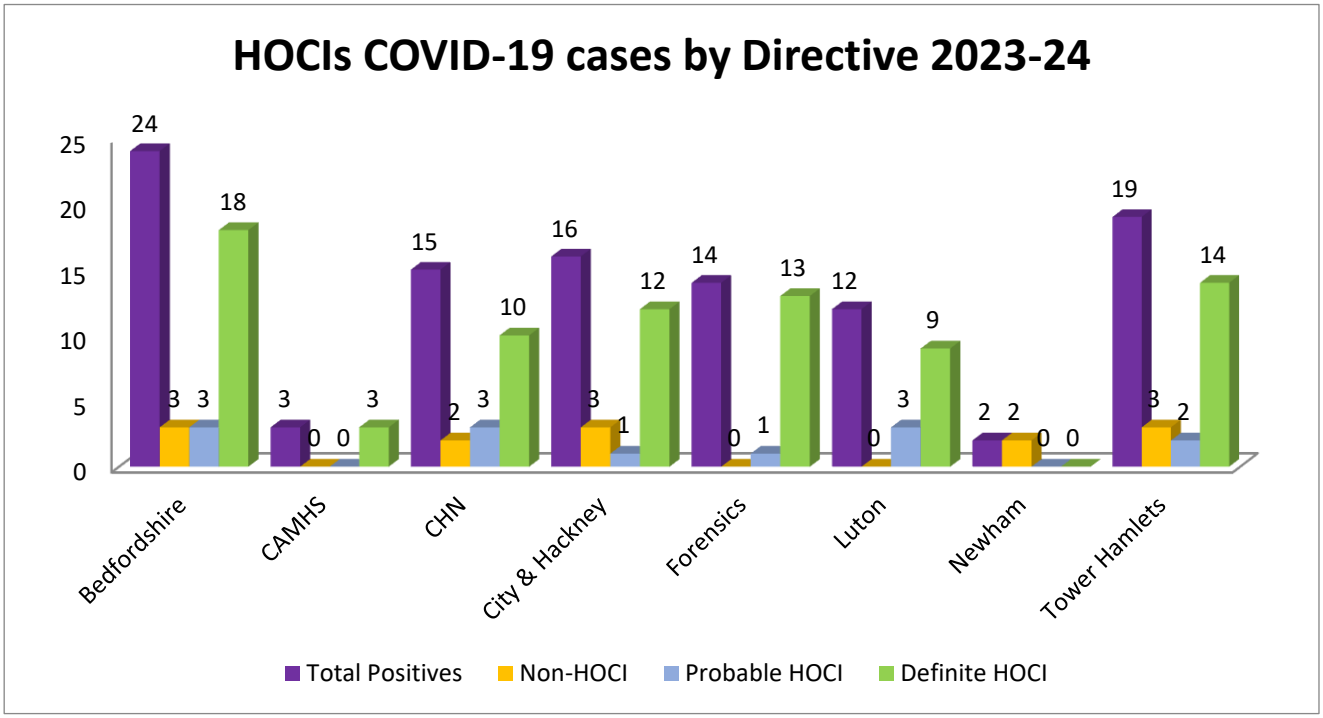


***Figure 15**. below shows a shows the Breakdown of HCOI data by Service in 2023-24. Bedfordshire had most confirmed HOCIs in 2023-24:*

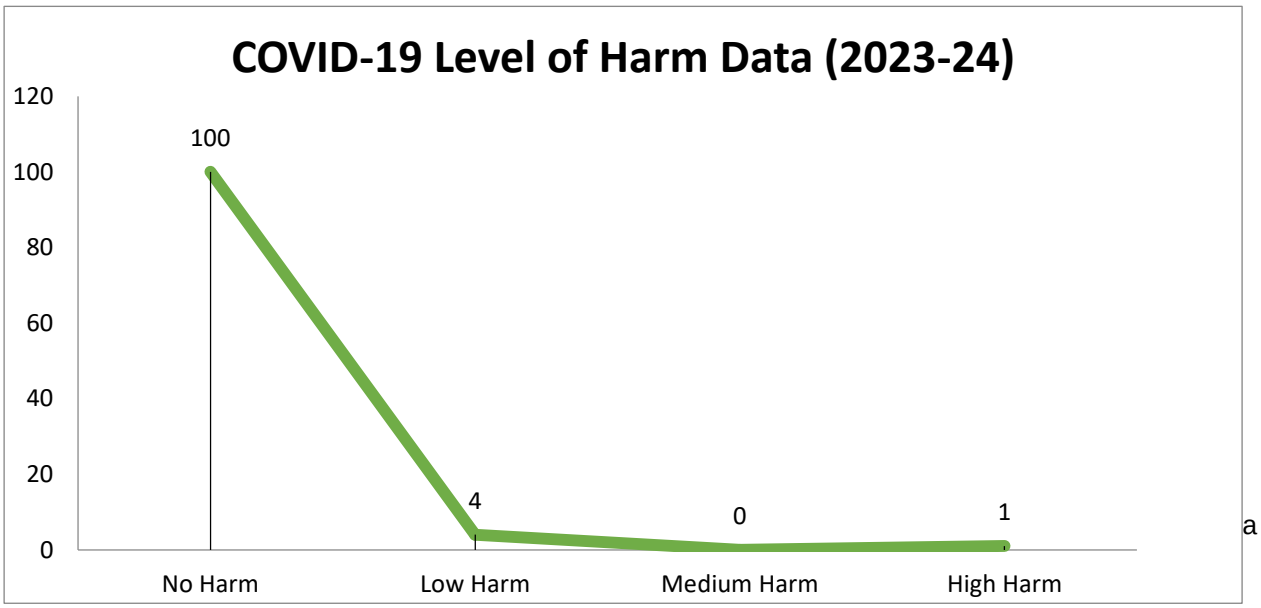


5.2 HOCI COVID-19 Cases – Levels of Harm

***Figure 16.** below displays the types of HOCI COVID-19 - Levels of Harm:*

Level of Harms	***Definition criteria***
No Harm	Asymptomatic
Low Harm	Low level support – oxygen therapy
Medium Harm	Admitted to ITU
High Harm	Death due to COVID-19 on Death Certification

***Figure 17.** below displays Covid-19 level of harm data during 2023-24:*



a

Figure 18. *below displays a breakdown of Covid-19 Levels of Harm:*

Month	***Ward***	***Level of harm***
May 2023	Fothergill Ward	High Harm - The patient was admitted from Newham University Hospital on 27th April 2023. The patient was end-of-life care and had previously had COVID-19 infection within the last 90 days. Sadly the patient passed away whilst on Fothergill ward.
	Ash Ward	Low Harm
	Fountains Court	Low Harm
June 2023	Bricklane Ward	Low Harm
Janaury 2024	Sally Sherman Ward	Low Harm

During 2023-24 there was 105 cases reported. 4 cases was low harm and 1 case was high harm. Root Cause Analysis reports for HOCI are conducted by IPC Nurses for each ward.

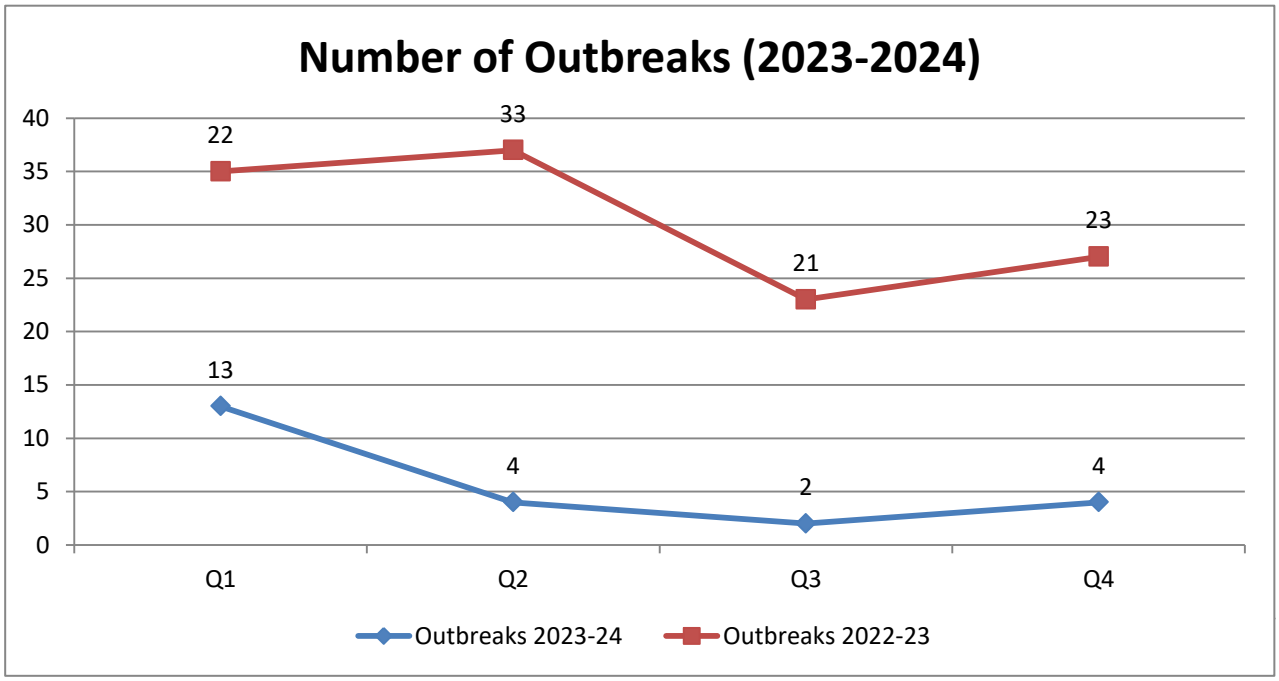
6.0 Outbreaks during 2023-24

6.1 Infection Prevention and Control Outbreak Management

The Health and Social Care Act (2008) mandates vigilance and responsiveness to emerging infectious diseases, necessitating prompt action on new COVID-19 cases. Outbreak management followed IPC Policy Manual and UKSHA guidance, with post-infection reviews or root cause analyses for suspected transmissions. Staff and patient contacts were managed according to Trust Occupational Health protocols.

This report section details outbreak reviews, lessons learned, and resultant changes or reinforced measures, ensuring accuracy with available data.

Figure 19. *below illustrates a breakdown of COVID-19 Outbreaks across the Trust in 2023-2024 by quarter:*



During 2023-24, 23 outbreaks were reported to UKSHA. This is a significant decrease from the previous year whereby 99 outbreaks were reported. This is a result of changes in testing guidance as well as more uptakes of COVID-19 vaccinations and a combined effort of IPC measures that have encouraged herd immunity.

Figure 20. *below illustrates a breakdown of COVID-19 Outbreaks by Service in 2023-2024:*

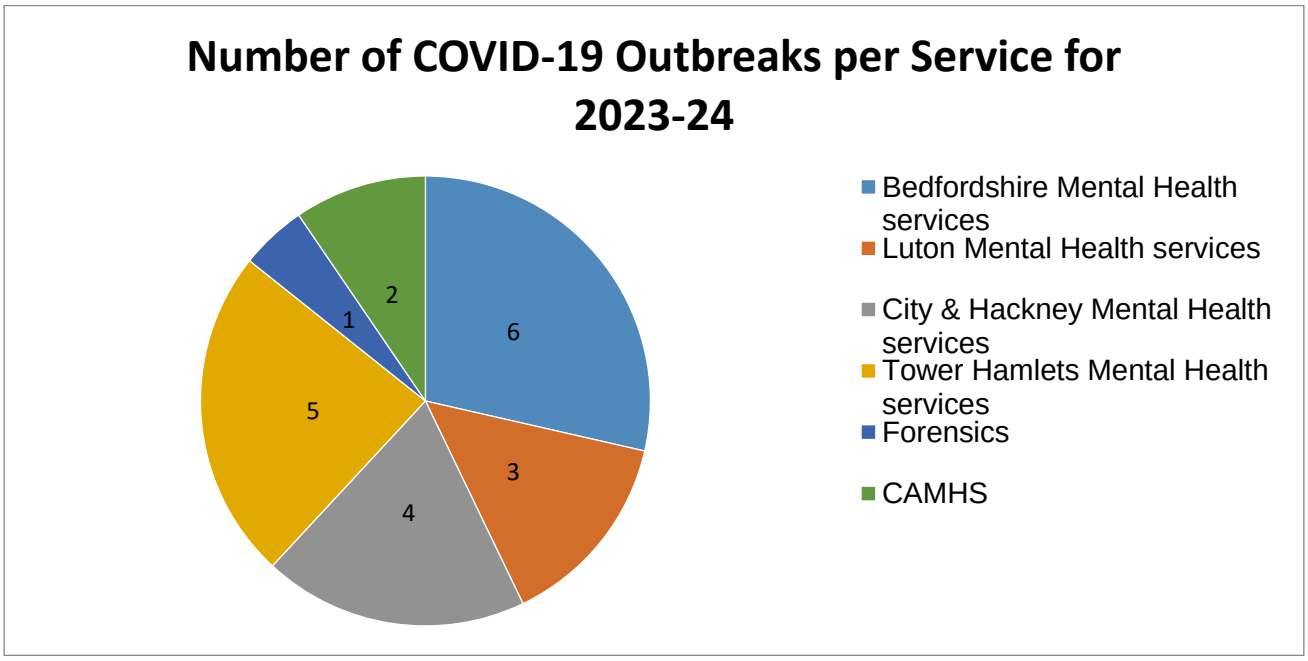
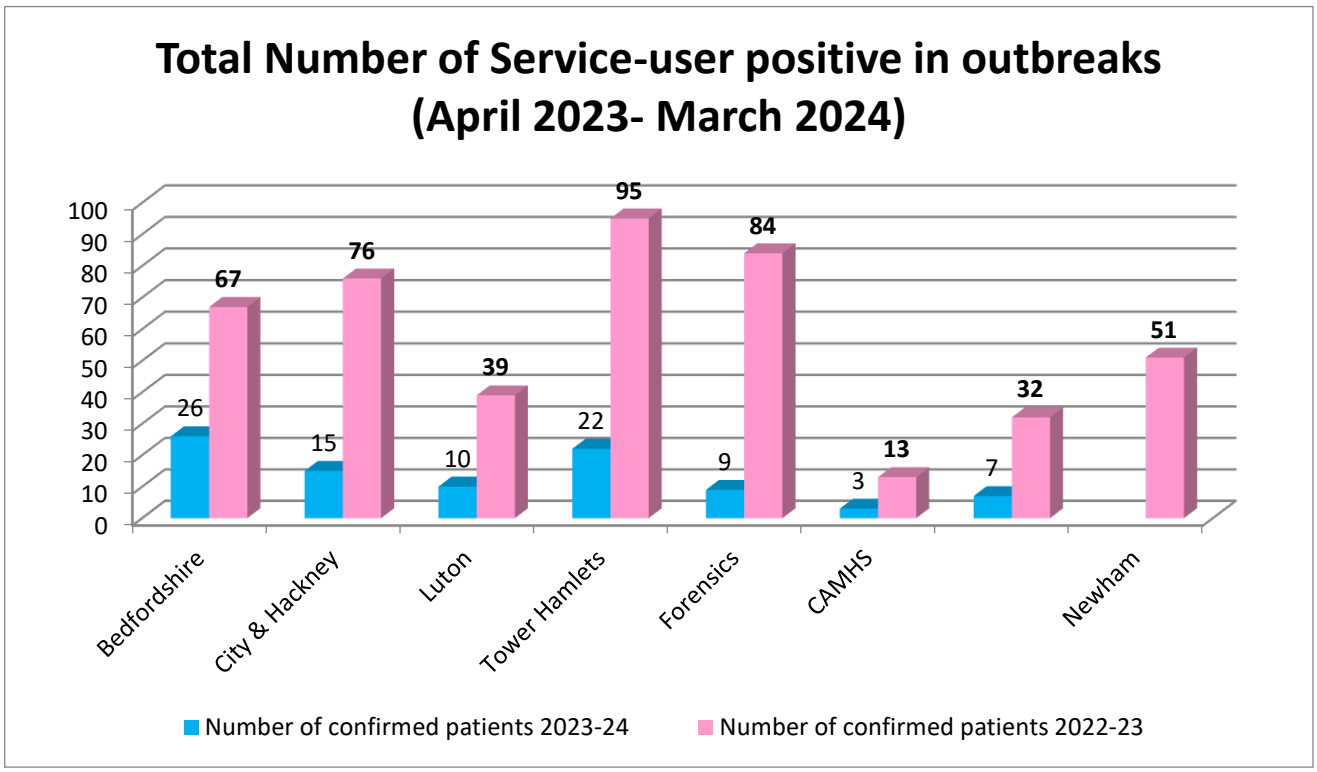


Figure 21. *below illustrates a breakdown of service-user positive cases in Outbreaks across 2023-2024:*

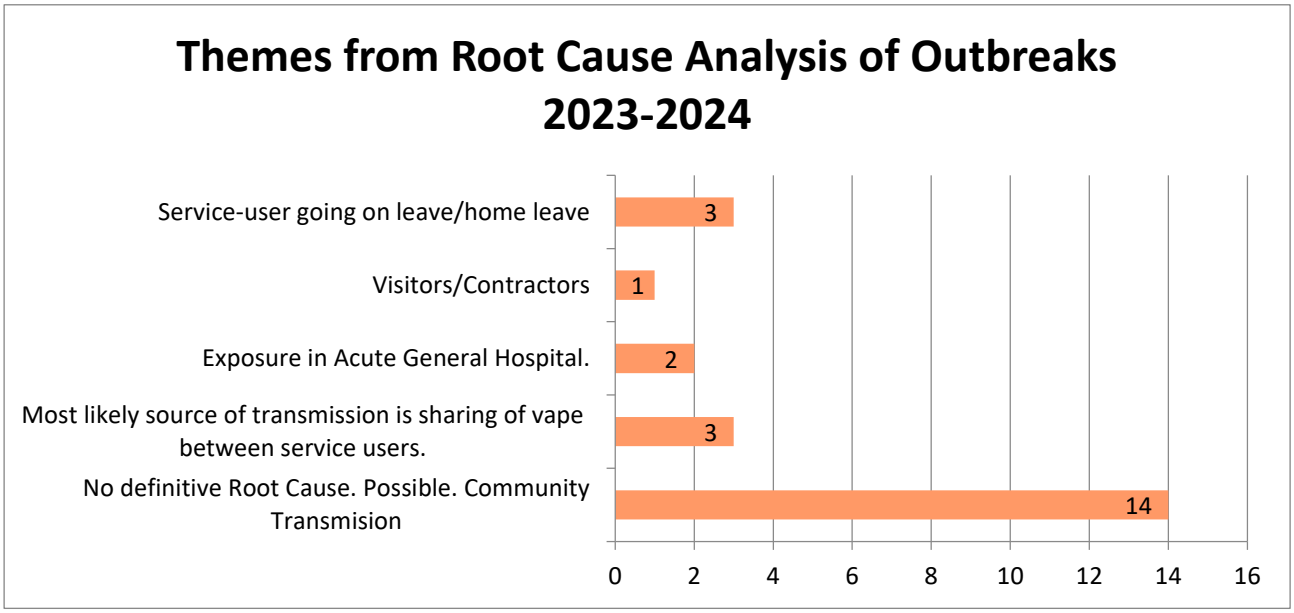


During 2023-24, Bedfordshire mental health services had the highest number of confirmed COVID-19 patients and outbreaks, whereas Tower Hamlets had the most cases in 2022-23, illustrating the dynamic nature of COVID-19 infection.

6.2 Root Cause Analysis Reviews

In summer 2020, NHS England/Improvement instructed all NHS providers to review hospital-onset COVID-19 cases (positive after 7 days of admission) to trace sources and identify issues, particularly those acquired in healthcare. The Trust held Root Cause Analysis (RCA) meetings, prioritizing outbreak cases and some individual cases, to investigate sources and contributing factors. They used a locally adapted RCA tool, updated with UKSHA guidance. RCA investigations focused on outbreak index cases and significant incidents like patient deaths within 28 days of diagnosis. Findings were analysed to improve care quality and shared at IPC Committees and with relevant teams. A summary of RCA themes follows below.

Figure 22. *below shows a breakdown of themes identified Root Cause Analysis reviews in 2023-2024:*



Majority of the COVID-19 outbreaks during 2023-24 had no definitive root cause but community transmission was suspected to be the most likely source.

6.3 Influenza Outbreak

Influenza, or 'flu', is a respiratory illness caused by the influenza virus, affecting the nose, throat, bronchi, and sometimes the lungs. There are two main types: Influenza A and B, with Influenza A generally causing more severe illness. These types should not be managed together.

In 2023-2024, there was one Influenza *A* outbreak, a decrease from the previous year, whereby two outbreaks were reported. The influenza outbreaks were managed effectively with prompt infection prevention measures and Tamiflu treatment. However, there were logistical challenges in obtaining flu swabs during contact tracing. A reflection event held in January 2024, attended by the involved teams, highlighted the key lesson of storing flu swabs in the Trust PPE stores to ensure availability.

7.0 Clusters of Infection

Clusters of infections are identified as potential groups of people or cases with apparent similar infections (e.g. flu, measles). Many apparent clusters have no specific cause. In rare cases, clusters may be related to common environmental exposures. Incidents of infections are listed chronologically by quarter below.

Figure 23. *below displays clusters of infection during 2023-24:*

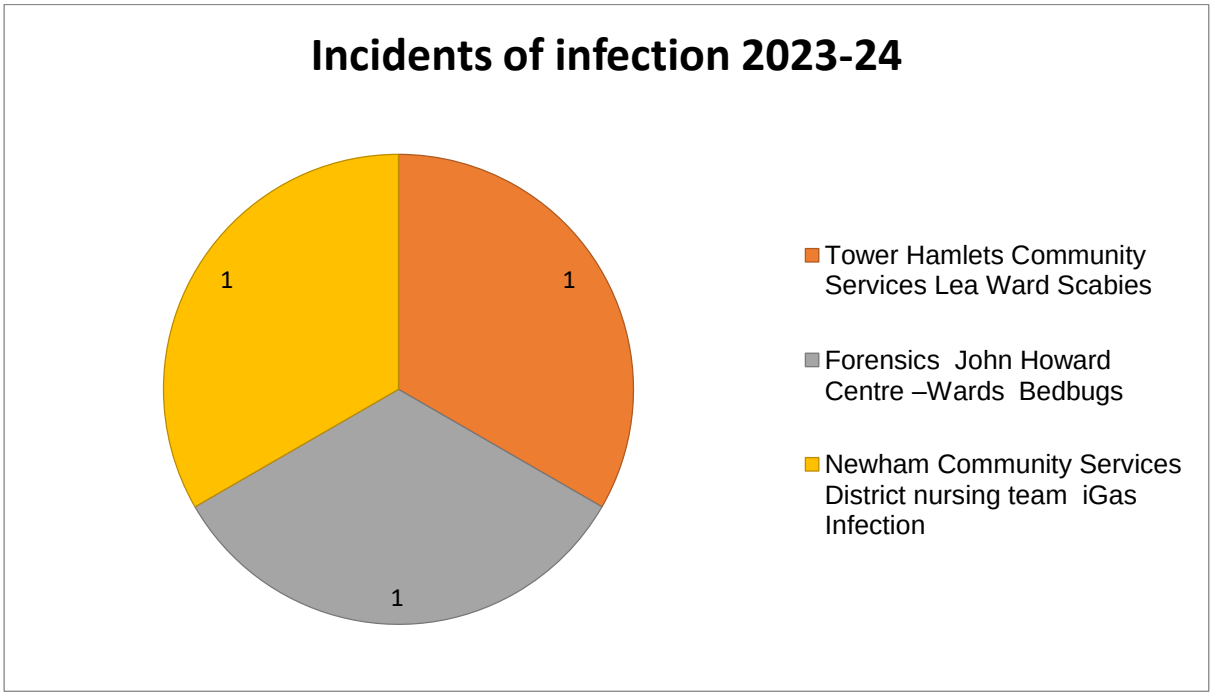
Directive	*Service*	*Infection*	*Cluster*
Tower Hamlets Mental Health Services	Cazaubon ward	Diarrhoea	*Four cases of diarrhoea were reported on Cazaborn unit, potentially linked to outside food. All cases resolved before stool samples returned negative for infection. Comprehensive infection prevention measures were implemented, and all patients have recovered.*
Newham Mental Health Services	Sapphire ward	Diarrhoea	*This was a small scale cluster of diarrhoea and vomiting Diarrhoea) amongst 5 patients. The symptoms of the index case were recognised early and prompt action by the ward staff. Full infection prevention measures were instigated. No further cases of diarrhoea were reported. Microbiological confirmation of stool specimens were not obtained as diarrhoea had self-resolved. The nursing staff managed this cluster of D&V well.*
Tower Hamlets Mental Health Services	Roman Ward	Head lice	*The index case was admitted with headline infection and underwent two unsuccessful treatment attempts. Despite the implementation of infection prevention measures, the patient did not isolate. Subsequently, three more patients were confirmed to have the headline infection. All four infected patients received anti-headline treatment, and no additional cases were identified. The ward effectively managed this cluster, despite the challenges posed by non-*

			isolating patients and movement across the ward.
Bedfordshire Mental Health Services	Poplars ward	Diarrhoea	*This was a small scale cluster of diarrhoea) amongst 4 patients. The symptoms of the index case were recognised early and prompt action by the ward staff. Full infection prevention measures were instigated. No further cases of Diarrhoea were reported. Microbiological confirmation of stool specimens were not obtained as diarrhoea had self-resolved. The nursing staff managed this cluster of Diarrhoea well.*

8.0 Incidents of Infection

During 2023-24 there were three incidents of infection reported.

Figure 24. *below displays further information about incidents of infections from 2023-24:*



8.1 Serious Incident – Lea Ward Tower Hamlets Centre for Mental Health

In Q2 2023-24, the IPCT supported the Trust Patient Safety/Serious Incident team in investigating the case of a 34-year-old male admitted to Millharbour ward under Section 2 of the Mental Health Act due to an acute relapse. The patient was treated for Scabies, showed improvement, and was transferred to Lea Ward on 20/04/23. After a recurrence of Scabies symptoms on 25/04/23, treatment resumed with isolation, but without further specialist input. On 08/05/23 the patient was found unresponsive and later died despite emergency interventions. The coroner concluded that specialist advice from IPC and dermatology should have been sought for managing Scabies infection.

8.2 Lessons Identified from the Serious Incident

The patient was isolated on Lea Ward from 25/04/23 to 08/05/23 for ongoing Scabies symptoms. A GP reviewed him, and staff sought inital IPCT advice on isolation measures. However:

1. A risk assessment should have balanced isolation with daily activities.
2. Regular consultations with the IPCT were needed to reassess the isolation.
3. A dermatology review should have been requested for the persistent skin condition.

8.3 Recommendations from the Serious Incident

The IPC team held an away day, facilitated by the IPC Doctor, to address the serious incident and derive lessons, resulting in a review of IPC internal processes for assessing patients with IPC issues.

8.4 Bedbugs infestation – Forensics: John Howard Centre

In Q3 2023-24, a significant bed bug infestation occurred at The John Howard Centre and Wolfson House from September until early December, when fumigation and site inspections were completed. The IPC team, alongside Estates and OCS, managed the infestation. Initial recommendations included laundering clothing, using PPE, isolating the affected service user, and escalating to Estates for pest control. The IPC team conducted regular site visits, ad-hoc training on hand hygiene and PPE, and facilitated training for service users employed at Oasis Café. They also supported high-level planning meetings and weekly local meetings, which staff found helpful.

IPC measures included PPE use, changing clothing when leaving the site, and reducing staff and service user movement to prevent impacting well-being. The IPC team created Bedbug Information Factsheets, SOP guidance, and collaborated with the Forensics Speech and Language team on service-user leaflets. These were shared with the East London Integrated Care board and the Pan-London Mental Health Infection Control Leads Group. The ELFT IPC team was also requested to develop a paper on bedbug infestation to assist other NHS organizations due to the current lack of guidance on pest management in healthcare settings.

8.5 Invasive Group A Streptococcal (iGAS) Disease, Newham District Nursing Team

This involves a 77-year-old man receiving District Nursing Service for leg and foot wounds. After a hospital visit for a fall and subsequent discharge with antibiotics for a chest infection, he called 999 on 18 January 2024, due to shortness of breath and was diagnosed with an iGAS infection.

Recovery followed, with district nurses adhering to infection control guidelines during visits. Contact tracing and information dissemination on iGAS were conducted for involved nurses. The infection's origin remains uncertain, possibly originating from the wound or sputum. Recommendations include discussions on hand hygiene audits and a risk-based approach to MRSA screening in community settings.

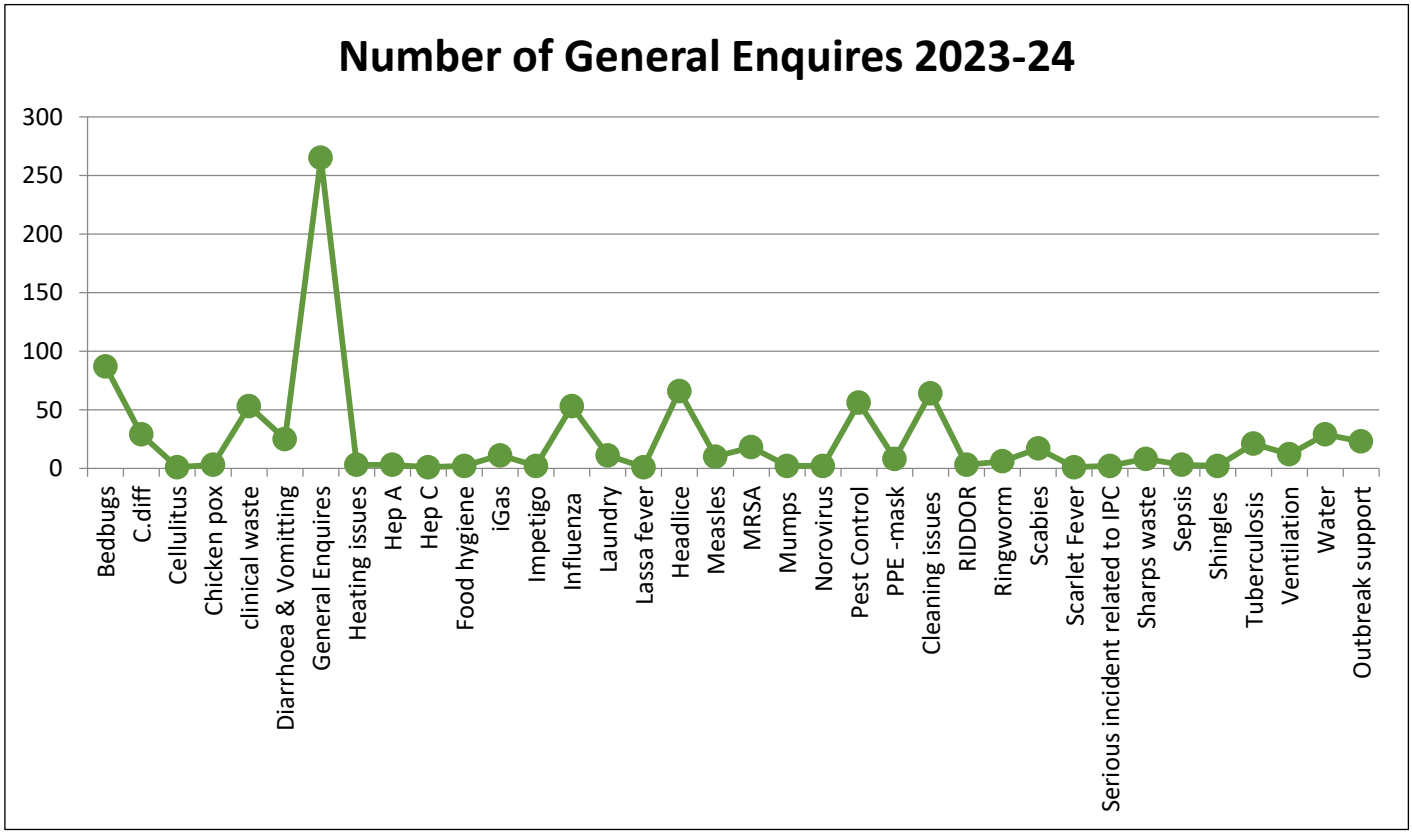
9.0 Notifiable Diseases

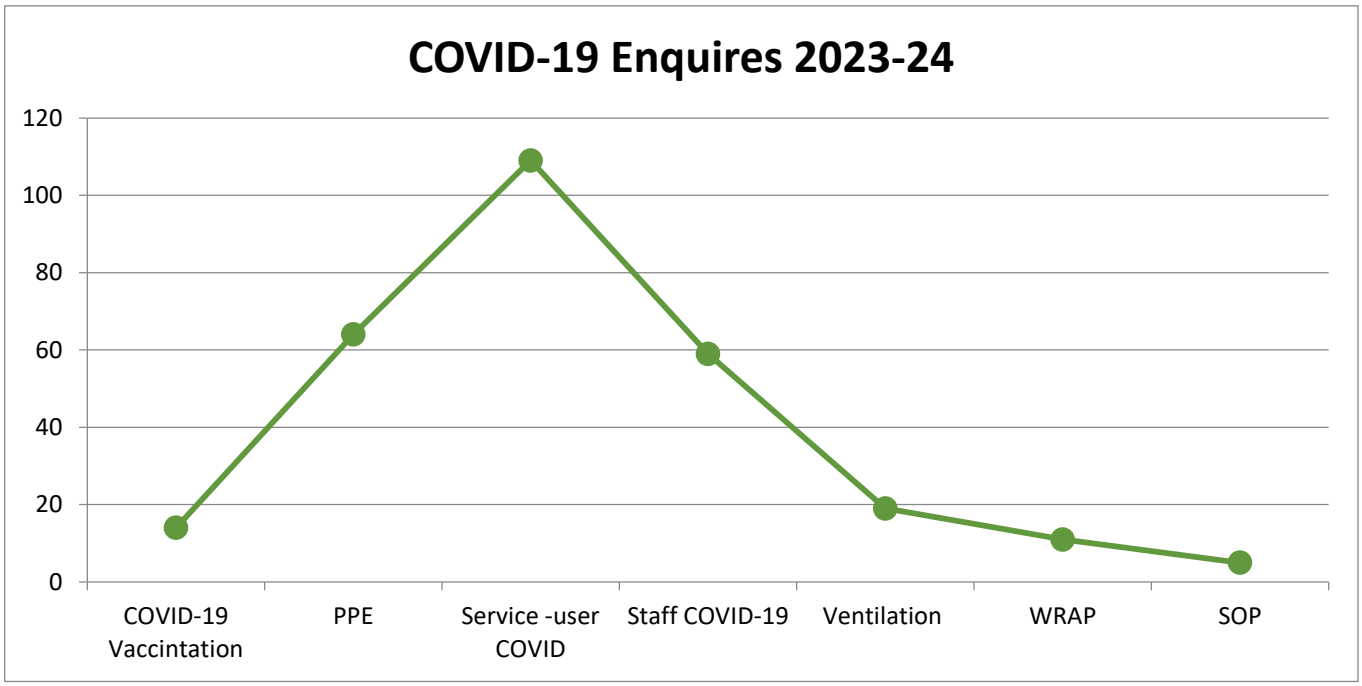
Figure 25. *below shows there were 105 notifiable diseases of infections reported to UKSHA during 2023-2024:*

Quarter	Notifiable Diseases	No. of patients	Health Care Acquired Infections
1	COVID-19	59	44
2	COVID-19	21	21
3	COVID-19	12	12
4	COVID-19	13	13

9.1 IPC Service Enquires Surveillance

The IPC team also offers advice and guidance on infections. ***Figure 26*** & ***Figure 27*** below presents an annual breakdown of these infections. The IPC service responded to 903 general enquires & 281 COVID-19 enquires.





10. IPC Statutory & Mandatory Training Compliance

IPC training is integral to the Trust's induction for new staff and includes annual updates tailored to clinical roles. Non-clinical staff undergo Level 1 training every three years, while clinical staff receive annual Level 2 training via e-learning. Ad-hoc face-to-face sessions are also offered during Directives away days to boost compliance. Compliance with IPC training across the Trust is improving, as shown in Figure 34 as of March 2023.

Figure 28. *below shows Level 1 and Level 2 Statutory & Mandatory Training compliance for 2023-24:*

Directorate	Infection Control - Level 1	Infection Control - Level 2
Bedford	93.09%	86.61%
Bedfordshire CHS	100.00%	92.47%
City & Hackney	85.99%	85.43%
CHS- Tower Hamlets	95.12%	88.04%
Corporate	89.74%	85.98%
Forensic Services	97.39%	92.17%
Luton	94.74%	90.20%
Newham CHS	95.74%	89.29%
Newham	95.33%	86.00%
Primary Care	90.53%	84.21%
Specialist CHS	100.00%	85.05%
Specialist Services	94.70%	83.07%
Tower Hamlets	93.33%	86.17%
Total	93.27%	87.37%

**Data provided by Learning & Development team*

11.0 Trust-wide Infection Prevention & Control Link Champion Programme

The Trust provides a robust educational program on IPC through webinars and meetings covering topics including outbreak management, environmental cleaning, diarrhoea and vomiting management (Norovirus and C. Diff), root cause analysis, hand hygiene, PPE audits,

environmental audits, tuberculosis, MRSA management, and infestations like bedbugs, scabies, and head lice. These sessions include Q&A segments to enhance staff learning and engagement.

12.0 Education & IPC Training

During 2023-24, the IPC team has proactively delivered the following services across the Trust:

- Collaborative efforts within the NEL ICB IPC Group have resulted in the creation of an educational framework for newly appointed Band 6 IPC Nurses. The ELFT IPC Band 6 Induction Programme has been adopted across the NEL ICB system for implementation by other NHS trusts and providers.
- Ad-hoc face-to-face training session provided on Jade ward.
- Ad-hoc face-to-face training session provided on Willow Ward.
- Ad-hoc face-to-face training session provided to Tower Hamlets People Participation Team.
- Training provided at Roman Ward, Tower Hamlets away-day.
- Ad-hoc face-to-face training session facilitated for new starter induction programme in Tower Hamlets.
- Monthly Statutory & Mandatory training were facilitated by IPCT.
- IPC Link Champion programme re-launched in October 2022. On-going programme led by Band 7 IPCNs.
- On-going IPC Link Champion programme led by Band 7 IPCNs. Q2 sessions covered the following topics: Root Cause Analysis, Physical Health & IPC, The role of the link practitioner.
- On-going IPC Link Champion programme led by Band 7 IPCNs. Q3 sessions covered the following topics: Diarrhoea & Vomiting; Management of Respiratory Infection & Environmental Cleaning.
- Ad-hoc training facilitated for scabies to CAMHS unit Newham.
- Ad-hoc training facilitated for Tower Hamlets for Head lice cluster of infection.
- Bespoke training facilitated for service-user working in Oasis café in John Howard Centre- Forensics.
- The IPC team received training on the new Patient Safety Incident Response Framework from ELFT Patient Safety Team.
- During national IPC week the IPC team facilitated roadshows across the Trust promoting IPC week. Roadshows were well received by teams and services.
- Ad-hoc face-to-face training session facilitated for new starter induction programme in Luton & Bedfordshire.
- Ad-hoc face-to-face training session facilitated for new starter induction programme in Tower Hamlets.
- Ad-hoc face-to-face training session facilitated for new starter induction programme in Coborn unit.
- Face-to-face Training provided at Joshua ward away day.

- Face-to-face Training provided at Ruth Seifert Ward Away Day.
- The IPC Leads Nurses received training on the new Patient Safety Incident Response Framework from ELFT Patient Safety Team.

13.0 IPC Campaigns

13.1 Hand Hygiene Roadshow

The World Health Organization initiated the "Save Lives: Clean Your Hands" campaign in 2009, celebrated annually on 5th May as World Hand Hygiene Day to promote and sustain hand hygiene practices in healthcare settings globally. In 2023, the WHO urged healthcare workers and facilities to prioritize effective hand hygiene with an "accelerate action together" approach. East London NHS Foundation Trust extended the event into a week-long campaign involving all staff, contractors, service users, and visitors to raise awareness about hand hygiene's critical role in infection control, especially during the increased waves of COVID-19 infection. The IPC team organized roadshows across the Trust, featuring hand hygiene activities and quizzes, and circulated a communication bulletin to emphasize the importance of World Hand Hygiene Day. Service users actively participated and enjoyed the interactive sessions.

13.2 Infection Prevention & Control Week

In Q3, the IPC team organized Trust-wide IPC Roadshows during National IPC Week in October 2023, engaging staff, service users, visitors, and contractors in infection control awareness. Collaborative sessions with physical health and smoking cessation teams addressed infection risks, such as sharing vapes. The campaign utilized X (formerly Twitter) for promotion, supported by senior leaders, resulting in widespread engagement and positive feedback.

13.3 World Antimicrobial Resistance (AMR) Awareness Week

During World Antimicrobial Resistance (AMR) Awareness Week 2023-communications was circulated to promote World Antimicrobial Resistance (AMR) Awareness. A number of webinars were shared for staff to join.

13.4 Projects

During 2023-24, the IPCT supported with the following projects:

- Quality improvement project reducing Gram-negative Rod Blood Stream Infections – Catheter associated urinary tract infections on Fothergill Ward. This was presented at NEL ICB IPC group.
- Gloves-off to reduce HCAI's and reduce cost and carbon footprint of the Trust across Fountains Court & Crystal Ward. This project will be further expanded across London ward.
- Ventilation – Air disinfection study at Fountains Court. The air disinfection study officially launched on Fountains Court on 15th of June 2023. This event was attended by the local MP and colleagues from Cambridge University Hospital.
- Patient Safety Incident Response Framework model aligned to IPC service. This work is being led co-collaboratively with the Trust Patient Safety team on healthcare associated infections that require RCAs or PIRs. Further work will continue in new annual work plan.

- Review of the InPhase audit programme, with the ELFT Quality assurance team. During Q3 the IPC team have been participating in the Trust Risk register working group which is looking to move risk register to the InPhase module.
- Tower Hamlets community service will be participating in the NHSE pilot testing of IPC mandatory training for community services. This is due to begin in Jan/Feb 2024.
- The IPC team have supported the BLMK ICB with a C.diff system-wide reduction plan.

13.5 Policies / Guidance Documents

During 2023-24, the IPCT provided support and specialist input on the following policies/ guidance documents:

- Patient COVID-19 testing and management flow chart continually updated to reflect changes in national guidance.
- Reviewed SOP Eating Disorder Clinic – Venepuncture
- Review of Pet Therapy SOP – Tower Hamlets Mental Health Group Therapy Team
- Staff COVID-19 testing and management guidance with flow charts updated
- Business development bids pertaining to IPC for new service acquisitions for the Trust's Business Development Team
- Respiratory Infection Policy updated
- Communications written regarding IPC measures / COVID-19 updates
- Measles fact sheet produced & circulated in light of increased Measles cases
- Chief Nurse/Director of Infection Control 'Living with COVID-19' letter updated.
- Memo on pest control – rodents for City and Hackney Mental Health Services.
- CQC response letter to a complaint related to cleanliness of the environment for City and Hackney Mental Health Services.
- Pest control factsheet on rodents updated.
- Factsheet and Guidance on the Use of Filtering Face Piece Mask (FFP3 Mask) updated.
- Workplace risk assessment tool updated.
- Written documents provided to support Chief Nurse/Director of Infection Control with CQC engagement meeting.
- Alert circulated on Food Botulism
- Chief Nurse/Director of Infection Control 'Living with COVID-19' letter update on the changes of supply of Lateral Flow Devices (LFD) in April 2024.
- COVID-19 Staff testing and management guidance with flow charts updated.
- Communications written regarding IPC measures / COVID-19 updates.
- Pest control factsheet on rodents updated.
- Workplace risk assessment tool updated
- Bedbug's fact sheet and guidance developed in relation to bedbug's infestation in forensics.
- A servicer-user leaflet on Bedbugs co-produced with Forensics Speech & Language therapy team & people participation team.
- Christmas and new year memo of IPC service
- Guidance on Guidance for respiratory tract infection (including COVID-19)
- Review of washing machines on Evergreen ward.
- Review of Pet Therapy SOP for Tower Hamlets
- Syringe driver SOP for Community Services
- Review of Treatment of influenza like-illness Flu guidance

- Review of Point of Care Testing (I-Stat Alinity) device
- Review of Catheter protocol for East Ham Care Centre.
- Review of corporate induction pack.

14.0 Freedom of information (FOI) requests

During 2023-24, four requests for data and information were received by the Trust under the Freedom of Information (FOI) Act (2000) relating to IPC. All requests were completed within the legislated timeframe.

15.0 Environmental Cleaning

The Trust facilities monitoring team carries out audits relating to cleaning, linen, waste and main kitchens and Meal Service at ward level. The Team reports directly to the Service Provider, Matron, Lead Nurse and Centre Manager (in community sites), and quarterly to the Infection Prevention and Control Committee.

Figure 29. *below displays cleaning and facilities services that are out-sourced by the Trust.*

Sites	Provider
Newham Centre for Mental Health	Grosvenor Facilities Management (GFM)
Tower Hamlets Centre for Mental Health	Bart's Health
John Howard Centre and Wolfson House	Outsource Client Solutions (OCS)
City and Hackney Mental Health Service	ISS under the HOMERTON University Hospital SLA
Community Health Newham	• Community Health Partnership, • Outsource Client Solutions (OCS) • NHS Property Services
Luton and Bedfordshire Mental Health	Outsource Client Solutions (OCS)
Bedfordshire community Health services	NHS Property Services & Mitie

15.1 Cleaning Audit Scores for 2023-24

Figure 30. *below displays cleaning Audits scores for 2023-24:*

Cleaning audit results *Target is 95%	Q1	Q2	Q3	Q4
OCS (Forensic John Howard Centre - London)	96.8%	98.0%	97.7%	97.5%
OCS (Forensic Wolfson House - London)	96.5%	96.9%	98%	98.2 %
ISS (City & Hackney Centre for Mental Health)	97.2%	96.8%	97.81%	*97.46%*
Bart's Health (Mile End Hospital)	98.53%	96.9%	99.8%	98.28%
GFM (Newham Centre for Mental Health)	94%	91%	-	-

(Data provided by Estates and Facilities department and cleaning contractors)
(Please note: where blank, cleaning scores were not submitted)

ELFT is meeting the national benchmark of 95% cleanliness, with Mile End Hospital and Forensic Services consistently achieving good standards. However, ongoing cleaning challenges persist at Newham Centre for Mental Health, Coborn Unit, and City & Hackney Mental Health Unit. Joint inspections by Estates and Facilities alongside the IPC team monitor and address these issues, conducting regular environmental audits with Ward Managers. Enhanced cleaning protocols, including three-times-daily chlorine-based cleaning, are implemented across all services to minimize microbial load during outbreaks. The IPC team evaluated OdorBac Tec4 as an alternative cleaning solution but advised against its use due to unsubstantiated efficacy against specific pathogens as a disinfectant. Significant pest control issues, particularly rodents, were managed at City & Hackney Centre for Mental Health, Townsend Court, and Mile End Hospital, with ongoing support from the IPC team and Estates. Throughout the year, the IPCT continued addressing environmental challenges and supporting cleanliness initiatives across ELFT, ensuring high standards of hygiene and pest control management.

15.2 Patient Led Assessment of Care Environment (PLACE) Inspections

The Patient Led Assessment of Care Environment (PLACE) is an annual programme mandated for all NHS-funded healthcare providers across the UK and overseen by the Health & Social Care Information Centre (HSCIC) on behalf of NHS England. It involves comprehensive assessments of inpatient settings, focusing on patient care aspects such as cleanliness, food quality, maintenance, privacy, dignity, and compliance with disability and dementia standards. Conducted by mixed teams of staff, patient assessors, and IPC personnel, the ELFT's PLACE assessment took place in October and November 2023, with exceptions for some John Howard Centre wards due to bed bug infestation. All audit data was submitted to the National Portal by March 2024, and action plans have been developed and distributed to address identified concerns. Regular reviews and updates will be conducted during Directorate Management Team meetings to ensure progress and resolution of issues.

15.3 ELFT and National PLACE Scores

Figure 31. *below displays PLACE scores nationally & for ELFT.*

Site Name	CLN (1)	Food (2)	Org Food (3)	Ward Food (4)	CAM (5)
ELFT Average	95.72%	85.01%	89.71%	78.90%	93.41%
National Average	98.10%	90.90%	91.20%	91.00%	95.90%
Homerton	94.10%	**75.00%**	91.15%	**56.10%**	90.18%
Cedar House / Fountains Court	99.48%	85.06%	89.76%	82.84%	97.83%
Townsend Court	96.61%	89.82%	88.19%	90.59%	97.83%
Calnwood Court	97.68%	94.63%	87.67%	96.03%	98.08%
NCfMH	**87.81%**	83.63%	79.76%	88.89%	**78.68%**
JHC	96.64%	77.81%	95.66%	**55.26%**	95.50%
Mile End	99.47%	91.32%	97.40%	85.11%	98.54%
WH	98.07%	91.57%	93.71%	89.02%	99.63%
EHCC	97.99%	85.65%	**76.22%**	96.43%	95.76%
Oakley Court	96.26%	94.05%	92.19%	94.95%	96.99%

(1) Cleanliness (how clean the environments are)
(2) An overall score for Food services, including quality, availability and choice.
(3) Organisation Food (the management of food provision such as food safety, menu choices and display etc.)
(4) Ward food (scores from the food tasting and presentation etc.)
(5) Condition, Appearance and Maintenance (the condition of the building and how well it meets the needs of those using it)

16.0 ELFT Fit-Testing Service

The Trust Fit Testing team continues to deliver fit testing services, following UKSHA and Health and Safety Executive guidance, to protect staff from airborne viruses like COVID-19 during aerosol generating procedures.

Please see below the most recent figures with updates on staff numbers fit tested:

Figure 32. *below shows fit-testing compliance during 2023-24:*

Testing Criteria – inpatient Trust wide	Q1	Q2	Q3	Q4
Total No. of staff passed an FFP3 fit-test	56%	58.5%	61%	68%
Staff non-complaint (not been tested at all)	44%	42.5%	39%	32%
Staff requiring re-testing	33%	35%	32%	20%

**Data provided by Fit testing team*

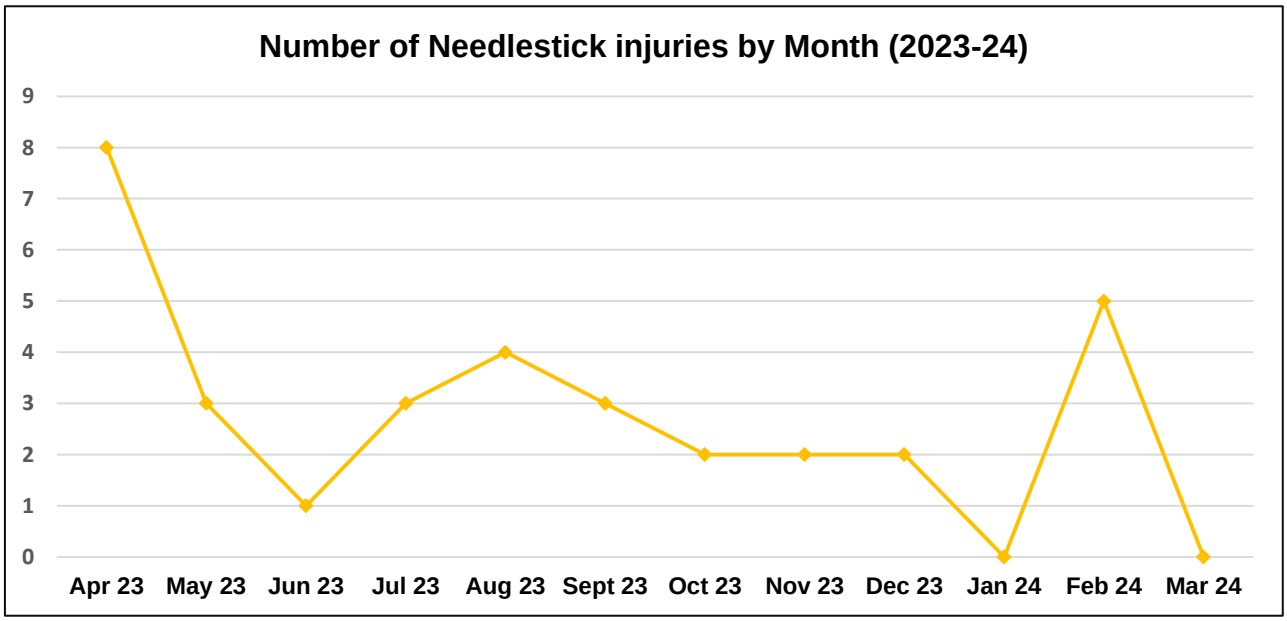
In 2023-24, a Fit Testing Lead was appointed and reorganized the service's systems and processes. Fit testers now prioritize community teams and GP surgeries, while still

accommodating ward staff requests. Regular clinics are held in Luton and Bedfordshire, with fit testers attending away days and visiting community teams by appointment. Compliance figures have decreased due to staff needing re-testing after their 2-year cycle lapsed and new staff requiring initial fit testing.

17.0 Sharps Injuries

In 2023-24, Optima Health, ELFT's Occupational Health provider, reported 33 sharps injuries, which increased from 30 incidents the previous year. The IPC Team provides follow-up, education, and training to minimize risks associated with needle stick injuries (NSIs). All reported sharps incidents are followed up within ELFT systems and by Optima Health, with a focus on learning from incidents.

Figure 33. *below shows NSIs by month in 2023-24:*



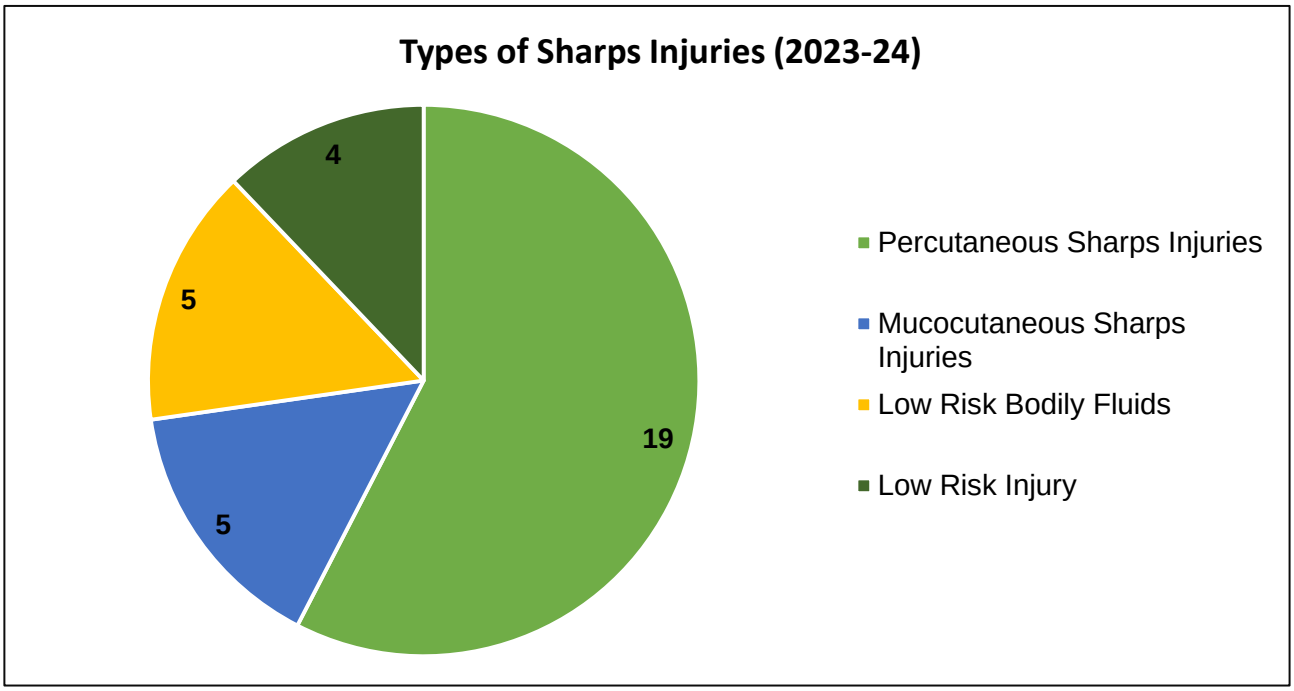
17.1 Safer Sharps Devices

The IPC team have been raising the profile on the safe disposal of used sharps, the management of NSI's, and the use of safer sharps devices (retractable needles) during IPC training sessions. Training also took place for new Trainee Doctors in August 2023.

Figure 34. *below shows a breakdown of Classifications of types of NSIs:*

Classification of Injury	Splash of blood/bodily fluid on intact skin
Mucocutaneous Exposure	where there is direct contact of blood/bodily fluid with eyes, nose or mouth or on broken skin e.g. uncovered cuts or eczema not covered with waterproof dressing.
Percutaneous Injury	is an exposure incident in which penetration of skin occurs by a needle or sharp object which was in contact with blood, tissue or other body fluid before the exposure including bites.

Figure 35. *below shows a breakdown of types of sharps injuries:*



18.0 Annual Work Plan 2023-2024

The annual work plan for 2023-2024 was developed in accordance with the infection control code of practice, incorporating stakeholder feedback and insights from IPC nurse visits. Key themes were identified to shape the action plan, as summarized in last year's diagram in Appendix 2.

18.1 IPC Audit Programme

Teams regularly submit self-monitored IPC audits focusing on hand hygiene facilities and products, decontamination materials, appropriate use of personal protective equipment (PPE), and clinical healthcare waste management. These audits emphasize a quality improvement approach, supported by robust monitoring.

18.2 Environmental Audits

The Trust conducts ongoing annual clinical environmental audits led by Infection Prevention and Control Nurses (IPCNs). IPC aims to involve staff in auditing low-risk areas, supported by IPCNs, with action plans and timelines developed and monitored by IPCNs, ward managers, and Matrons. Areas scoring below 85% undergo re-audits, prioritizing in-patient areas to maintain infection control standards. This process is crucial for preventing and controlling infections, ensuring safe, clean premises at East London NHS Foundation Trust. Collaboration with Estates, clinical teams, and contractors has contributed to achieving these standards during 2023-24.

18.3 Hand Hygiene Validation Audits and PPE Doffing and Donning Audits

High-risk areas like older adult wards, the IPC nurse and matron conduct quarterly electronic hand hygiene validation audits, focusing on WHO's 5 moments of hand hygiene.

19.0 Antimicrobial Resistance (AMR) Quarterly Meetings

Quarterly Antimicrobial Resistance (AMR) Meetings were held. During 2023-24 a live dashboard linked to electronic patient records for enhanced data analysis. Key findings from antimicrobial prescribing audits were reviewed to monitor trends and quality indicators as part of Trust-wide Antimicrobial Stewardship initiatives. In Q3, the IPC team collaborated with ELFT's Antimicrobial pharmacist to promote World Antimicrobial Awareness Week 2023 through webinars and communication bulletins.

19.1 Antimicrobial Prescribing Audits

The ELFT pharmacy team conducts quarterly audits across all sites over a two-week period, reviewing clinical notes and medication charts against antimicrobial guidelines or microbiology advice to measure compliance with standards outlined in the Antimicrobial Stewardship Policy.

Figure 36. *below shows the top 10 wards prescribing Antimicrobials for 2023-24:*

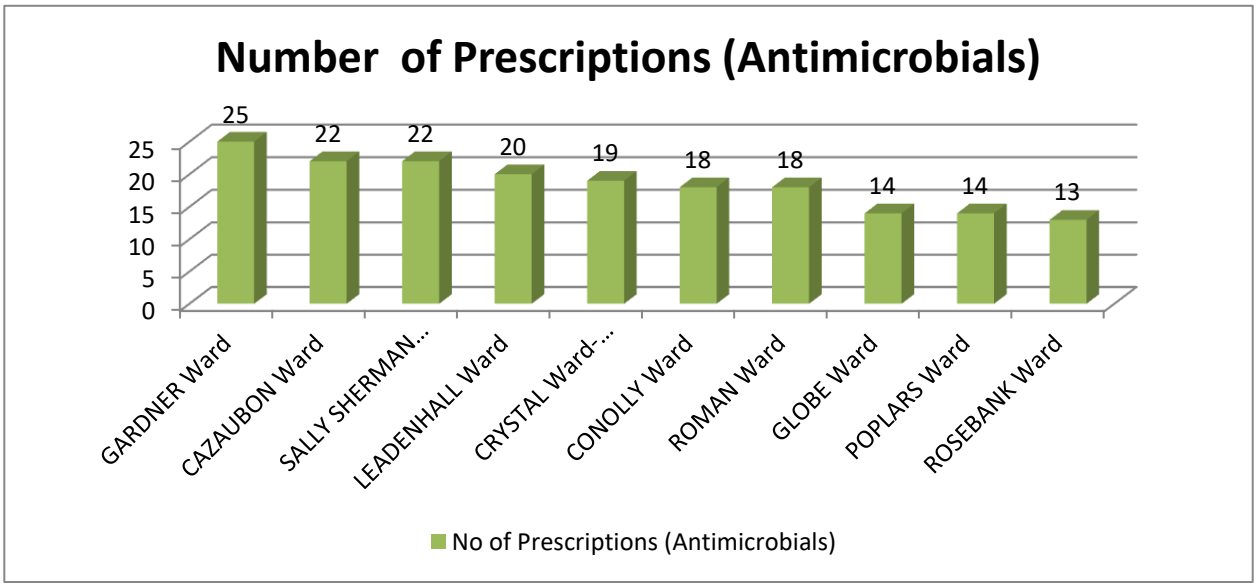
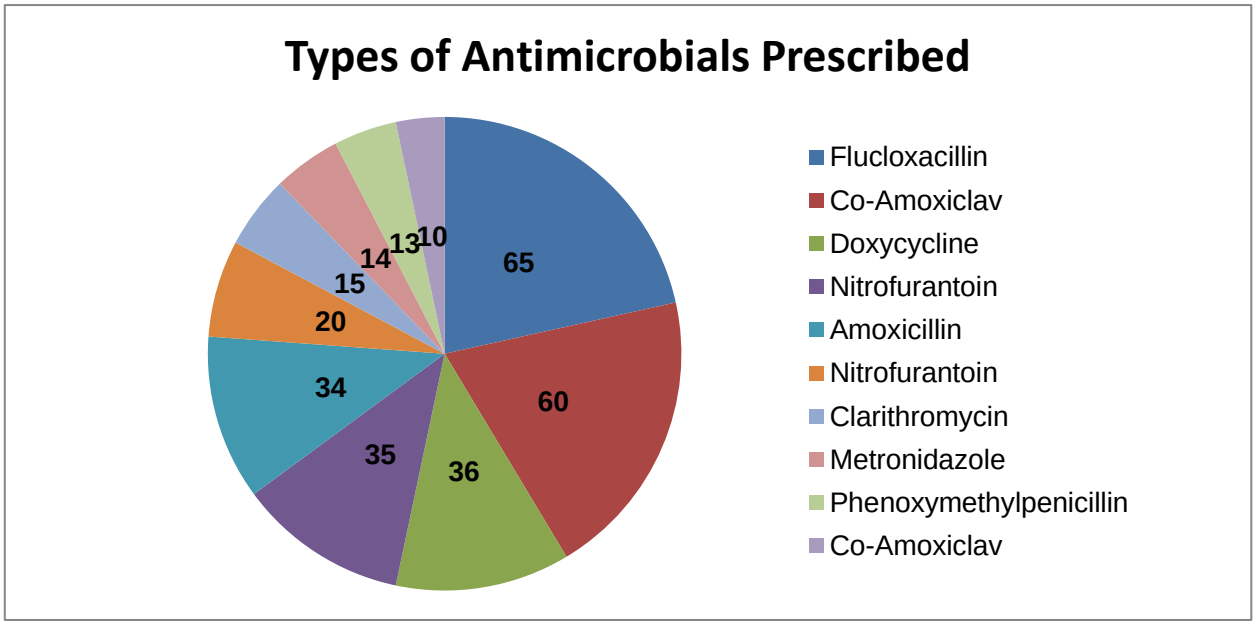


Figure 37. *below shows the types of Antimicrobials prescribed during 2023-24:*



20.0 Seasonal Influenza Vaccination Programme: Healthcare Workers

ELFT has actively promoted and administered immunizations following national strategies to protect staff and service users from Influenza and COVID-19. The Influenza vaccine campaign focused on improving staff vaccination rates through communication strategies such as case studies, interactive games, targeted emails, and mobile vaccination clinics, aiming to raise awareness and increase vaccine uptake. The campaign achieved a 93.85% offer rate to staff, despite a decrease in frontline staff uptake reported to NHS England from 62.3% last year to 29.76% in 2023-24.

Figure 38. *below shows data for the Seasonal Influenza Vaccination Programme for Healthcare workers:*

Influenza Vaccination data						
Directive	***Yes***	***No***	***Total (Yes & No)***	***Total Staff***	***% Vaccinated (front line staff***	***% including declines***
Bank	110	369	479	2455	4.48%	**19.51%**
Bedford	328	430	758	792	41.41%	**95.71%**
Bedfordshire CHS	287	174	461	461	62.26%	**100.00%**
City & Hackney	138	458	596	628	21.97%	**94.90%**
Tower Hamlets Community Services	78	123	201	201	38.81%	**100.00%**
Corporate	144	574	718	748	19.25%	**95.99%**
Forensic Services	111	429	540	543	20.44%	**99.45%**
Luton	141	236	377	377	37.40%	**100.00%**
Newham CHS	88	330	418	452	19.47%	**92.48%**
Newham	194	358	552	563	34.46%	**98.05%**
Primary Care	66	62	128	133	49.62%	**96.24%**
Specialist CHS	78	94	172	177	44.07%	**97.18%**
Specialist Services	308	985	1293	1308	23.55%	**98.85%**
Tower Hamlets	238	378	616	641	37.13%	**96.10%**
Vaccination clinic	14	2	16	781	1.79%	**2.05%**
Grand Total	**2323**	**5002**	**7325**	**7805**	**29.76%**	**93.85%**

21.0 Decontamination of Medical Devices

Inadequate decontamination can result in the transmission of various microorganisms, including blood-borne viruses such as HIV and Hepatitis B, as well as fungal and common bacterial infections. Ensuring the safe and effective decontamination of all reusable equipment between uses is crucial for maintaining cleanliness and preventing infections.

A single-use device (SUD) is designed for use on one patient during a single procedure and is then discarded. These devices are labelled as disposable and are not intended for reprocessing or reuse on another patient. All service lines within ELFT adhere to European legislation regarding the use of single-use devices.

The Trust primarily utilizes single-use, non-invasive medical devices. However, some clinics, particularly within Podiatry services, use reusable devices that are decontaminated at sterile service facilities.

All equipment within the Trust, including beds, sphygmomanometers, and commodes, is cleaned between uses according to the Trust's Decontamination Policy. This process is monitored as part of the annual environmental audit programme.

In Q2 of 2023-24, ELFT conducted a collaborative Duty of Care visit with the Infection Prevention & Control and Medical Devices departments to ensure compliance with health regulations for medical device decontamination. Despite initial access challenges at Enabled Living Healthcare, an audit report and action plan were generated, highlighting deficiencies in meeting national decontamination standards and MHRA requirements. The findings were presented to the Trust's Medical Devices Committee and documented as risks on respective risk registers. Discussions with Tower Hamlets Community Health Service underscored the need for ongoing improvement and scheduled further visits to monitor progress.

22.0 Water Testing / Water Safety

The Estates & Facilities Department monitors water quality across all Trust sites using external maintenance contractors and specialist sub-contractors, adhering to HTM 04-01 and Approved Code of Practice and guidance for controlling legionella bacteria in water systems (ACOP L8).

22.1 Management of Water Systems

The Water Safety Group (WSG) oversees Trust-wide water safety governance, meeting quarterly to review reports from the ELFT Estates and Facilities Team on water safety issues. An Authorised Engineer ensures compliance with water safety legislation, collaborating with the IPC Team and contractors reporting to the WSG. Robust proactive and reactive measures are implemented to manage Legionella risks, with quarterly updates provided to the IPC Committee.

22.2 Water Risk Assessments

Water monitoring services at ELFT are out-sourced to several providers.

Figure 39. *below shows water monitoring services out-sourced to providers by site:*

Sites	Service Provider	Number of Sites
London Sites – Newham & TH	Aqua Protec	28
	CHP/G4S – Lift Co	6
	NHSPS	12
Forensic Sites + The Lodge & Alie Street	Rydon	4
Tower Hamlets – Mile End & Health E1	Bart's Health	2
City & Hackney Centre for Mental Health	Homerton Hospital	1
Newham Centre for Mental Health	GFM – sub contractor WCS Group	1
Luton & Bedfordshire Sites	Rydon – sub contractor is Evolution	33

	Bedford Hospital	1
Bedford Community	NHSPS	17
	Bedford Hospital	1
	CHP	1
	Central Beds	1

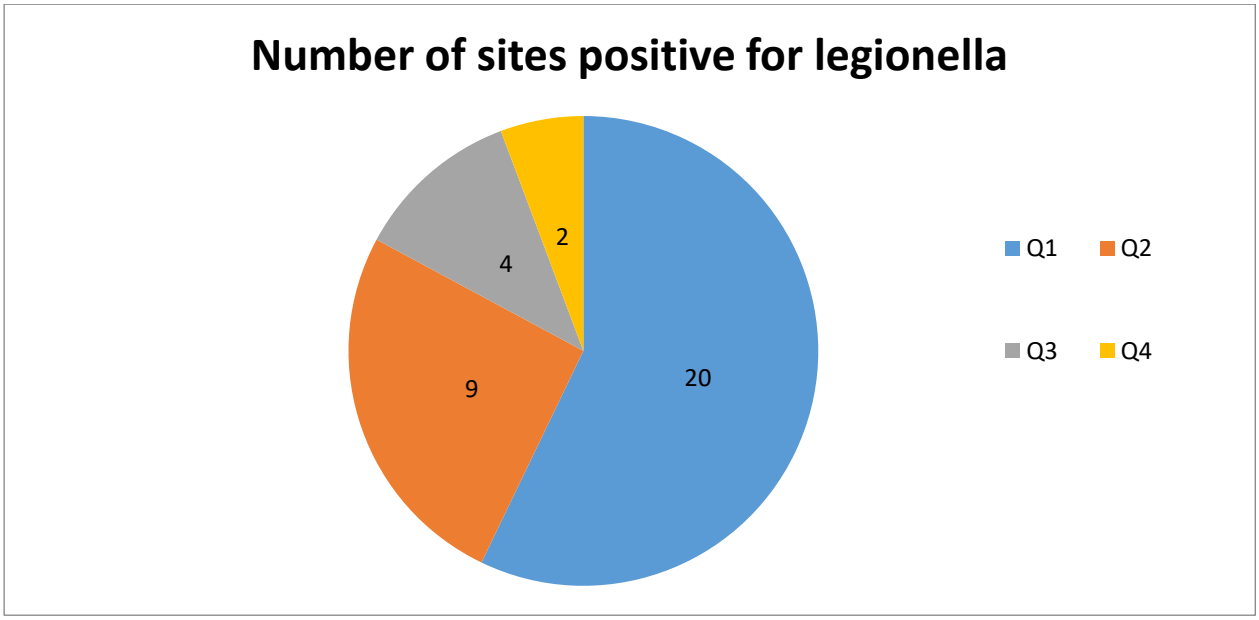
22.3 Legionella Testing

Trust sites undergo regular water quality monitoring by the Estates & Facilities Department using external contractors and specialist subcontractors, adhering to HTM 04-01 and ACOP L8 guidelines for Legionella control.

Legionella poses a risk to any organization, but robust proactive and reactive measures are in place. Monthly meetings of the Water Safety Sub-group with Estates & Facilities, IPC, and the authorizing engineer oversee water management issues.

Contractors are tasked with maintaining hot and cold water systems, conducting monthly temperature checks and water sampling. They also perform water tank disinfections and showerhead cleanings, with all site visits and certifications accessible via contractor portals. London site data is available on the Zetasafe portal, while Rydon/Evolution manages Luton & Beds site responsibilities.

Figure 40. *below shows sites that reported positive legionella samples during 2023-24:*



22.4 Water Safety Training

During 2023-2024, the IPC team & Estates & Facilities department received Water hygiene training via the Trust Authorised Engineer on:

- Water Management – hygiene & awareness
- Water Management & Responsible persons training

23.0 Ventilation Safety

ELFT has established a Ventilation Safety Group (VSG) in accordance with HTM guidelines, chaired by the Director of Estates and comprising representation from ELFT Microbiologist, Health and Safety, IPC, and staff-side representatives. Work Place Risk Assessments (WPRA) are conducted and escalated to the group as needed, with an appointed advisor providing guidance on ventilation assessments. Air-conditioning units in wards, particularly those in medication and treatment rooms, have been deactivated following an alert due to their recirculation of air without fresh intake. Ventilation strategies are integral to outbreak management, with risk assessments and control plans developed accordingly. FFP3 mask use is encouraged in areas with insufficient ventilation to mitigate COVID-19 risks, supported by a dedicated Ventilation policy overseen by the IPC team at VSG meetings.

During 2023-2024, the IPC team reviewed ventilation practices at various sites including

- Podiatry clinics at Shrewsbury Road Health Centre
- 71 Johnstone Clinic,
- The use of phenol in Newham and Tower Hamlets Podiatry services.

23.1 Air Cleaning Study

The IPCT, Estates, and Luton and Bedfordshire Mental Health Clinical teams are collaborating on Cambridge University Hospitals Trust's (CUH) Addenbrookes Air Disinfection Study, which aims to implement air disinfection units to prevent hospital-acquired infections on older adult inpatient wards. The study, launched at Fountains Court on June 15, 2023, has demonstrated the effectiveness of air cleaning units in removing airborne traces of COVID-19 virus and other pathogens. The IPCT contributed to designing these units to meet ligature and health and safety requirements for mental health settings (see Appendix 3). Results from the study have been presented at regional and national conferences, including the Infection Prevention Society (IPS) conference in London and the East of England, and a national estates conference. Plans are underway to potentially expand the study to Mile End Hospital.

24.0 Waste Management & Sustainability

The Trust remains compliant with waste management regulations outlined in Health Technical Memorandum 07-01. Ongoing efforts during 2023-24 have addressed staff awareness issues through updates in IPC training sessions and the implementation of new waste management signage across all sites. Significant changes in the supply chain have been made to align with the Trust's waste policy. Although there were temporary waste collection issues in Q1 at Three Colts Lane and Passmore Edwards Building, these have been resolved. Additionally, sustainability initiatives include piloting reusable cutlery and food waste caddies in Forensic Services and a current pilot project for reusable sharps waste at Newham Centre for Mental Health, supported by the IPC team and waste management staff in collaboration with clinical teams.

25.0 Capital Projects

The IPC team provide IPC advice for new projects and refurbishments to ensure that ward moves / new projects are compliant with IPC standards and clinical sign-off is considered prior to all moves. IPC also receive, review and approve capital bid projects.

26.0 IPC Risk Register

IPC risks are presented to the IPCC meetings. Throughout the year there has been on-going monitoring and management of risk.
During 2023-2024 the following items were reported on IPC risk register:

1. Ongoing concerns persist regarding adequate ventilation in specific clinical areas, particularly treatment rooms. This is actively monitored by the Trust Ventilation Safety Group. At the time of writing report this risk is closed.
2. Continuing challenges exist regarding staff awareness of waste management systems and processes across the Trust, attributed to the implementation of a new waste management system in April 2022. To address this risk, updates have been made to the waste management process during IPC Statutory & Mandatory training sessions. Sharpsmart, the new clinical waste contractor, conducted clinical waste compliance audits, yielding baseline audit data from 43 audits in Q1. In the same quarter, 30 staff members completed online OLM waste training, and a new waste matters email was introduced. Signage has been distributed to all sites to provide clarity on waste streams with efforts ongoing to address this risk comprehensively. These bags have been removed from ordering on the supply chain. At the time of writing report this risk is closed.
3. Risk linked to novice/inexperienced IPCNs and the provision of support to provide expert IPC advice. Risk mitigations include adherence to the IPC Policy, seeking guidance and support from the Lead IPCNs and active participation in daily IPC huddles. Junior IPCNs are undergoing training and supervision with mentoring and they are also enrolled on a Master's course in IPC. The Trust-wide Lead IPCN is facilitating tailored IPC training sessions with Band 6 IPCNs to further enhance expertise and preparedness. At the time of writing report this risk is closed.
4. Risk associated with ineffective decontamination of re-useable medical devices by Enabled living healthcare services. Enabled Living Healthcare have been advice to implement recommended action plan to ensure the service meets essential quality requirements for decontamination as per decontamination guidance. This risk is currently being monitored at the locally-led Contracts meeting by Tower Hamlets Community Health services. At the time of writing report, a re-audit is due in July to monitor for further improvements.
5. The reduction in IPC specialist nurse, within the IPC service poses significant organizational risks. In Q4, a workforce review was conducted, benchmarking against similar NHS Trusts, including Central & North West London NHS Foundation Trust (CNWL) and North East London NHS Foundation Trust (NELFT), both of which deliver comparable services across large geographical regions. Due to cost-saving measures, the team was reduced by one Band 6 specialist nurse. This reduction presents the following risks to the organization:
6. Ensuring compliance with legal and statutory requirements outlined in the Health and Social Care Act (2015) to fulfil provider duties.
7. Rise in healthcare-associated infections and outbreaks leading to significant impacts on patients, staff, and the overall cost of treatment, prolonging hospital stays, and increasing morbidity and mortality rates.
8. Inability to assist the Trust in maintaining a clean and safe environment for patient care, which can affect patients, staff, and visitors, and result in the Trust failing to meet its legal obligations under the Health and Social Care Act (2015).
9. Potential lack of assurance to regulatory bodies such as CQC, ICB, and UKSHA regarding the Trust's achievement of statutory components of infection prevention and

control measures, potentially leading to further financial penalties from regulatory authorities. Risk mitigation is to prioritise the annual work programme for 2024-2025.

27.0 IPC Service

During 2023-24, the IPC service initially operated from 9am to 5pm, Monday to Friday, facing staffing challenges in Q1 due to sickness and vacancies. Two Band 6 IPC Nurses were successfully recruited in Q2. Two Band 7 IPC Nurses completed Master's degrees in IPC, & a further two Band 6 IPC Nurses enrolled in post-graduate courses. The Trust-wide Lead Infection Prevention & Control Nurse completed an NHS England Pan-London IPC Fellowship during this period. However, a funding cut in Q4 resulted in one full-time Band 6 IPC nurse position being eliminated, highlighting risks to the service's capacity, including delays in response and compliance with statutory requirements under the Health and Social Care Act. Ongoing IPC staffing capacity issues are currently prioritized on the IPC risk register.

28.0 Conclusion

This report highlights the challenges faced throughout the year, particularly during the pandemic, and recognizes achievements and lessons learned. Despite these successes, HCAI prevention and control in mental health and community services remain ongoing challenges. Throughout 2023-24, collaborative efforts with estates, clinical teams, and contractors were pivotal in achieving high infection prevention and control standards. The unique nature of infection prevention and control in these settings requires tailored approaches, and East London NHS Foundation Trust remains committed to maintaining a safe environment for patients, staff, visitors, and carers. The Annual Plan objectives for 2023-2024 have been met, and reflections on post-pandemic resilience are guiding the development of the 2024-25 plan detailed in the Driver Diagram (Appendix 1), aligning with Trust strategies. The CQC Board to Floor assurance document will continue to be updated to reflect new evidence and guidance.

29.0 Summary of Annual Work Programme 2024-2025

The national priorities for 2024-25, as set by the Department of Health and UKSHA, prioritize addressing emerging and re-emerging infections, Gram-negative rod bloodstream infections, and community-acquired MRSA and MSSA bacteraemia. The overarching goal is zero tolerance for avoidable healthcare-associated infections (HCAIs) and robust antimicrobial stewardship. ELFT's annual work programme for 2024-2025 aligns with these priorities to ensure compliance with national standards, focusing on implementing the Health and Social Care Act 2008 guidelines, maintaining CQC IPC and COVID-19 assurance frameworks, employing a specialist workforce for IPC service delivery, and conducting ongoing surveillance and collaboration for infectious diseases including SARS-CoV-2 and COVID-19.

30.0 Action being requested by Committee:

The author should use one of the following statements or variations thereof: “The Board/Committee is asked to….

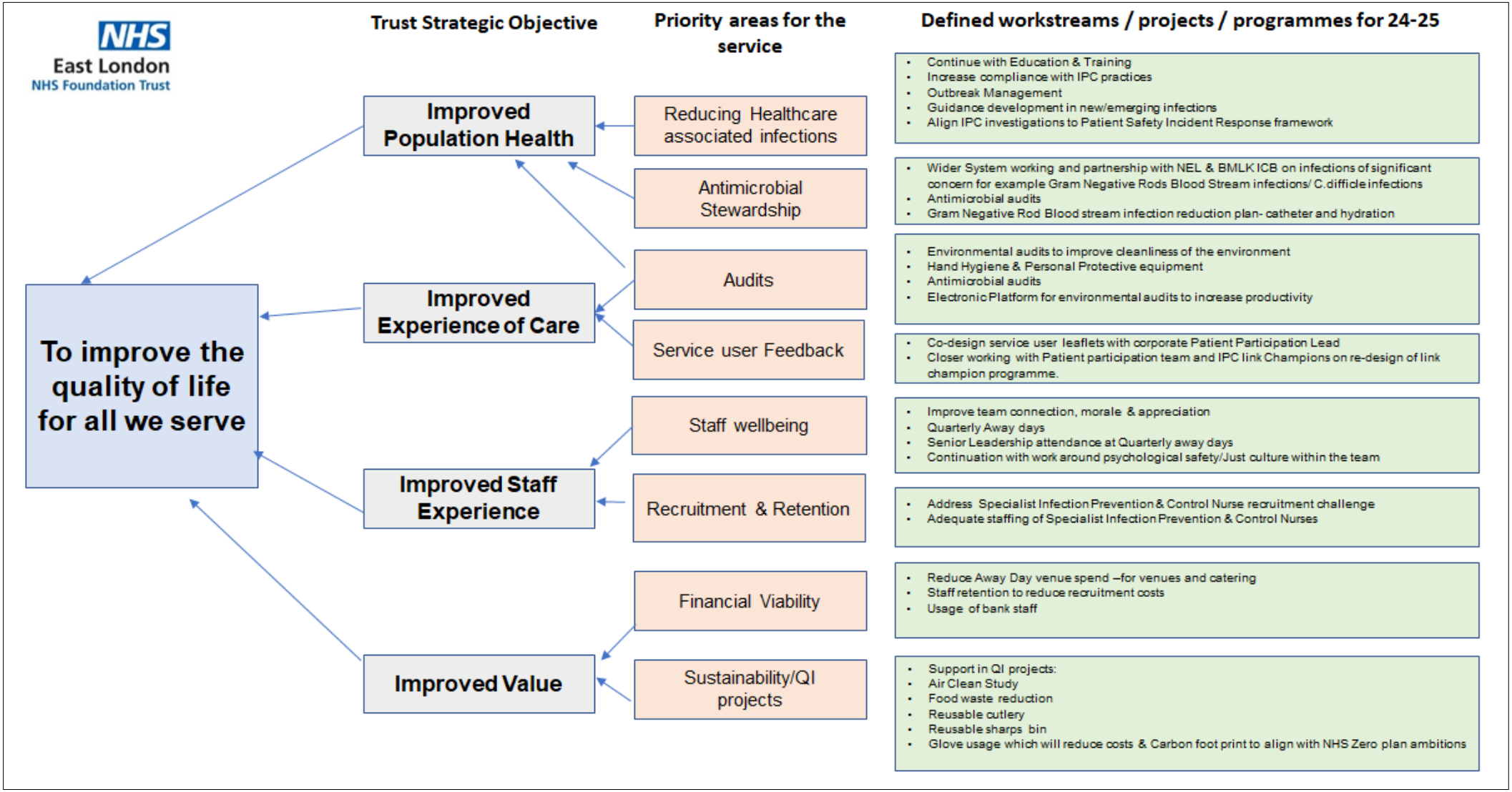
RECEIVE and DISCUSS the findings of the report and **APPROVE** the IPC annual report.

30.0 References

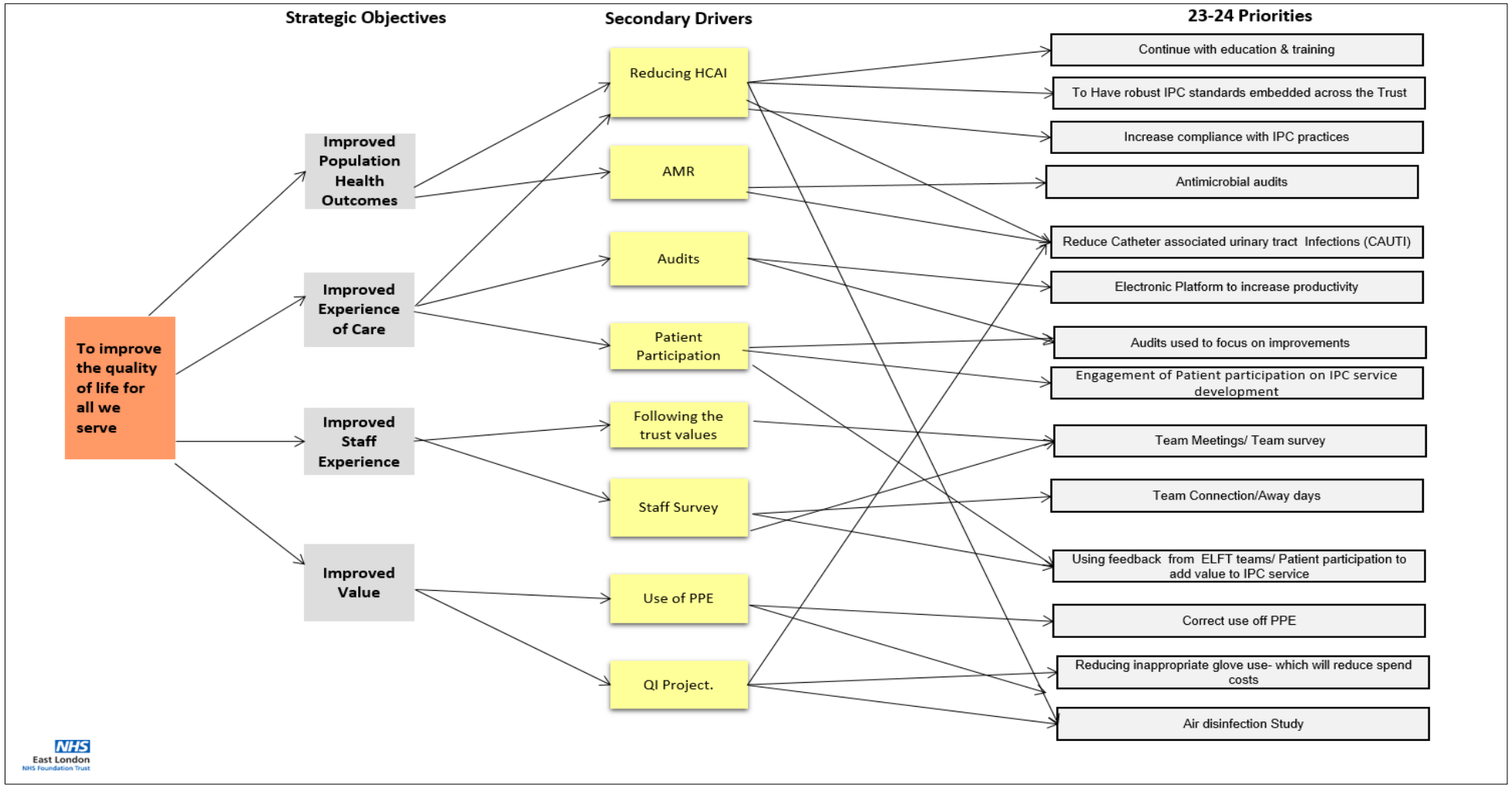
- DH (2015) The Health and Social Care Act (2008)- Code of Practice on the prevention and control of infections and related guidelines
- DH (2015) 'Start Smart - Then Focus' Antimicrobial Stewardship Toolkit for English Hospitals
- DH (2019) UK 5-year action plan for antimicrobial resistance 2019 to 2024
- DH (2024) Health Technical Memorandum 07-01: Safe and sustainable management of healthcare waste
- DH (2013) Water Systems. Health Technical memorandum 04-01: Addendum
- Pseudomonas aeruginosa – advice for augmented care units
- DH (2024) Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises
- DH (2012) Updated guidance on the diagnosis and reporting of Clostridium difficile.
- DH (2023) Start smart then focus: antimicrobial stewardship toolkit for inpatient care settings
- DH (2011) Antimicrobial stewardship: 'Start smart – then focus'. Guidance for antimicrobial stewardship in hospitals (England).
- Health and Safety Executive (2013) Legionnaires' disease. The control of legionella bacteria and guidance on regulations
- NHS Improvement (2017) Preventing healthcare associated Gram-negative bloodstream infections: an improvement resource
- Public Health England (2015) Toolkit for managing carbapenemase-producing Enterobacteriaceae in non-acute and community setting
- The National Institute for Health and Care Excellence (NICE) (2015) Healthcare-associated infections: prevention and control in primary and community care
- Infection Prevention Society (2020) Competency Framework for Infection Prevention & Control Practitioners https://www.ips.uk.net/ips-competencies-framework
- Loveday H. P. et al, epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England, Journal of Hospital Infection 86S1 (2014) S1–S70
- NICE Infection prevention and control Quality standard https://www.nice.org.uk/guidance/qs61/resources/infection-prevention-and-control-pdf-2098782603205
- NHS England IPC Education Framework https://www.england.nhs.uk/long-read/infection-prevention-and-control-education-framework/

31. Appendices

Appendix 1 – Driver Diagram of Infection Prevention & Control Service Annual Work plan (2024-25)



Appendix 2 – Driver Diagram of IPC Work plan (2023-24)



Appendix 3 –Air Disinfection Study Poster

AirPurity

NHS East London NHS Foundation Trust

HAVE YOU SEEN THESE BOXES AT FOUNTAINS COURT?

These are no ordinary boxes.

This is the latest collaborative project between ELFT & AirPurity.

Employing evidence-based research and innovation to improve the experience of care for both patients and staff.

Following extensive pre-deployment planning, colour-coded ligature prevention casing was modified for additional safety features & camouflaging effect.

Pioneering study in Mental Health Nursing

This new study commissioned the inclusivity for clean air to a wider patient group and concrete our commitment in delivering equality of care.

We are bridging the gaps between delivering safer air for service users and staff to reduce risk of infection transmission, ventilation improvement and sustainability for estate and maintenance and high quality of care combining ELFT visions with real outcomes.

SAFER AIR FOR EVEVRYONE

LIGATURE RISK COMPLIANT

NET ZERO FRIENDLY

CARE | RESPECT | INCLUSIVITY

If you wish to have a visit or speak to someone about this intervention and research, please contact Suzy at suzaane.enoarthur@nhs.net or 07788229558 (Text Preferred)

NHS
East London
NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE - 18 July 2024

Title	**Mental Health Law Annual Report**
Authors	Dominique Merlande, Associate Director of Mental Health Law
Accountable Executive Director	David Bridle, Chief Medical Officer

Purpose of the report

Provide an update on mental health law related activities in 2023-24 and set out work-plan for 2024-25.

Summary of key issues

The report covers the period from 1 April 2023 to 31 March 2024 and examines data and activity in relation to the use of the Mental Health Act (MHA) 1983 and the Mental Capacity Act (MCA) 2005 and how the Trust discharges its statutory duties and responsibilities under both pieces of legislation.

It highlights how Operations have significantly improved their compliance with Tribunal Rule 32 (Tribunal report timeliness) and identifies issues around compliance with consent to treatment/admission provisions and Section 132A MHA (statutory duty to inform community patients of their rights) – for which action plans are being delivered.

Following the successful roll out of the digital Mental Health Act solution, Thalamos version 1, the Trust is now in the process of implementing version 2 as part of the OneLondon eMHA project.

Strategic priorities this paper supports

Improved population health outcomes	☒	See work plan
Improved experience of care	☒	See work plan
Improved staff experience	☒	See work plan
Improved value	☒	See work plan

Committees/meetings where this item has been considered

Date	**Committee/Meeting**
20/05/2024	Mental Health Law Monitoring Group
22/05/2024	Quality Committee

Implications

Equality Analysis	The report highlights concerns around the disproportionate use of the Mental Health Act within the black population.
Risk and Assurance	The report identifies risks of legal challenge around Tribunal Rule 32 compliance, DoLS applications not being granted, consent to treatment/admission and 132A compliance.
Service User/Carer/Staff	The report emphasises the need for staff to understand the legal framework within which they work and what it means for service users in practice.
Financial	The report identifies opportunities for partnerships with neighbouring general hospitals and the Tribunals service via Mental Health Act Administration and clerking Service Level Agreements.
Quality	The report highlights the success achieved by the trust so far in driving up quality e.g. in relation to Tribunal Rule 32 and identifies means to further drive up quality as part of the work plan.

Supporting documents and research material:

MHA Statistics, National Figures for 2022/23
Government Response to Joint Parliamentary Committee on Mental Health Bill
CQC Report on Monitoring the MHA in 2022/23

Abbreviation	In full
AHM	Associate Hospital Manager
CQC	Care Quality Commission
CTO	Community Treatment Order
DMT	Directorate Management Team
DoLS	Deprivation of Liberty Safeguards
EPR	Electronic Patient Records
LPS	Liberty Protection Safeguards
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983
MHLD	Mental Health Law Department
MHLMG	Mental Health Law Monitoring Group
QAG	Quality Assurance Group
Tribunal	First-Tier Tribunal (Mental Health)

1 Introduction

The report covers the period from 1 April 2023 to 31 March 2024 and examines data and activity in relation to the use of the Mental Health Act (MHA) 1983 and the Mental Capacity Act (MCA) 2005 but also how the Trust discharges its statutory duties and responsibilities under both pieces of legislation.

2 Mental Health Law Governance

Governance around the MHL function is provided by the MHLMG, which now gets quarterly reports from:

- Each of the 6 mental health DMTs (Luton & Beds, City & Hackney, Newham, Tower Hamlets, CAMHS and Forensics);
- Each of the 3 Community Health Services' Leadership group/QAGs (Newham, Tower Hamlets, Bedfordshire);
- The Primary Care QAG.

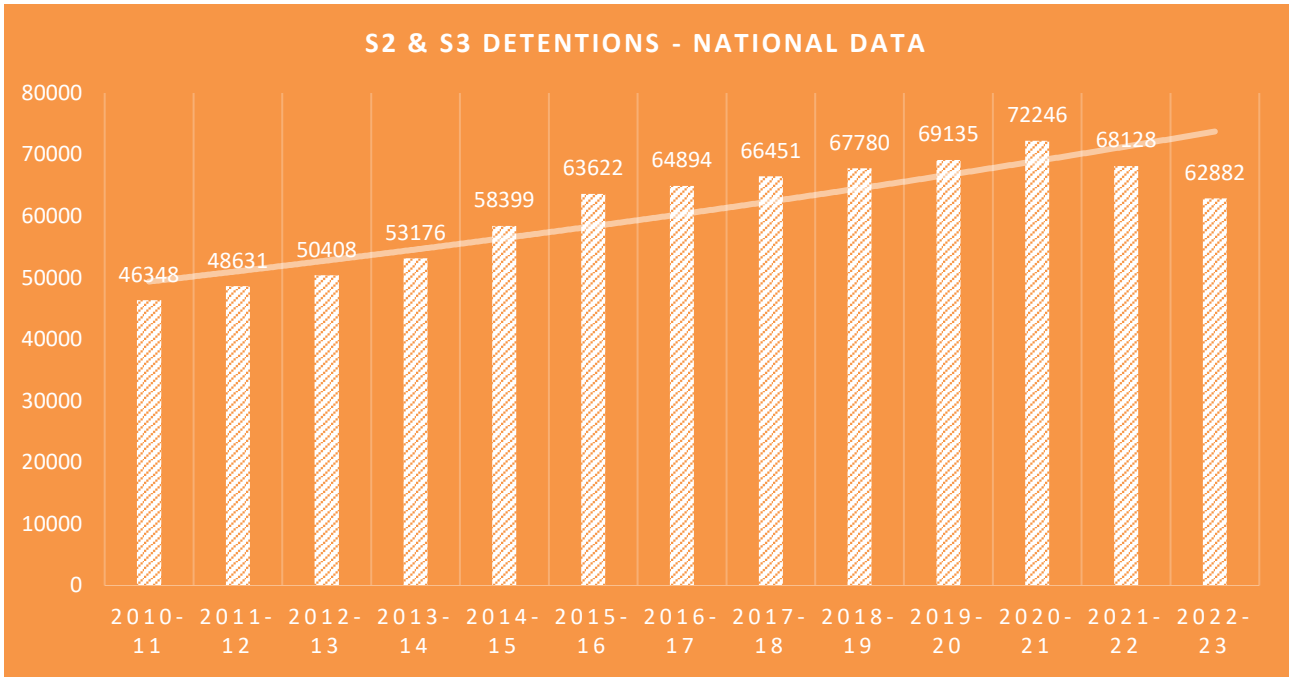
Following the demise of the MCA Operational Governance Group in 2023, CHSs and Primary Care have been including MCA KPIs as part of their regular QAG/Leadership Group meeting agenda.

The Statutory Advocacy Provider Forum was also dismantled in 2023 with ELFT now sending representation to contract management meetings held by the local authorities re statutory advocacy service provision.

3 Use of the Mental Health Act 1983

3.1 National Context – Detentions in Hospital and Use of Community Treatment Orders

On 25/01/24 NHS Digital published its **MHA Statistics, National Figures for 2022/23**. The figures show a decrease in detentions of 7.7% from the previous year. This is the second year in a row a decrease is observed at national level. The figures also show that rates of detention are over 3.5 times higher for the Black and Black British Group than they are for the White group (the rates of CTO being over 11 times higher). They are 3.5 times higher in the most deprived areas than least deprived ones.

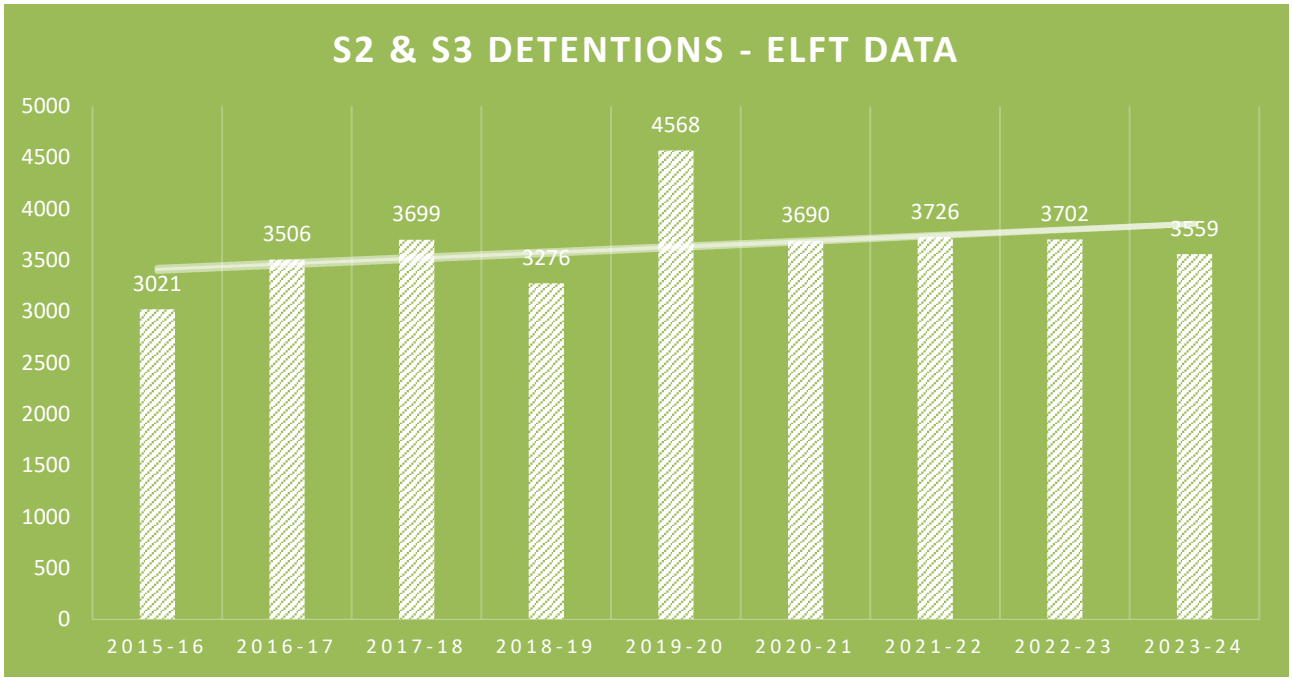


Source: NHS Digital ; Note: Detentions under the MHA figures exclude: short term detention order (Sections 4, 5(2), 5(4), 135 and 136); Detentions following recalls from CTO and conditional discharge.

It is expected that national figures for 2023/24 will be issued by NHS Digital in October 2024.

3.2 ELFT Data - Detentions in Hospital and Use of Community Treatment Orders

In 2023/24, there were a total of **3557** S2 and S3 admissions to ELFT - a 4% decrease from the previous year which is in keeping with the national picture.



On 31 March 2024, there were a total of **866** people subject to the MHA in ELFT. Of these people, **200** were subject to a CTO (an increase of 5.8% from the previous year). The remaining **666** were detained in hospital (+10.8%): **461** were subject to civil sections (+8%) and **205** to forensic sections (+17.8%). In 2023/24, 386 new CTOs were made in ELFT. There is overrepresentation, at trust level too, of Black and Black British people in MHA detentions and Community Treatment Orders. The trust launched the Patient and Carer Race Equality Framework (PCREF) in November 2023, ahead of it becoming mandated across NHS Mental Health Trusts. ELFT is implementing PCREF across all mental health directorates and services.

3.3 Legal Developments and Impact on ELFT

3.3.1 Mental Health Act Reform

A draft Mental Health Bill was published on 27/06/2022 containing proposals to update the MHA. A Joint Committee of both Houses of Parliament was appointed in July 2022 to scrutinise the draft bill. It heard evidence from a number of expert witnesses including ELFT Consultant Dr Chloe Beale and published its report on 19/01/23, which made 55 recommendations. On 21 March 2024, the government published its long awaited response to the Joint Committee's report. It said it would seek to introduce a revised bill "when Parliamentary time allows". However the bill was not included in the 2023 King's Speech, making it all but certain that is will not be introduced before the next general election.

3.3.2 Derbyshire Judgement

On 14/12/2023 the High Court handed down its judgment in Derbyshire Health Care NHS Trust v Secretary of State for Health and Social Care and others [2023] EWHC 3182 (Admin) ("the Derbyshire judgment"). It found that a remote examination does not qualify as "personal examination" for the purpose of section renewals and CTO extensions. The court declined to make a declaration in relation to the making of a new CTO and ambiguity therefore remains in this regard.

Following the 2021 Devon judgement, which found that applications for detention made on the basis of remote examinations were unlawful, ELFT had adopted a cautious approach and rescinded any detention/CTO which had started/been renewed on the basis of a remote examination. This meant that, when the Derbyshire judgement was handed down, there was not a single patient in ELFT who was subject to a section/CTO which had been renewed/extended following remote examination.

3.4 Associate Hospital Managers

3.4.1 Role

Associate Hospital Managers (AHMs) are lay people, who are appointed by ELFT to review whether the power of discharge ought to be exercised in the cases of patients who are subject to the MHA. Their role and powers are set out in the Code of Practice to the MHA.

3.4.2 Appointments

There were 18 AHMs in ELFT at the start of the year. There was one resignation in 2023/24 and the trust would like to thank **Beverley Woodburn** for her dedication and commitment to the role over the years. Sadly there was one death in service as **Joseph Ogunremi**, an AHM with 40 years of experience who was based in Bedfordshire and had joined ELFT in 2015, passed away. Joseph is dearly missed by his fellow AHMs and by the MHLD as a whole for his expertise, his kindness and his unfaltering focus on patients' rights.

ELFT was in the process of revising its AHMs' terms of appointment (and of introducing a requirement to attend a minimum of 12 reviews and 2 AHM Forums/training events per annum) when the Employment Appeal Tribunal found, in the Moon case that an Associate Hospital Manager qualified as worker under the Employment Rights Act 1996 and was "employed under a contract personally to do work" under the Equality Act 2010. ELFT is seeking legal advice on the implications of the Moon case and has paused the revision work around the terms of appointment.

3.4.3 AHM Activity and Timeliness of Reviews

There were a total of **201** AHM reviews held in ELFT in 2023/24. The AHM Forum agreed last year to introduce a new KPI whereby AHM reviews must be completed within a set timeframe (initially 8 weeks – extended to 10 weeks in summer 2023). To achieve this, the MHLD restructured its services and launched a dedicated MHA Office for AHMs on 22/05/2023. This office was tasked with clearing a backlog of AHM reviews and with reporting to the AHM Forum on the timeliness of non-backlog reviews every quarter. The backlog was officially cleared in March 2023 and the number of non-backlog AHM reviews held within the required timeframe increased from 20% in Q1 to 50% in Q4. The MHA Administration service is working on bringing this to 80%.

The introduction of the dedicated MHA Office for AHMs also mean that AHMs now have one single point of contact and reviews are arranged in a standardised way across the trust. The payment of the AHMs' honorarium has also now been automated and is now overseen by the MHL Supervisor for AHMs.

3.4.4 Training

A comprehensive training programme was delivered to the AHMs in 2023/24 including refresher training on how to conduct AHM reviews, understanding risk assessments and risk management reports and the "nature or degree" criterion.

3.5 Care Quality Commission Findings

3.5.1 National Findings

The CQC published its report on Monitoring the Mental Health Act in 2022-23 on 20/03/2024. The key messages were that:

- Workforce retention and staffing shortages remain one of the greatest challenges for the mental health sector, affecting the quality of care and the safety of both patients and staff.
- Longstanding inequalities in mental health care persist. More work is needed to address the over-representation of Black people detained under the MHA and to prevent prolonged detention in hospital for people who need specialist support.Despite additional investment, rising demand and a lack of community support means that children and young people face long waits for mental health support, and a lack of specialist beds means they continue to be cared for in inappropriate environments.
- We expect care to be person centred and are committed to helping services promote positive cultures. While we have seen improvements in some areas, there is still significant work to be done to reduce restrictive practices.
- It is promising that people, including staff, are aware of the drivers that can lead to a closed culture developing. But we are still concerned that too many abusive and closed cultures persist in mental health services.

3.5.2 Findings on ELFT Wards

In 2023/24 the CQC conducted 21 MHA Reviews on the following ELFT wards:

Ward	Locality	Date	Care Plans	S132	Detention	S17 Leave	Consent	Environment
Globe	TH	19/04/2023						
Opal	NH	04/05/2023						
Jade	L&B	16/05/2023						
Evergreen	CAMHS	16/05/2023						
Coral	L&B	17/05/2023						
Crystal	L&B	17/05/2023						
Crystal	NH	31/05/2023						
Leadenhall	TH	28/06/2023						
Ash	L&B	04/07/2023						
Hoxton	FX	01/08/2023						
Moorgate	FX	08/08/2023						
Sapphire	NH	21/08/2023						
Brick Lane	TH	23/08/2023						
Fountains Court	L&B	12/09/2023						
Westferry	FX	14/12/2023						
Rosebank	TH	31/01/2024						
Brett	C&H	21/02/2024						
Coborn Centre - Acute, PICU and Galaxy	CAMHS	05/03/2024						
Limehouse	FX	06/03/2024						
Joshua	C&H	15/03/2024						
Topaz	NH	25/03/2024						

	Standard met		Standard not met

The top three concerns raised by the CQC were:

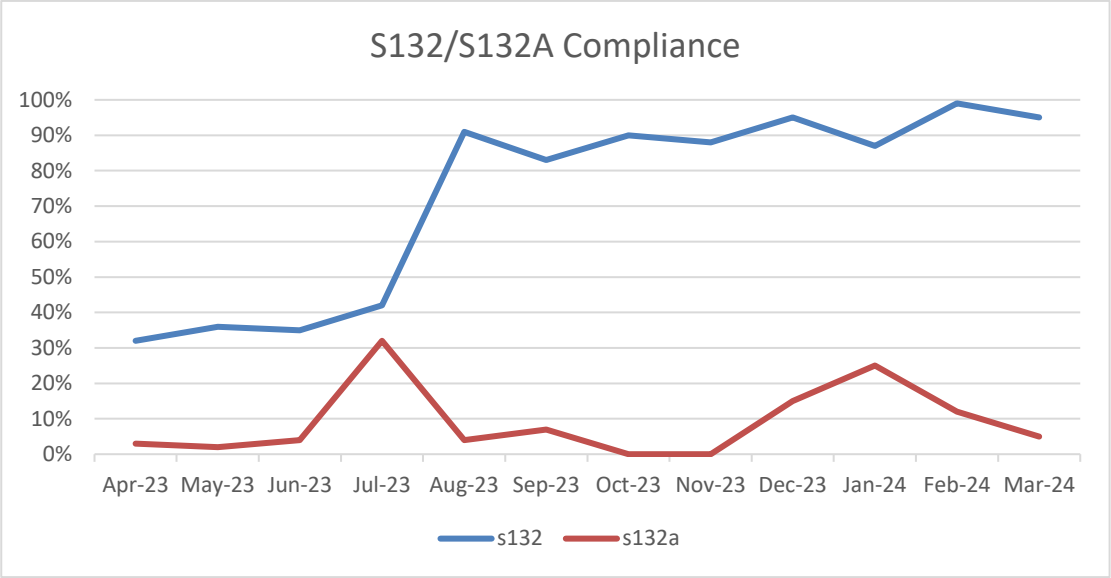
- **Consent**: some assessments of capacity to consent to treatment/admission were not evidenced.
- **Environment issues** e.g. ward in need of update or repair, seclusion room not fit for purpose, broken window, lack of viewing panel, pest control issue.
- **S132:** attempts made to explain their rights to patients were not always evidenced.

The MHLD is working closely with Operations to address these concerns. New consent/capacity recording tools are being introduced on EPR to support Operations to achieve compliance. The MHLD also now uses InPhase to monitor consent compliance issues and report quarterly to DMTs. All environmental concerns have been addressed except for a few long term projects which Estates are actively supporting Operations with. S132 compliance has drastically improved since Aug 2023 (see 3.6).

3.6 MHA Related Clinical Audits

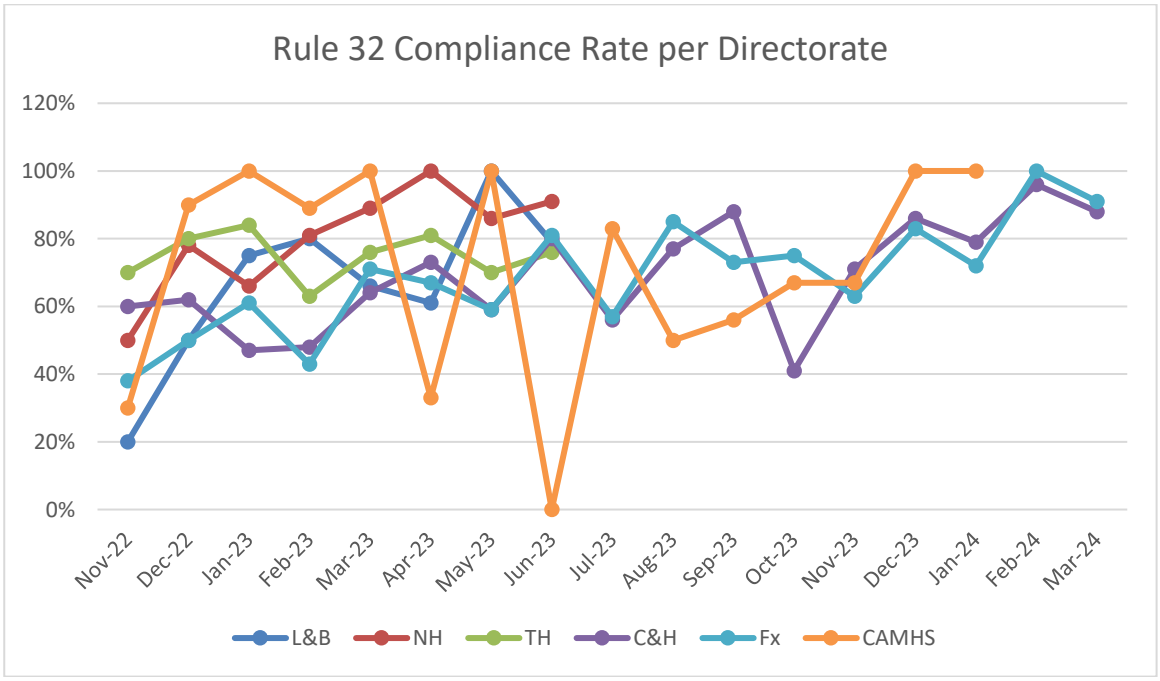
- **Patients Rights under S132 and S132A**

The trust is statutorily required to make attempts to inform patients who are subject to the MHA in hospital (S132) and who are subject to CTOs (S132A) of their rights under the MHA. The trust has been closely monitoring the timeliness of the first attempt made (within 24hrs for inpatients, within 7 days for CTO patients). Although timeliness has improved for S132, no significant movement has been observed for S132A yet. A S132A QI project is being launched in 2024/25, whereby new standards will be introduced via the Mental Health Law Supplementary Policy, training will be delivered to CTO patients' Care Coordinators and Corporate Performance and Analytics will support Operations with compliance monitoring.



- **Tribunal Rule 32**

Following a number of complaints received in 2022 from the Tribunal with regards to breaches of Rule 32 (late submission of reports leading to adjournments), a QI project was launched by ELFT to support directorates to improve their performance. New standard operating procedures, for both the Mental Health Act Administration service and report authors, were introduced. The project was successful – and therefore came to an end – in CAMHS, Tower Hamlets (TH), Newham (NH) and Luton & Beds (L&B):



ELFT is receiving regular and consistent support from District Judge Wescott on this project which shall continue in City & Hackney (C&H) and the Forensics service (Fx) until a sustained improvement has been demonstrated.

3.7 MHA Related Incidents, Complaints and Claims

There were a total of 161 MHL related incidents reported in 2023/24 (3% increase). The top 4 themes are:

- Failure to comply with treatment certificate requirements by statutory deadline - compounded by MHA Office's failure to escalate to DMTs (36)
- S140 policy triggers (15)
- Failure to abide by SOP on Responsibility for Preparing Reports and Attending hearings (13)
- Failure to receive and accept statutory documents (12)

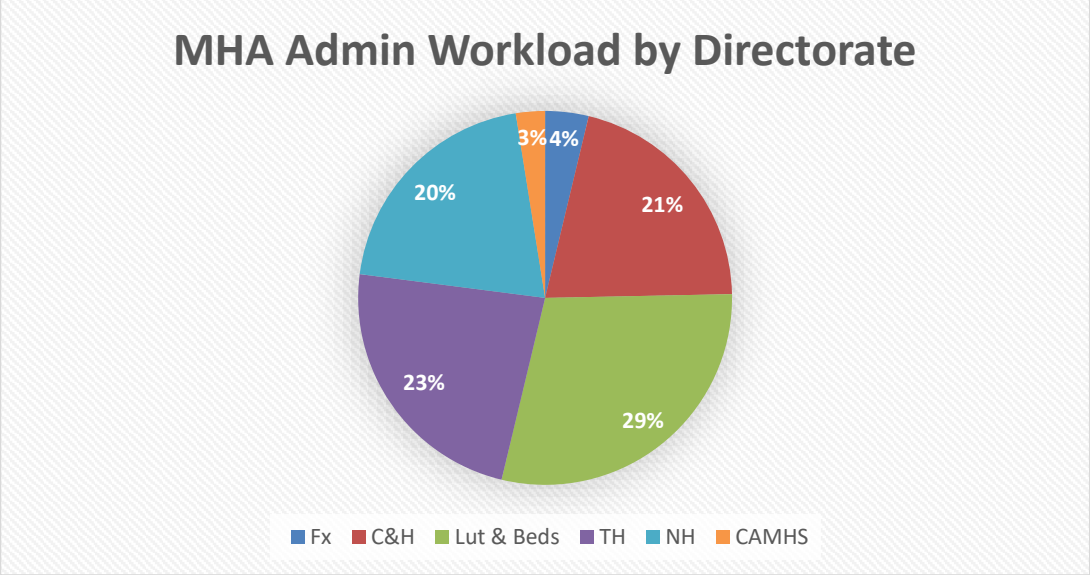
As mentioned at 3.5.2, new recording tools are being introduced on EPR to support Operations to achieve better compliance. The MHLD also uses InPhase to monitor compliance and report quarterly to DMTs. MHL related incidents are now systematically and consistently reviewed and root causes identified so as to inform quarterly duscussions with Operations and action plans.
Development pathways for the MHLD will also focus on leadership skills in 2024/25.

3.8 MHA Training Compliance

At the end of March 2024, **89%** of ELFT staff were compliant with MHA training. Operations and the MHLMG are presented with quarterly data on training compliance.

3.9 MHA Administration Service

Following 3 successful substantive appointments, the MHA Administration service has now filled vacancies that were previously covered by staff bank workers. 5 WTE B5s and 11.2 WTE B4s currently run the MHA administration service (1.6 WTE B4 are currently covered by staff bank workers due to 1 B5 being currently seconded to a B6).
Following a shift to hybrid working in 2022/23, and a return to locality assigned MHA offices, the service recognised that the attempt to pool staff into a hub style of working had caused a disconnection from Operations. Therefore, throughout 2023/24, the service has made increasing efforts to rebuild connections. With an increase of office-based days, attendance at localised meetings and the implementation of Standard Operating Procedures, which support Operations and improve communication, the service is bridging the gap and rebuilding relationships. However, this is still an ongoing objective of the service.
The return to localised MHA offices also prompted a new analysis of current MHA resources, to achieve a fair work distribution for our staff and ensure that resources are utilised in an efficient and effective way. The service has worked alongside Informatics to pull accurate data from Power BI and monitor levels of MHA Admin activity across the Trust:



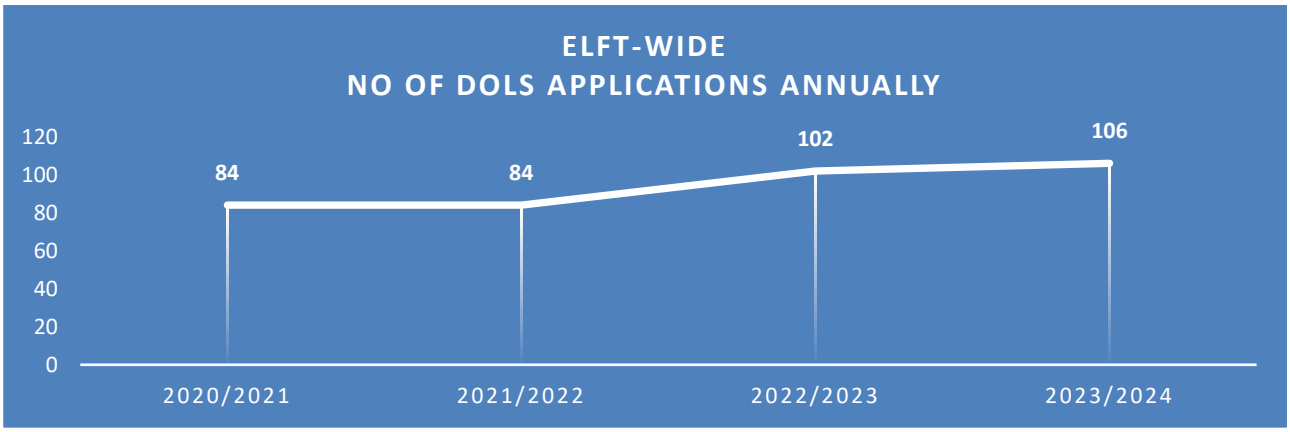
The clerking Service Level Agreements (SLA) with the Tribunals Service was resurrected in 2023/24 and generated £3k of income.
The Trust's MHA Administration SLAs with Bedfordshire Hospitals NHS FT, Barts Health NHS FT and the Homerton Healthcare NHS FT are now in the final stages of being revised. These will provide a robust MHA admin service to our partner general hospitals and generate income for ELFT in 2024/25.

4 Use of the Mental Capacity Act 2005

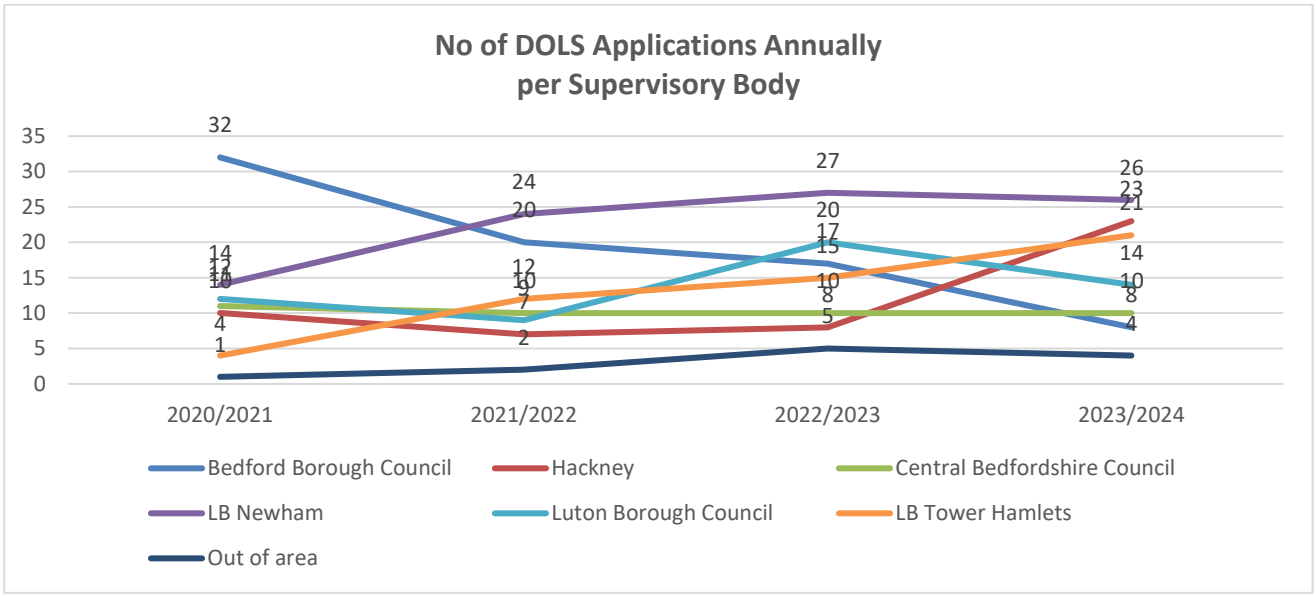
4.1 MCA Activity

The Trust acts as Managing Authority, under Schedule 1A to the Mental Capacity Act 2005, which implements the DoLS framework. This means that ELFT clinicians must make DoLS applications to the Supervisory Body (the Local Authority) when a care plan amounts to a deprivation of liberty.

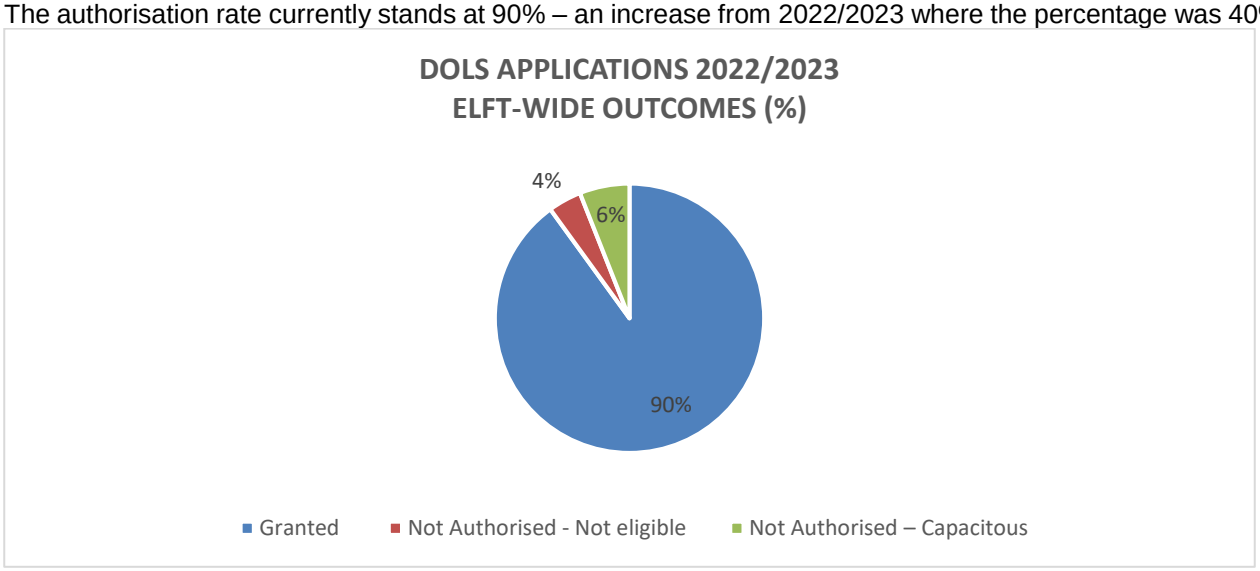
We have seen a 4% increase in DoLS applications made by ELFT in 2023/24:



The most significant increase was for applications made by ELFT wards to the London Borough of Hackney (+320%):



The authorisation rate currently stands at 90% – an increase from 2022/2023 where the percentage was 40%.



4% of applications were rejected due to patients not meeting the eligibility criteria. This is a significant improvement since 2022/23 where the rate of applications rejected on those grounds was 9%. The MCA team introduced a DoLS Administration SOP in January 2024 with the aim of improving standards across the trust to ensure the correct legal framework is used. This has reduced the rate of applications being rejected on eligibility grounds as the quality of the recording of the rationale for the application and need for the person to be deprived of their liberty is quality assured by the MCA team on receipt.
The MCA Manager and MCA Officer work closely with Operations and Supervisory Bodies to monitor any outstanding authorisations.

4.2 MCA Administration and Workforce Establishment

Staffing the MCA function adequately has been a concern in 2023/24 as both the Mental Health Law Manager responsible for MCA and the MCA Lead have had long periods of absence and the delivery of the MCA strategy has been delayed as a result. One of the B6 MHL Senior Supervisors has been seconded to the B7 Mental Health Law Manager role and has been running the MCA function together with the B5 Mental Capacity Act Officer and under the supervision of the Associate Director of MHL since November 2023. Their focus is on MCA governance and MCA Administration. Complex case management work has now returned to Legal Affairs and Trust solicitors. A review of MCA staffing needs will take place in 2024/25.

4.3 MCA Audits

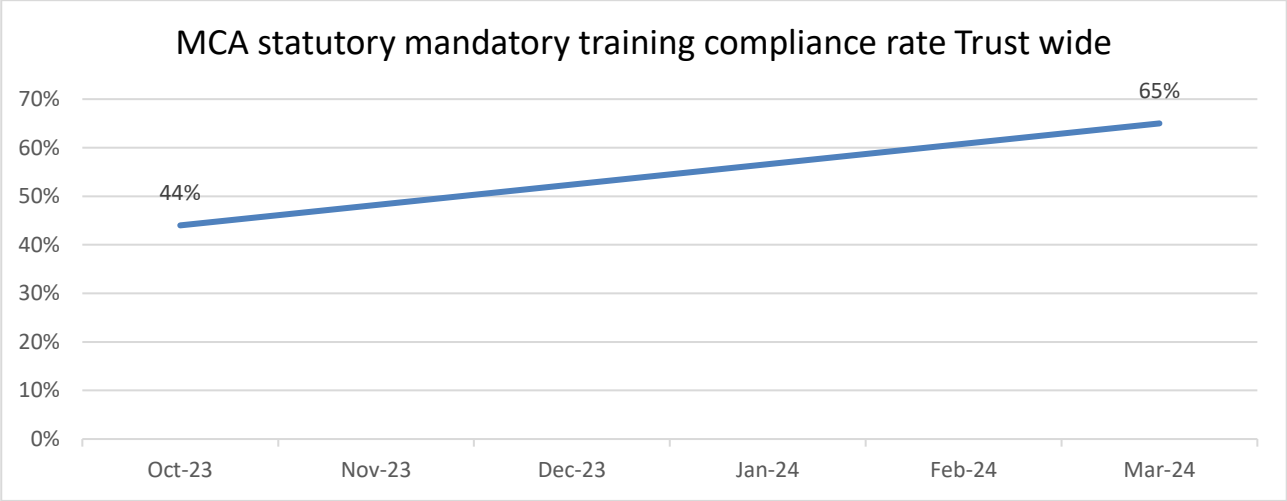
Staffing difficulties have made it difficult to undertake a robust MCA internal audit cycle prior to April 2024. However, the development of new MCA recording tools is underway and the MCA team have started to work with directorates to monitor the quality of recordings.
External audits, carried out by the CQC via MHA reviews (see 3.5.2), have identified the following concerns:

- Lack of and/or poor quality of recordings of assessments of capacity to voluntary admission;
- Lack of and/or poor quality of recordings of assessments of capacity to consent to treatment;
- Lack of recordings of mental capacity assessments and best interest decisions regarding treatment of physical health needs of patients admitted to mental health wards.

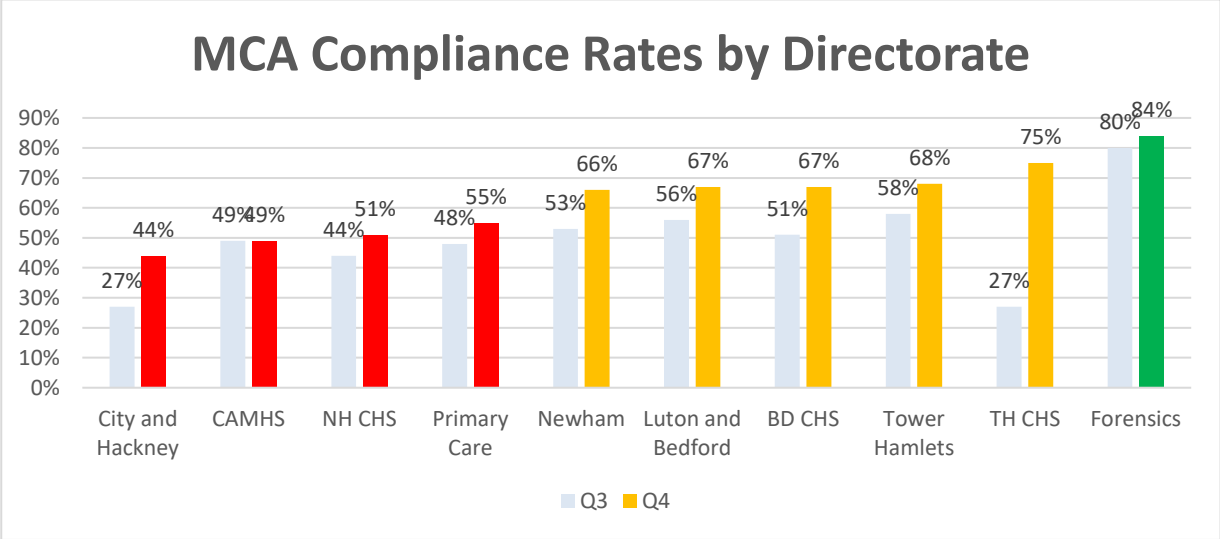
An MCA internal audit cycle, focusing on the 3 above areas, is being re-introduced in 2024/2025. The MCA recording tool will allow the MHLD to monitor the quality of capacity assessments completed for physical health needs and identify where there is a need for a best interest decisions. Audit results will be shared with DMTs and the MHLMG on a quarterly basis.

4.4 MCA Training Compliance

At the end of 2023/24, the MCA training compliance rate was 65%.



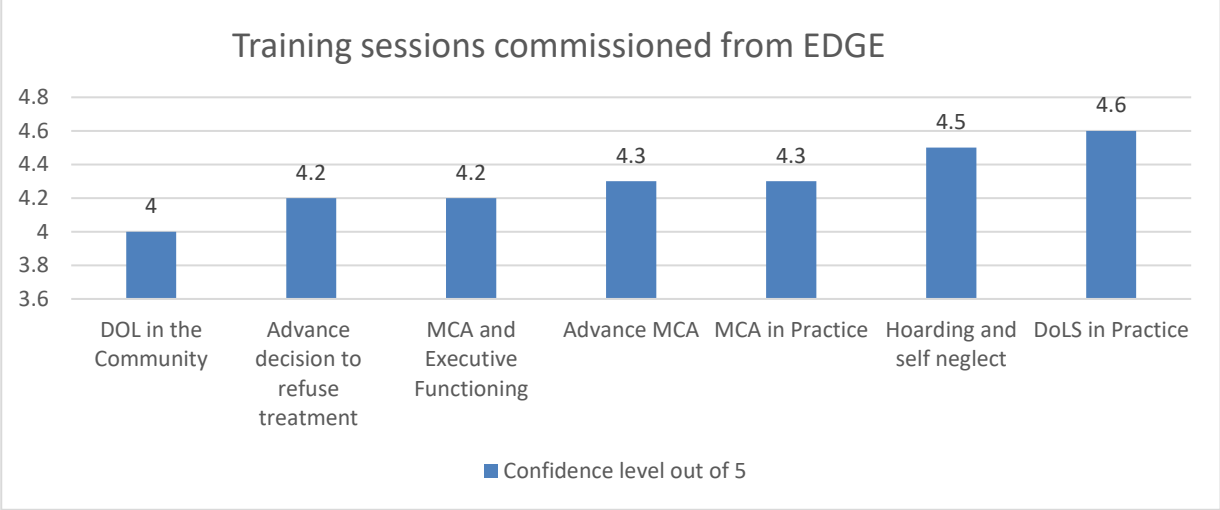
The MHL Manager responsible for MCA reports to DMTs and QAGs/Leadership Groups on a quarterly basis. The biggest success was seen in one of the CHSs, which managed to increase its compliance rate from 27% to 75% between Q3 and Q4.



To order to support all clinical services to improve their compliance with MCA training, the plan is for the MHL Manager (MCA) will conduct of a review of the training material and of the workforce mapping in 2024/25.

4.5 Edge Training

ELFT received funding from NHS England in 2022/23 to commission training. To support directorates to improve their compliance with MCA Core Skills training, live MCA training was delivered in 2023/24 by Edge on the topics listed below. Delegates' confidence levels in the subject matters have averaged 4.3 across all topics peaking at 4.6 for DoLS in practice. This is reflected in the decrease in the number of DoLS applications being rejected on eligibility grounds mentioned at 4.1.



MCA in practice and Advanced MCA training sessions have been commissioned until September 2024.

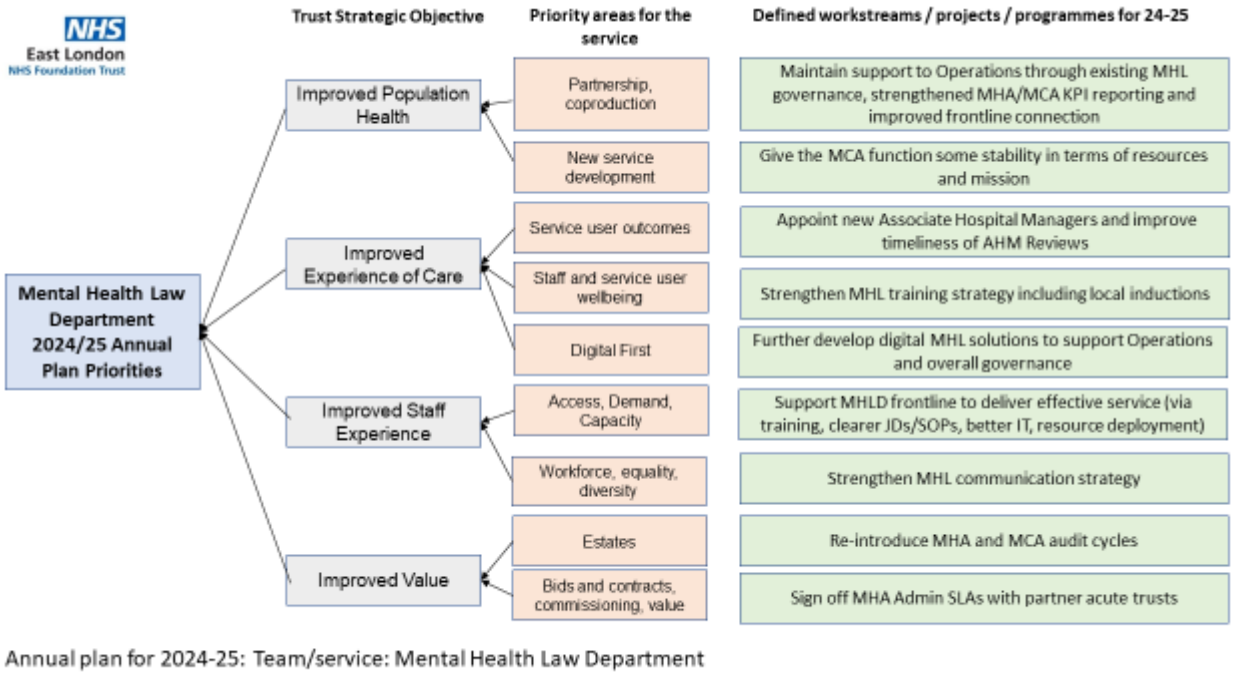
5 Progress made against 2023/24 Work Plan and New Work Plan for 2024/25

5.1 Progress made against 2023/24 Work Plan

- Improved relationship with and support to Operations through strengthened governance arrangements: there are now structured MHL compliance reports going to each DMT/QAG/Leadership Group, with quarterly reports to the MHLMG. Governance arrangements are more robust and Operations are better supported.
- Strengthen AHM Function: the introduction of the dedicated MHA office means the backlog has been cleared and there is now a standardised approach to AHM reviews. Payments are also now automated. Appointing new AHMs will be an objective for 2024/25.
- Implement digital solutions to support Operations and overall governance: Thalamos version 1 was successfully rolled out in 2024/25. The focus will be on rolling out version 2 as part of the OneLondon eMHA project in 2024/25. The PowerBI MHA tile was launched in 2023/24, which gives Operations more visibility on their MHA data. The MHLD was also actively involved in the InPhase roll out.

- Develop MHL Training Strategy: a strategy, including a combination of eLearning packages and live training (remote or face to face) has been agreed with Learning and Development and will need to be delivered in 2024/25.
- Review and Strengthen MCA function: despite staffing challenges the MCA function has been reviewed and strengthened. Our objective for 2024/25 will be to deliver the audit strategy.
- Review Structure, job roles and development pathways for MHLD: date is now collated to inform structure however job roles have now been reviewed and, following preliminary discussions with People & Culture, development pathways need to be agreed. This will be an objective for 2024/25.
- Review working arrangements and office space for MHLD: this objective was met with DSE risk assessments completed and work life balance arrangements revisited.
- Review SLAs with partner acute trusts: SLAs have been renegotiated and will need to be signed off in 2024/25.
- Review and resurrect SLA with HMCTS: this objective was met and generated a £3k income in 2023/24.
- Consolidate MHL communication strategy: the MHL Forum was held on a regular basis in 2023/24, as a joint initiative between People Participation and the MHLD. More work is however required to fully consolidate the MHL communication strategy and this will be an objective for 2024/25.

5.2 Work-plan for 2024-25



Annual plan for 2024-25: Team/service: Mental Health Law Department

No.	Key Priorities	Key Milestones	Lead(s)	What corporate/DMT is required?	Expected Delivery date / Progress
1	Maintain support to Operations through existing MHL governance, strengthened KPI reporting and improved frontline connection	Improved Rule 32 compliance Improved S132A compliance Improved quality of capacity assessment recordings Improved MCA training compliance	AD of MHL/MHA Manager/MCA Manager	All DMTs/ QAGs/ Leadership Groups	31/03/25
2	Give the MCA function some stability	Consolidate policies Devise audit strategy Review resources	MCA Manager	Clinical Governance	31/07/24

3	Appoint AHM Function and improve timeliness of reviews	Review Terms of Appointment Appoint new AHMs 80% of reviews held within 10 weeks	AD of MHL	People & Culture	30/11/24
4	Strengthen MHL Training Strategy	Identify training needs and resources available Deliver local inductions	MHA Manager/MCA Manager	L&OD	30/09/24
5	Further develop digital MHL solutions to support Operations and overall governance	Thalamos version 2 InPhase Power BI	AD of MHL/MHA Manager	Digital QA Analytics	31/12/24
6	Support MHLD fronline to deliver effective service	Revise JDs Introduce development/ leadership programmes Introduce SPs Provide better IT tools Data based resource allocation	Senior Supervisors	L&OD	31/03/25
7	Strengtthen MHL communication strategy	Intranet Public facing website	AD of MHL/MHA Manager/MCA Manager	Comms	30/09/24
8.	Reintroduce audit cycles	Improved Rule 32 compliance Improved S132A compliance Improved quality of capacity assessment recordings Improved MCA training compliance	AD of MHL/MHA Manager/MCA Manager	All DMTs/ QAGs/ Leadership Groups	31/03/25
9.	Sign off SLAs with partner acute trusts and deliver Financial Viability Plan	Signature Limit cost pressures Maximise income	AD of MHL/MHA Manager	Commercial development Finance	31/03/25

Reports on progress will be made via the MHLMG.

The work plan will be contingent on potential financial resourcing implications, both in respect of local savings requirements and legislative impacts. Financial impacts will have to be weighed against the risks associated with day to day running of the Mental Health Law department and day to day assurance.

6 Action Being Requested

The Committee is asked to approve this report.

ANNUAL REPORT TO THE QUALITY ASSURANCE COMMITTEE

18th July 2024

Title	Emergency, Preparedness, Resilience and Response Annual Report 2023/2024
Author	Richard Harwin Emergency Planning Manager
Accountable Executive Director	Edwin Ndlovu Chief Operating Officer

Purpose of the report

The purpose of this report is to detail ELFT's Emergency Planning, Resilience, and Response (EPRR) and business continuity arrangements for 2023/24, and to evaluate how the Trust fulfils its statutory and mandatory obligations in these areas.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Key messages

- The Trust's arrangements for Emergency Planning, Resilience and Response (EPRR) and business continuity continued to be strengthened during 2023/24. This progress has been supported by developing a comprehensive framework of plans to address the most critical risks and conducting exercises to rigorously test these plans.
- The Trust participated in the Assurance exercise carried out by NHS England (London) EPPR Team in October 2023. This annual assurance process marks compliance against the NHS England Core Standards for EPRR 2023. Based on the 2023 annual assurance submission to NHS England (London), the Trust did not receive any amber or red ratings and therefore rated as FULLY COMPLIANT.
- The Assurance Report from NHS England concluded that ELFT maintains a high standard in its EPRR arrangements. The report highlighted the robustness of the Trust's emergency preparedness and business continuity arrangements, evidenced by the high quality of its plans and the schedule of training and exercises.
- The Trust organized a series of Business Continuity Workshops aimed at supporting teams in effectively managing their Business Continuity Plans (BCPs). These workshops were meticulously designed to provide comprehensive guidance and enhance the preparedness of our teams across various aspects of business continuity.
- The Trust declared an internal critical incident on 20th March 2024 due to sustained high levels of bed occupancy - Trust implemented a range of measures to manage the situation effectively
- The 2023/24 period has witnessed significant NHS industrial action, which has had a considerable impact on services - the Trust implemented several strategic measures to mitigate this.

Strategic priorities this paper supports

Improved population health outcomes	☒	Maintaining operational continuity during emergencies or significant incidents.
Improved experience of care	☒	By identifying risks and implementing control measures to eliminate or minimize them, ensuring the safety of service users.
Improved staff experience	☒	Supporting and empowering staff by providing policies, procedures, and training to enable them to safely perform their roles.
Improved value	☒	Ensuring compliance with the statutory obligations of the Civil Contingencies Act 2004 and meeting NHS England EPRR Core Standards 2015.

Implications

Equality Analysis	There are no impacts on equalities in relation to this report.
Risk and Assurance	The Trust is legally obligated to adhere to the Civil Contingencies Act 2004, with potential penalties for non-compliance. Mitigation measures have been implemented to address the identified risks outlined in the report.
Service User/ Carer/Staff	Considerations for service users, carers, and staff, evaluate the impact of this document across all departments and service groups within the Trust.
Financial	Inadequate management of emergencies or insufficient business continuity planning may result in financial implications for the Trust.
Quality	This report does not raise any implications for Quality Improvement.

1.0 Background

1.1 The Trust under the Civil Contingency Act 2004 as a Category 1 Responder and Department of Health 'Emergency Planning' Regulations, has the following responsibilities:

- Carry out a risk assessment
- Have in place plans to respond to emergencies
- Have in place business continuity plans
- Collaboration and co-operation with other agencies
- Warn and inform the public and other agencies
- Training and exercising.

1.2 The Trust has a statutory obligation to train and exercise with a live exercise every three years, and annual table top exercise and a six-monthly test of the communication cascade.

1.3 The NHS England Core Standards for EPRR 2023 sets out how NHS organisations are to meet their responsibilities and the NHS England EPRR Framework (2022) states that NHS provider organisations are required to have appropriate systems in place.

1.4 With the implementation of the Health and Social Care Act 2012, the responsibility for overseeing EPRR arrangements passed from Primary Care Trusts to NHS England. Local Health Resilience Partnership Groups (LHRP) were established.

1.5 The Trust's EPRR responsibilities are managed and overseen by:

- Accountable Emergency Officer – Chief Operating Officer
- Health, Safety, Security and Emergency Planning Manager
- Emergency Planning and Business Resilience Officer for Luton and Bedfordshire (Mental Health and Community Services)
- Associate Director of Governance & Risk Management – overseeing the work of the Emergency Planning Manager.

2.0 Trustwide EPRR Plans

2.1 Incident Response Plan (IRP) is modelled against the NHS England Core Standards for EPPR and was evaluated as part of the NHS England and NHS Improvement Annual Assurance process. The subsequent EPRR Assurance Report described the IRP as 'comprehensive in content, of a very good standard and considered as 'good practice'.

2.2 The Trust Wide Business Continuity Plan has been created and reviewed, with focus on infrastructure.

2.3 The following plans were reviewed as part of the annual review cycle:

- Incident Response Plan
- Heatwave Plan
- Business Continuity Policy
- Surge Plan
- Pandemic Flu Plan
- Emergency Contacts List
- Flood Plan
- FuelPlan

2.4 Business continuity plans have been refreshed by all Directorates as part of the Trust's response to COVID-19 and will be reviewed again considering any lessons learnt and in response to exercises.

3.0 Annual EPRR Assurance

3.1 <u>London</u>

The Trust participated in the Assurance exercise carried out by NHS England (London) EPPR Team in October 2023. This annual assurance process marks compliance against the NHS England Core Standards for EPRR 2022 and ensures that NHS organisations in London are prepared to respond to an emergency and have the resilience in place to continue to provide safe patient care during a major incident or business continuity event.

Based on the 2023 annual assurance submission to NHS England (London), the Trust did not receive any amber or red ratings and therefore rated as **FULLY COMPLIANT**.

NHS England (London) concluded in the Assurance Report that ELFT continues to maintain a high standard for EPRR arrangements, evidenced through the assurance submission and by the submitted plans/policies. It was noted that the high quality of submitted plans, schedule of training and exercising, highlighted a robust emergency preparedness and business continuity arrangement. Furthermore, the Trust's Incident Response Plan and EPRR Policy continue to be identified as being of a very high standard and continue to be included on the national EPRR database of good practice.

3.2 <u>Luton and Bedfordshire</u>

Organisations which operate across Local Health Resilience Partnerships (LHRP) borders present their completed EPRR self-assessment return to their lead ICB and host LHRP as appropriate. Our self-assessment and subsequent report was shared with BLMK ICB.

4.0 Business Continuity

4.1 New Business Continuity Plan Template and Off-the-Shelf Exercise

Given the added winter pressures, bed demand, and industrial action, there is now an increased need for the Trust and its services to ensure business continuity and resilience. To address this, a new Business Continuity Plan (BCP) template for services, accompanied by a BCP handbook was created. This new template was streamlined for a more user-friendly approach.

Throughout 2024/2025, the EPRR team will support directorates in completing their BCPs by conducting a series of workshops. These workshops aim to encourage directorates and teams to adopt a localized and focused approach to testing their resilience in the event of a business continuity incident.

4.2 Governance of Business Continuity Plans

To ensure comprehensive oversight and support for Business Continuity Plans (BCPs), the Trust will be storing all BCPs on the InPhase platform. This centralized approach will facilitate easier access, management, and updating of the plans across all services. The InPhase dashboard will offer a user-friendly interface that provides an accurate timeline for updates, ensuring that all BCPs remain current and reflective of the latest risk assessments and operational needs.

By utilizing InPhase, the Trust can monitor the status of BCPs in real-time, track any changes or revisions, and ensure that all relevant stakeholders are promptly informed of updates. This system will enhance the Trust’s ability to maintain robust business continuity and resilience, providing a reliable framework for responding to potential disruptions.

This centralized storage of BCPs on InPhase will not only streamline the process of managing these critical documents but also ensure that they are readily available during an emergency. This initiative underscores the Trust's commitment to maintaining high standards of preparedness and operational continuity, ultimately contributing to the safety and well-being of patients, staff, and the wider community.

4.3 Business Continuity Workshops

In May 2023, the Trust organized a series of Business Continuity Workshops aimed at supporting teams in effectively managing their Business Continuity Plans (BCPs). These workshops were meticulously designed to provide comprehensive guidance and enhance the preparedness of our teams across various aspects of business continuity.

The workshops covered a wide range of critical topics, including:

- Incident Classifications**:** Participants were educated on the different types of incidents that could disrupt operations, ranging from minor disruptions to major emergencies. Understanding these classifications is essential for tailoring responses and allocating resources appropriately during an incident.

- Command Structures**:** The workshops provided detailed insights into the establishment and operation of command structures during emergencies. This included defining roles and responsibilities, ensuring clear lines of communication, and maintaining effective leadership throughout the incident response.

- Legalities**:** Participants were briefed on the legal frameworks and obligations related to business continuity and emergency response. This segment covered statutory requirements, regulatory compliance, and the legal implications of decision-making during crises.

Additionally, the workshops addressed other essential elements of business continuity planning, such as risk assessment, resource management, and recovery strategies. Through interactive sessions, case studies, and scenario-based exercises, teams were encouraged to apply their knowledge practically, fostering a proactive and resilient approach to managing potential disruptions.

The feedback from participants indicated that the workshops were highly beneficial in enhancing their understanding of business continuity principles and their ability to develop and implement robust BCPs. Moving forward, the Trust plans to continue offering such workshops regularly, ensuring that all teams remain prepared and capable of responding effectively to any business continuity challenges that may arise.

5.0 Training

5.1 Strategic Leadership in a Crisis Training

In September 2023, NHS England and NHS Improvement provided the Trust 'Strategic leadership in a Crisis' training sessions to our on-call directors, receiving excellent feedback from the participants.

5.2 On-Call Director and On-Call Manager Training

The EPRR team has recently begun developing an On-Call Director training package which will be added to the Trust Learning Academy portal, requiring all On-Call Directors to complete the training online with a view to supporting them in their role. This training package is expected to go live by October 2024..

An On-Call Manager training will also be made available online as part of the annual work plan.

6.0 Testing and Exercising

6.1 With effect from July 2013, NHS England (London) EPRR had been conducting communication exercises whereby the Director on-call is contacted for a response to a pager message within ten minutes or as soon as is practicable – good practice being to respond within thirty (30) minutes and best response within ten (10) minutes. The Trust's response times are below:

	May 2023	June 2023	Aug 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	April 2024
Response Time	3	No	10	30	36	4	7	No	No

To ensure a timely response to these exercises, and as a response to the COVID-19 outbreak, the director on-call pack is now accessed remotely via Microsoft Teams and any pager messages being diverted to the director's mobile telephone.

Although response times have generally been prompt and consistent, there have been occasions when the alert was not answered, mainly due to connectivity issues. This will form a key part of the forthcoming director on-call e-learning package.

6.2 Annual Cyber Incident Exercise

The annual Cyber Incident Exercise is scheduled to take place on 27th June 2024. This event will be held at Trust Headquarters and is designed to thoroughly evaluate the Trust's response capabilities in the face of complex and evolving threats.

The exercise will centre on a primary scenario involving a sophisticated ransomware attack, which is a realistic and increasingly prevalent threat in today's digital landscape. To intensify the challenge and test the resilience of our response strategies, the exercise will incorporate additional injects that simulate exacerbating factors, such as severe weather conditions and subsequent power outages.

These injects are carefully designed to create a multi-faceted crisis environment, compelling participants to navigate not only the immediate cyber threat but also the compounded impact of infrastructure failures. By simulating these concurrent emergencies, the exercise aims to assess the robustness of our emergency preparedness, identify potential vulnerabilities in our response protocols, and ensure that our teams are well-equipped to manage complex, high-pressure situations.

The comprehensive scope of this exercise underscores the Trust's commitment to maintaining high standards of cyber security and operational continuity. Through realistic and challenging scenarios, we aim to enhance our preparedness, improve coordination among different departments, and ultimately ensure the safety and security of our systems and services.

This exercise will also provide valuable insights and lessons that will inform future training and preparedness activities, further strengthening the Trust's resilience against cyber threats and other emergency situations.

An exercise report will be available post exercise - any lessons learned with accompanying actions will be added to the 2024-25 workplan.

6.3 Exercise Safe Passage – 21st June and 8th July 2024 facilitated by ELFT.

Exercise Safe Passage is a joint initiative between the John Howard Centre and the Metropolitan Police, scheduled to rigorously test our emergency response capabilities. This exercise focuses on a high-stakes scenario involving a hostage situation coupled with critical injuries to both staff and patients.

The exercise is designed to simulate a realistic and urgent crisis, requiring seamless coordination and rapid response from both mental healthcare professionals and law enforcement officers. By engaging in this collaborative exercise, participants will be challenged to apply their training in a high-pressure environment, making critical decisions that prioritize the safety and well-being of everyone involved.

During Exercise Safe Passage, teams will practice essential skills such as crisis communication, tactical response, medical triage, and evacuation procedures. The scenario will demand a coordinated effort to resolve the hostage situation while simultaneously addressing the immediate medical needs of those injured. This dual-focus approach ensures that both the security and healthcare aspects of the emergency are managed effectively.

The involvement of the Metropolitan Police brings an additional layer of realism and expertise to the exercise, fostering a deeper understanding of interagency collaboration and enhancing our collective ability to respond to such incidents. Participants will gain first-hand experience in working alongside law enforcement, learning how to integrate their efforts to achieve a swift and safe resolution.

This exercise underscores the commitment of the John Howard Centre to maintaining a high level of preparedness for any emergency situation. By rigorously testing our protocols and response strategies in collaboration with the Metropolitan Police, we aim to identify any potential gaps, refine our procedures, and ensure that our teams are well-equipped to handle complex emergencies.

The insights gained from Exercise Safe Passage will be invaluable in further strengthening our emergency preparedness and response capabilities, ultimately contributing to a safer environment for staff, patients, and the broader community

7.0 Declaration of Internal Critical Incident

7.1 The Trust declared an internal critical incident on 20th March 2024 due to sustained high levels of bed occupancy and other system-wide operational and service-level pressures across both North East London (NEL) and Bedfordshire, Luton, and Milton Keynes (BLMK) Integrated Care Systems (ICS).

This declaration was necessitated by the exceptionally high demand for services, which placed significant strain on our resources and capacity. The persistent high levels of bed occupancy, coupled with various operational challenges, created an urgent need for a coordinated response to maintain the quality and safety of patient care.

7.2 During this critical incident, the Trust implemented a range of measures to manage the situation effectively. Key actions included:

- Resource Allocation**:** Efforts were made to optimize the use of available resources, including staff, equipment, and facilities, to address the increased demand and ensure patient care was not compromised.

- Enhanced Coordination**:** The Trust intensified coordination with partner organizations within the NEL and BLMK ICS to manage patient flow, share resources, and support each other in mitigating the pressures faced by the healthcare system.

- Communication and Command Structures**:** Clear communication channels and command structures were established to streamline decision-making processes and ensure that all teams were informed and aligned in their response efforts.

- Patient Safety Measures: Specific protocols were activated to prioritize patient safety and manage the high bed occupancy rates. This included reviewing patient discharge processes, expediting transfers where possible, and closely monitoring patient care standards.

7.3 The declaration of the internal critical incident underscored the Trust's commitment to proactive crisis management and ensuring the resilience of our healthcare services during periods of extreme pressure. By responding swiftly and effectively, the Trust aimed to mitigate the impact on patients and staff while maintaining the highest possible standards of care.

The experience and insights gained from managing this critical incident will inform future preparedness and response strategies, enhancing the Trust's ability to navigate similar challenges in the future.

8.0 Impact of NHS Industrial Action on Services in 2023/24

8.1 The 2023/24 period has witnessed significant NHS industrial action, which has had a considerable impact on the Trust's services. These industrial actions, including strikes and other forms of workforce protest, have challenged the Trust's ability to maintain uninterrupted service delivery and meet the high standards of patient care.

8.2 To manage the effects of these industrial actions, the Trust implemented several strategic measures:

- Contingency Planning**:** Comprehensive contingency plans were developed and activated to ensure that essential services remained operational during periods of industrial action. These plans included reassigning duties, leveraging temporary staff, and adjusting service schedules to prioritize critical care areas.

- Enhanced Communication: Clear and consistent communication channels were established to keep staff, patients, and stakeholders informed about the status of services, expected disruptions, and alternative arrangements. This transparency helped to manage expectations and reduce uncertainty during industrial actions.

- Resource Management: The Trust focused on optimising the use of available resources, including personnel, facilities, and supplies. Efforts were made to deploy staff flexibly and ensure that resources were allocated to areas with the greatest need, minimizing the impact on patient care.

- Support for Staff: Recognizing the additional stress on staff during industrial actions, the Trust provided support through counselling services, stress management resources, and increased managerial support. This helped to maintain staff morale and ensure that those who continued to work were supported and appreciated.

- Collaboration with Partners**:** The Trust worked closely with other healthcare providers, local authorities, and community organisations to coordinate responses and share resources. This collaboration was crucial in managing patient flow, reducing service disruptions, and ensuring that patient care continued as effectively as possible.

8.3 The industrial actions of 2023/24 highlighted the resilience and adaptability of the Trust's staff and systems. Despite the challenges, the Trust remained committed to delivering safe and effective care. The lessons learned during this period will be invaluable in strengthening future response strategies and ensuring that the Trust can continue to provide high-quality care even during times of industrial action or other significant disruptions.

9.0 Multi-agency Working

9.1 Emergency Planning Network Forums

The Emergency Planning Manager is a member of the following meetings and attends regularly, contributing accordingly.

- Tower Hamlets, Newham, Hackney and Bedfordshire Local Resilience Forums
- NHS England (London) Northeast North Central (NENC) Network Meetings

9.2 The Trust’s Emergency Planning Officer leads operationally for L&B Mental Health and Community Services with full participation in their Local Health Resilience Partnership Forum

9.3 The AEO attends the London wide Local Health Resilience partnership meetings whilst four strategic leads share the responsibility of attendance at the Bedfordshire Local Health Resilience Partnership.

10.0 ELFT EPRR progress against work plan 2023/24

KEY ACTION	STATUS AT 31/03/2024
Review all plans relating to emergencies and business continuity to ensure they reflect current guidance and legislation.	Completed – 21st October 2023
Update emergency contact list to ensure it is up to date.	Completed – 14th February 2024
Continue multi-agency working (LHRPs, Luton and Bedfordshire patch LHRP, Borough Resilience Forums, NHS England (London) NENC Network Meetings)	Completed – ongoing – bi monthly
Annual audit of all Trust Incident Control Centre.	Completed – 20th November 2023
Review and updating of all service business continuity plans	Completed - ongoing
Gold (strategic) training to be provided to directors on-call	Carried forward
Undertake Immediate Operational response training (Hazmat) to community health centres.	Completed – 7th January 2024
Conduct six monthly communication exercise – trust wide and directorate level	September 2024
Carry out an exercise to involve all levels of staff affected by ICT outage, as mandated by The DSP (Data Security and Protection) Toolkit	Completed – 27th June 2023
Quarterly reports to Quality Committee	Completed – ongoing- quarterly
Identify further staff to attend PHE loggist training.	Completed – 12th December 2023

10.1 We have consistently provided routine assurance to the Trust, NHSEI, and ICBs regarding the EPRR Framework, ensuring our ability to respond to both business continuity and major incidents. The Trust has been rated as FULLY COMPLIANT by NHS England (London).

10.2 The Emergency Planning Team successfully completed 77% of the actions outlined in the work plan for this reporting period as well as planning for both industrial action and the critical incident.

10.3 We have been able to deliver and support against the trust strategy work in relation to population health.

11.0 Work plan for 2024/25

Key Action	Outcome measure	TCD	Lead
Review all trust wide plans relating to emergencies and business continuity to ensure they reflect current guidance and legislation.	Approved trust wide policies and plans in place.	30th September 2024	Emergency Planning Manager
Continue to review and develop local business continuity plans in conjunction with new template	Local plans in place.	30th November 2023	Service Directors / Senior Managers
Review emergency contact list to ensure it is up to date.	Maintained contact list in place and available to key staff.	Bi-Monthly	Emergency Planning Manager
Continue multi-agency working (LHRPs, Resilience Forums, NHS England (London) NENC Network Meetings)	Partnership relationships effective.	Quarterly	Emergency Planning Manager

Annual audit of all Trust Incident Control Centres and their emergency boxes	All boxes complete.	31st October 2024	Emergency Planning Manager with senior managers
Business continuity plans to be added to Inpase	Dashboard created to monitor compliance	30th September 2024	Emergency Planning Manager/EPO
Carry out an exercise to involve all levels of staff and outside agencies affected by ICT outage, as mandated by The DSP (Data Security and Protection) Toolkit	Completed exercise and lessons learnt	30th June 2024	Emergency Planning manager and IT
Conduct a communication exercise of the IT system	Completed exercise and lessons learnt	30th September 2024	Emergency Planning manager and IT
Director on-call e-learning package uploaded to Learning Academy	Learning package uploaded.	30th November 2024	Emergency Planning Manager/Officer

11.1 All progress against the work plan will be reported to the Quality Committee in the form of quarterly reports.

11.2 The Emergency Planning Team have identified the following key priorities for the coming financial year:

- Exercising and testing of the Trust's IT resilience in response to threat of cyber attacks
- Business Continuity Workshops aimed at supporting teams in effectively managing their Business Continuity Plans (BCPs) and to enhance the preparedness of teams across various aspects of business continuity.

11.3 In order to deliver our forthcoming plan the Emergency Planning team will engage with Staff side, People Participation, Clinical services, Estates, Infection Control Team and People & Culture throughout the year and formally at the Quality Committee.

11.4 The Emergency Planning Team will also engage with both NEL and BLMK ICBs, our relevant Borough Resilience Forums and both Metropolitan and Bedfordshire Police.

12.0 Action Being Requested

12.1 The Committee is asked to RECEIVE and APPROVE the report and the associated work plan for 2024/25 set out in section 11.

East London NHS
NHS Foundation Trust

ANNUAL REPORT TO THE QUALITY ASSURANCE COMMITTEE

18 JULY 2024

Title	Health, Safety and Security Annual Report 2023-24
Author	Richard Harwin, Health, Safety, Security and Emergency Planning Manager
Accountable Executive Director	Edwin Ndlovu, Chief Operations Officer

Purpose of the report

To brief the Trust Board on progress made to ensure the Trust is meeting its obligations under the Health and Safety at Work Act 1974 and to set out progress against the work plan for the past financial year with the proposed work plan for the coming financial year.

Committees/meetings where this item has been considered

Date	Committee/Meeting
17.07.24	Health, Safety and Security Committee

Key messages

The attached report identifies the work undertaken during the period 01.04.2023 to 31.03.2024. The following key points are detailed:

- The Health, Safety and Security Committee meets on a bi-monthly meeting schedule. The Committee is well attended by relevant departments including a strong representation from staff side.
- Service Users' and Carers' Health and Safety Working Group has now been established on a monthly basis with 10-15 in attendance. Its terms of reference has been approved together with an agreed agenda and it provides regular updates to the Trust wide H&S Committee.
- For the period of 2023-24, 310 incidents of violence and aggression resulted in some form of contact with the police which is a significant decrease from its peak of 507 in 2021-22 and 360 in 2022-23. To address this, the Trust will be implementing Operation Cavell in collaboration with the police.
- The Trust has adopted the People Safe Lone working Smartphone App with compliance across the Trust currently at 88% with 1520 staff having access to the App. A full implementation and training programme has taken place including extensive publicity on the intranet. A series of webinars has also taken place to further improve compliance and to raise awareness.
- The Health & Safety team has worked collaboratively with NEBOSH (The National Examination Board in Occupational Safety and Health) to attain their endorsement of the trust's Risk Officer training course. As a result, ELFT is now the **first** NHS Trust to have their health & safety learning programme endorsed by NEBOSH.

Strategic priorities this paper supports

Improved population health outcomes	☐	Ensuring the Trust meets HSE Statutory regulations and CQC guidelines.	
Improved experience of care	☐	Through identifying risk and providing the control measure to remove or reduce them.	
Improved staff experience	☐	Empowering and supporting staff in providing them with the tools, correct policies and procedures, documentation, and training to carry out their roles safely.	
Improved value	☐	Ensuring the Trust meets HSE Statutory regulations and CQC guidelines. Reducing potential risk where possible by providing robust control measures and in house training.	

Implications

Equality Analysis	This report has no direct impact on equalities	
Risk and Assurance	Mitigating actions are in place in relation to the risks identified within the report.	
Service User/ Carer/Staff	Monitoring and supporting health and safety at work is fundamental to good staff and service user experience.	
Financial	There are no direct financial implications associated with the report.	
Quality	There are no implications for Quality Improvement raised in this report.	

1.0 Introduction

Following the introduction of the Health and Safety at Work Act 1974 (HASWA) various Approved Codes of Practice (ACOP), guidance and regulations have been introduced to compliment the Act.

'Successful health and safety management' (HSG65) was first prepared by the Health and Safety Executive (HSE) accident advisory unit (now operations unit) in 1991 as a practical guide for directors, managers, health and safety professionals and employee representatives who want to improve H&S in their organisations.

The Regulatory Reform (Fire Safety) Order 2005 came into effect in October 2006 and consolidated all fire safety legislation for non-domestic premises into a single Order. Whilst it abolished the requirement for healthcare premises to hold a fire certificate, under the Order, NHS Trusts are required to actively pursue and maintain fire safety and take responsibility for staff and others visiting their premises.

Health and safety, fire and NHS Protect (now disbanded) guidance also cites that as 'good practice' health and safety should appear regularly on the agenda for board meetings. It recommends that the Chief Executive can appoint a Health and Safety 'champion' to represent the board and act as a scrutiniser to ensure processes to support H&S are robust, delivered, monitored, and reviewed effectively.

2.0 Background

The Trust has a statutory duty under the HASAWA (1974) to (in particular):

- **Section 2** General duties of employers to employees
- **Section 2(3)** To provide a H&S Policy
- **Section 2(4) to (7)** Functions of safety representatives and the H&S committee
- **Section 3** Duties to other persons other than employees
- **Section 7** General duties of employees at work
- **Section 37** Offences by bodies corporate

Additionally, the Trust has a statutory duty under the management of Health and Safety at Work Regulations 1999 to (in particular):

- **Regulation 3** Provide suitable and sufficient risk assessments
- **Regulation 5** Provide health and safety arrangements
- **Regulation 10** Provision of information to employees
- **Regulation 13** Assurance of the employees' capabilities and provide training

Furthermore, the Trust has a duty under the Regulatory Reform (Fire Safety) Order 2005 to focus on risk reduction and fire prevention. The instrument to fulfil this responsibility are mandatory detailed Fire Risk assessments for all Trust premises which are duly submitted to the local Fire Authority.

The Department for Communities and Local Government (CLG) provides additional guidance to assist with the preparation of fire risk assessments in specific premises – including healthcare (Department of Health).

3.0 The Health, Safety and Security Team

The Chief Operating Officer is the Executive Director who is responsible for Health & Safety (H&S) and Security activity. The Health, Safety and Security team sits within the Governance and Risk Department and usually consists of two staff members - the Trust's Health, Safety, Security and Emergency Planning Manager and Health, Safety and Security Advisor. However, the team has functioned for the past year with only the manager whilst the H&S advisor was seconded to the Inphase Implementation Team

Within the Estates, Facilities and Capital Development Directorate are three Fire Officers who are responsible for carrying out Fire Risk Assessments, fire investigations, training of staff, in addition to advising on a wide range of matters relating to fire safety across the Trust.

4.0 The Quality Committee

The Quality Committee, chaired by the Chief Nurse, meets monthly. An exception report is presented to the Committee by the Health, Safety and Security Team every quarter providing H&S updates and proposals for action.

5.0 The Health, Safety and Security Committee

In addition, a Trust wide Health and Safety Committee, chaired by the Chief Operating Officer has been established and is attended by staff side representatives, Chief People Officer, Director for Estates and Facilities, People Participation and the Health and Safety Lead for the Trust. This group discusses and promotes trust wide health and safety issues which remain unresolved at

directorate level. This group also promotes a culture of understanding and co-operation across the Trust to ensure the health, safety and welfare of all staff, patients, and visitors. Feedback from this committee is highlighted at the Quality Committee.

6.0 Health & Safety Policy

Within the H&S policy and in line with H&S guidance it is recommended that each service area has a risk officer, and each directorate has a risk facilitator who oversees each directorate's H&S issues. Each risk officer is invited to the local H&S meeting, which is chaired by the facilitator. Any issues which require escalation, are taken to the respective Directorate Management Team DMT and then to the trust wide H&S Committee if required.

The H&S policy was reviewed in July 2021, in line with HSE guidance, and ratified by the Quality Committee. This periodic review also included the inclusion of the workplace risk assessment template. This policy is currently under review with ratification planned for August 2024

7.0 Incident Reporting and Follow Up

The Trust monitors all H&S incidents via its incident reporting database (Inphase)

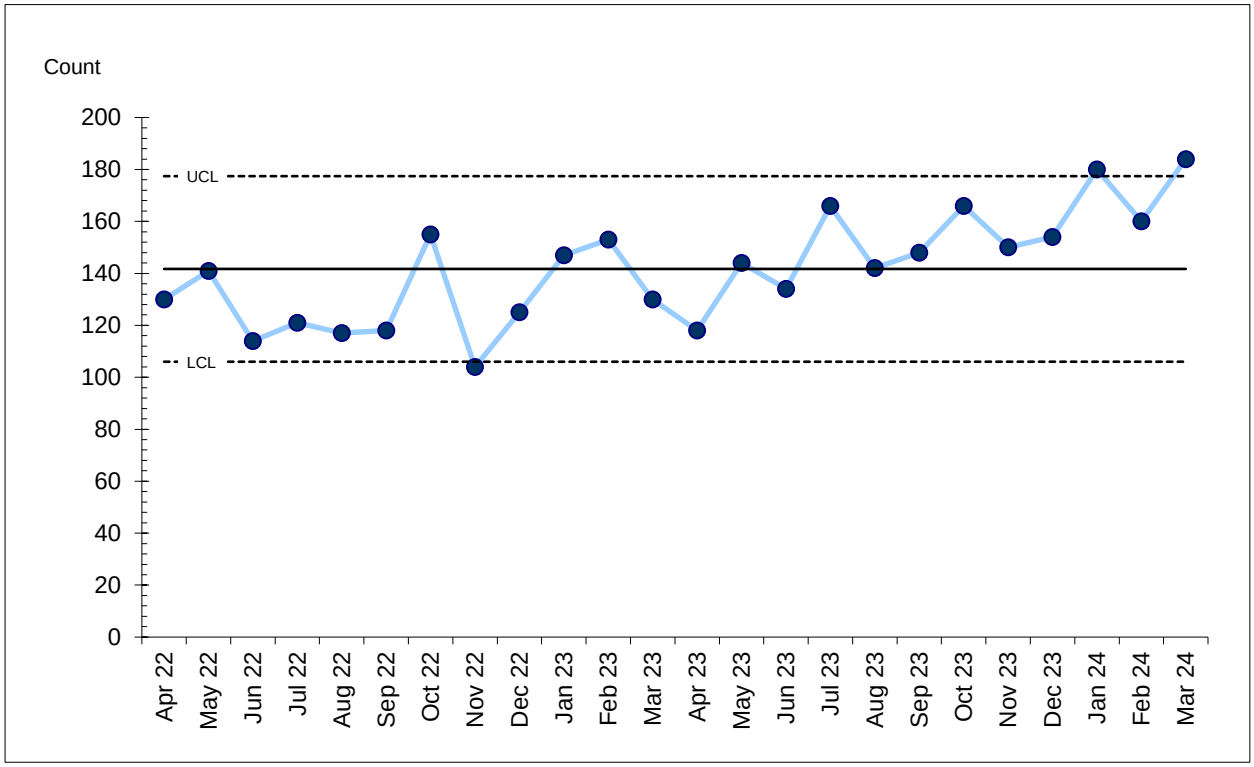
The Trust monitors every incident of actual or potential violent acts. Additionally, the Health, Safety and Security Team is automatically notified of all H&S and security incidents so that they can be followed up to ensure that appropriate action is being taken to implement assessments and control measures to minimise future reoccurrence of similar situation.

Highlighted below is a summary of the reporting period for:

- Health, safety and security incidents by month and directorate (involving staff and patients)
- Smoking in an unauthorised area by month and directorate
- Fire incidents by month and directorate
- Non-clinical slips, trips and falls by month and directorate
- RIDDOR incidents by directorate (involving staff and patients)
- Security incidents by month and directorate (involving staff and patients)
- All incidents of violence and aggression by month and directorate (involving staff and patients)
- Physical violence towards staff by month and directorate

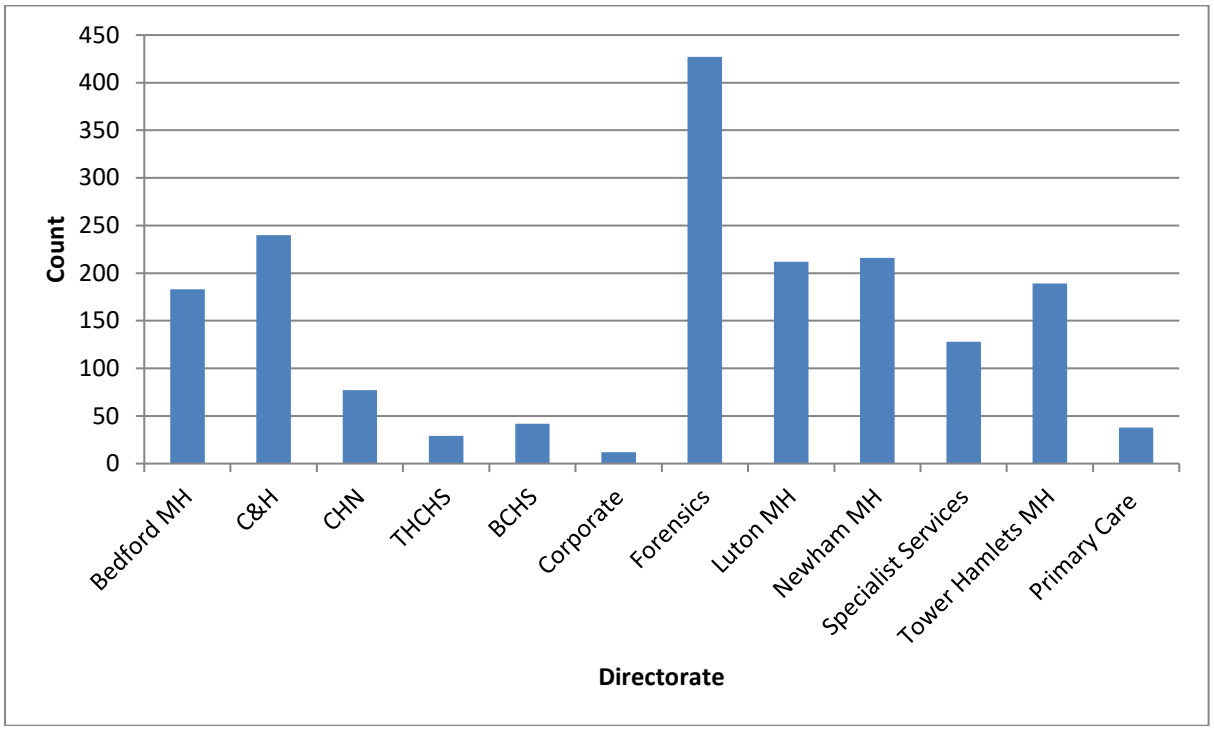
Health, Safety and Security incidents

All reported Health, Safety and Security incidents – Trust wide:



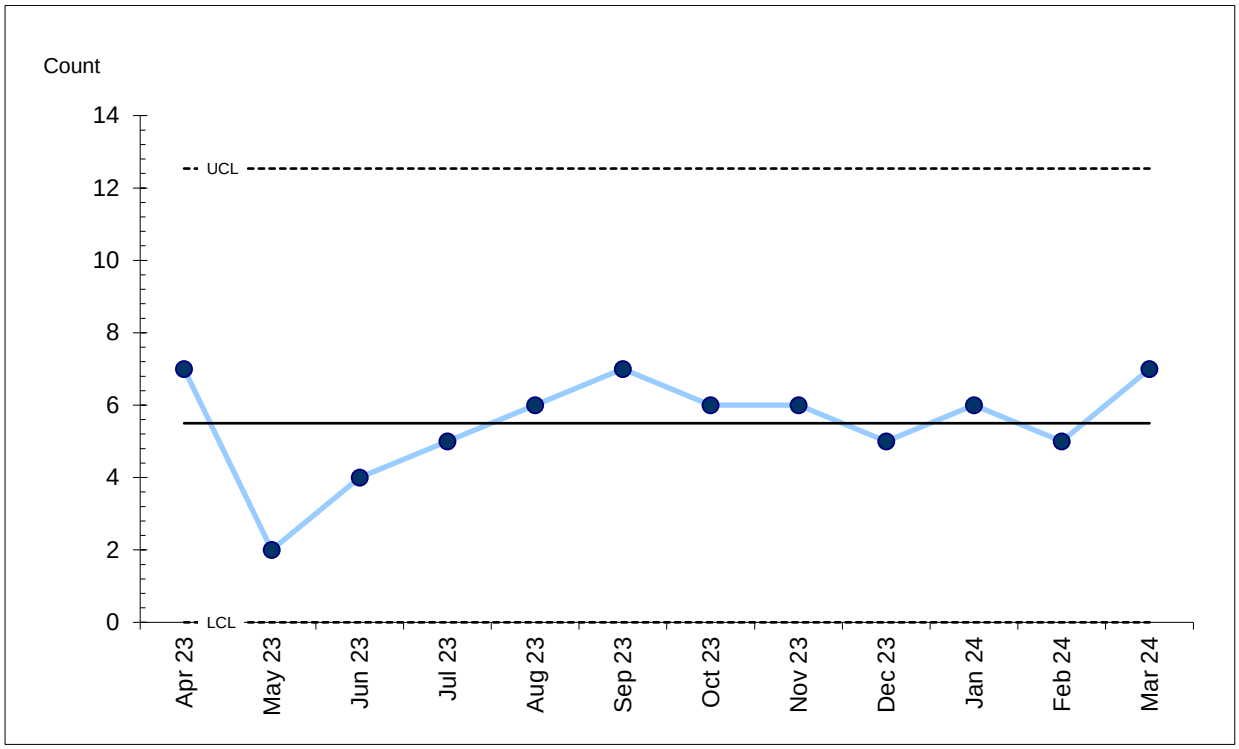
A total of 1823 Health, Safety & Security incidents were reported for 2023/24. This has risen slightly in comparison with the 1555 reported incidents in 2022/23.

All reported Health, Safety and Security incidents by Directorate April 23- March 24

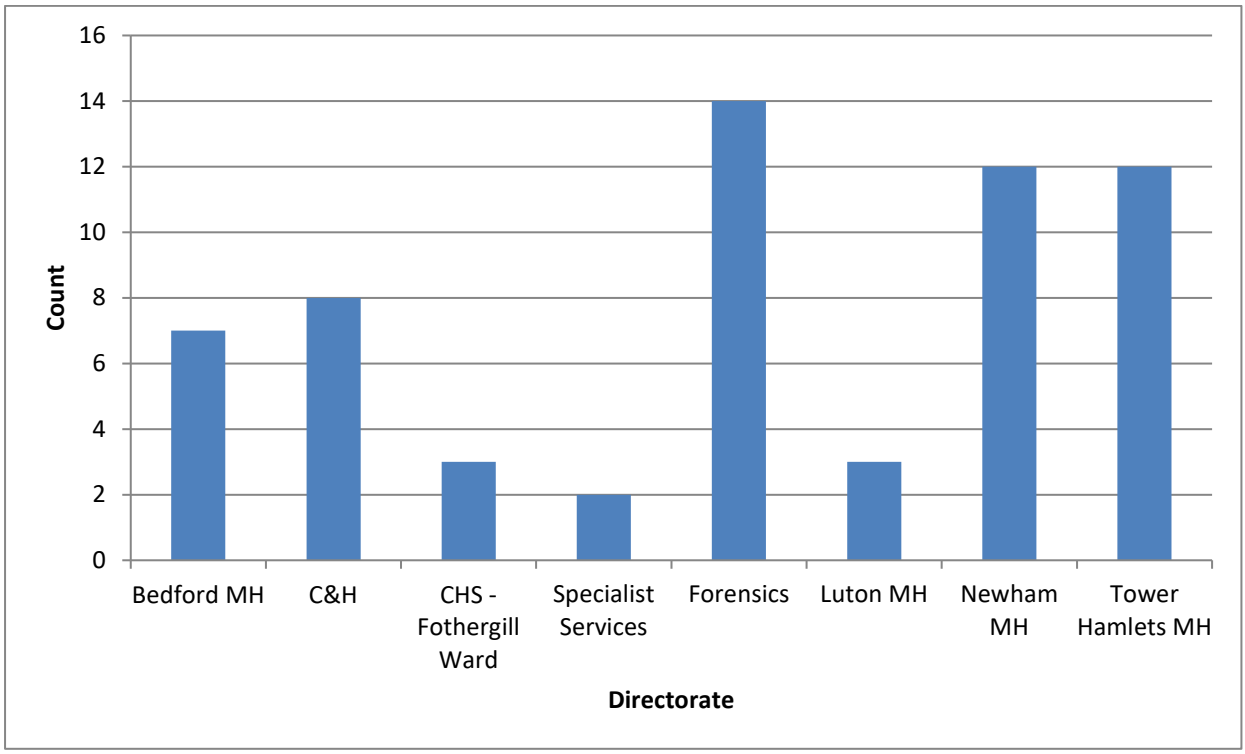


The significantly larger number of incidents within forensic services reflect security breaches such as reports of finding prohibited items as well as other breaches such as doors being left unlocked and associated housekeeping. The comparatively large number of these incidents within forensic services is not unusual due to the acuity of the patients/services users and the larger number of wards in that service.

Smoking in an unauthorised area Trust-wide



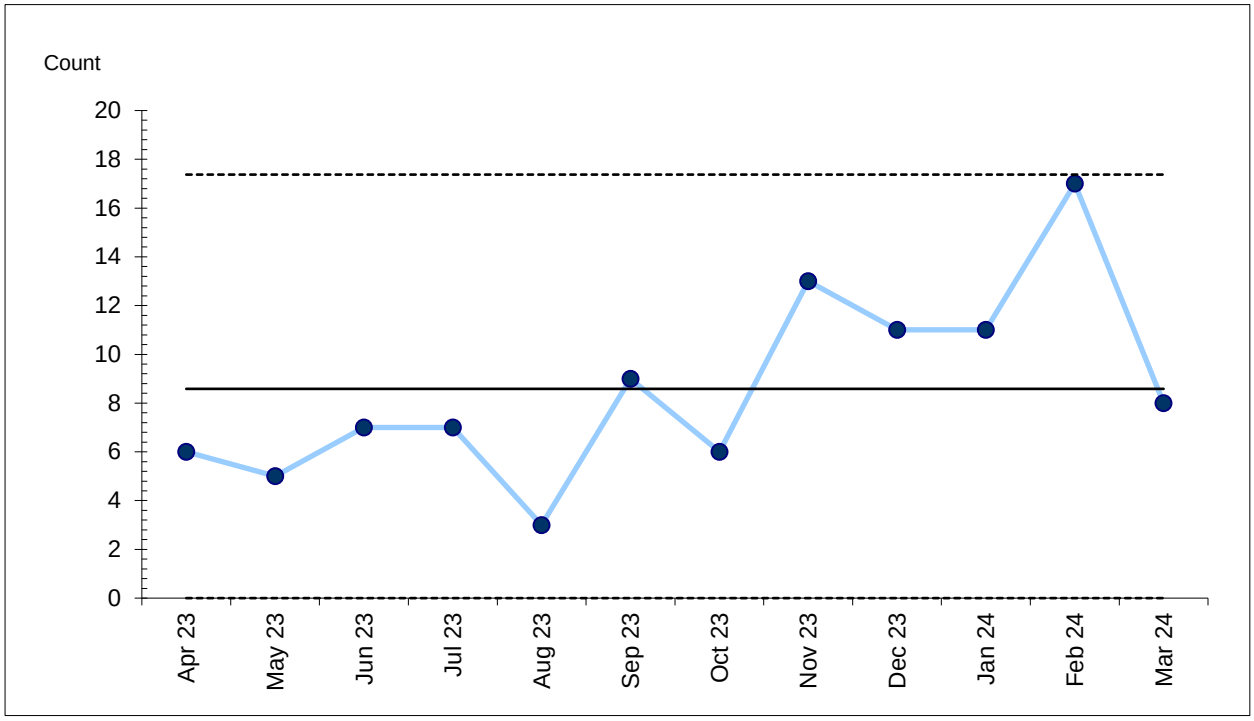
Smoking in an unauthorised area by Directorate April 23- March 24



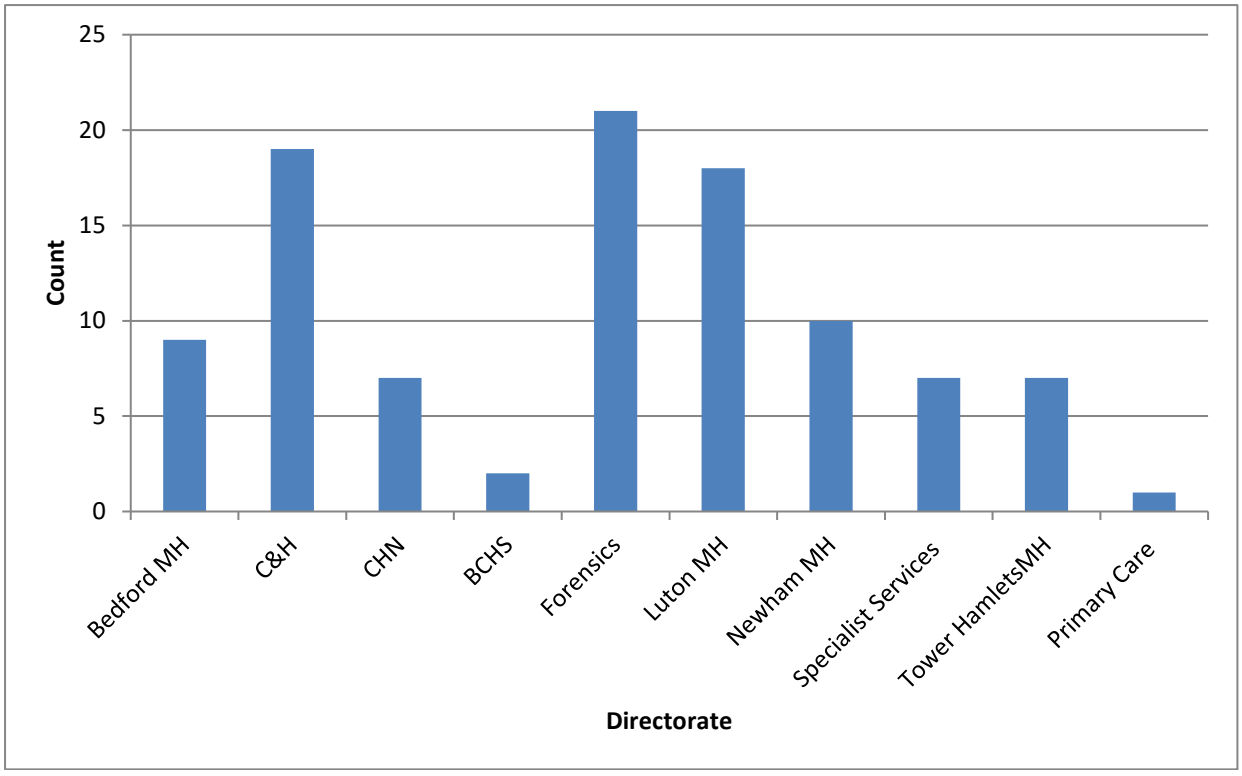
Most incidents of smoking in an unauthorised area tend to occur in the forensic directorate predominantly due to the nature of the service and its patient population.

Fire incidents - All fire incidents reported

All fire incidents (including false alarms) reported Trust-wide:

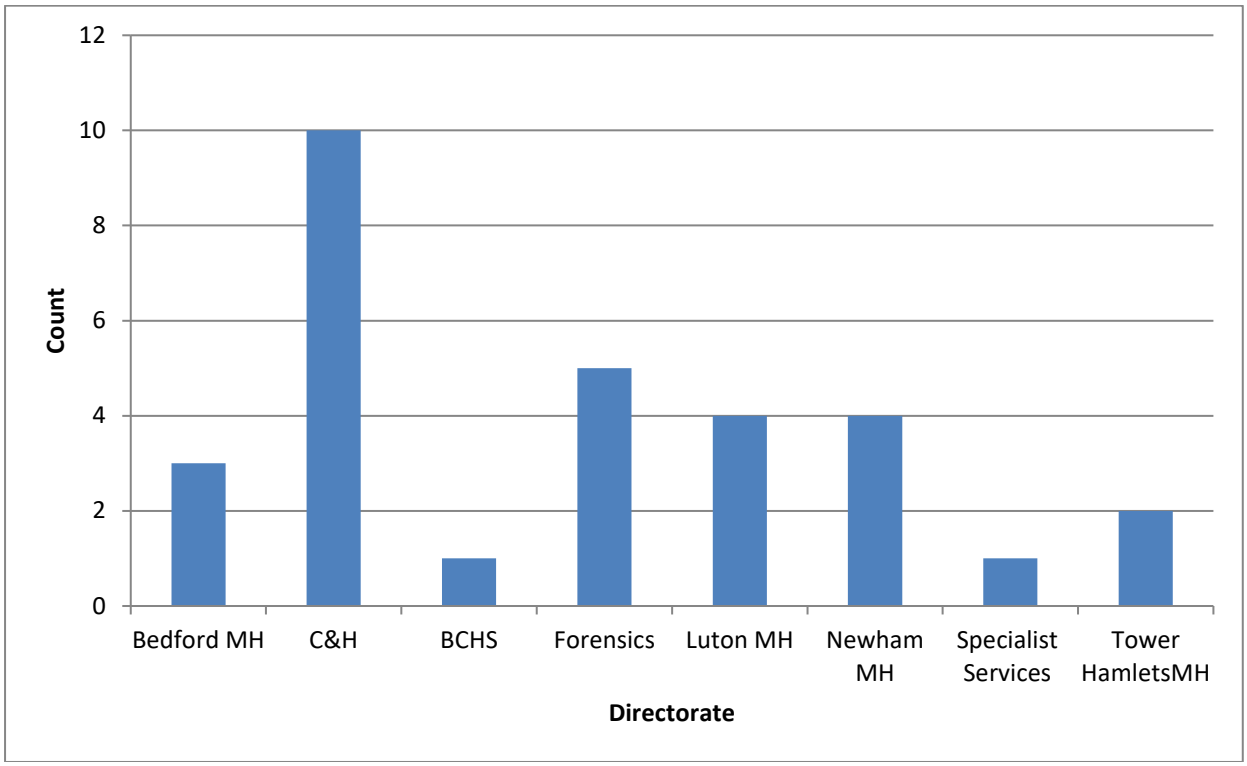


All reported fire incidents (including false alarms) by Directorate April 23- March 24



Most fire incidents relate to 'false alarms' such as a smoke detector being activated by covert smoking in bed areas or set off from steam from ensuite shower rooms.

All reported as actual fires by Directorate April 23- March 24:



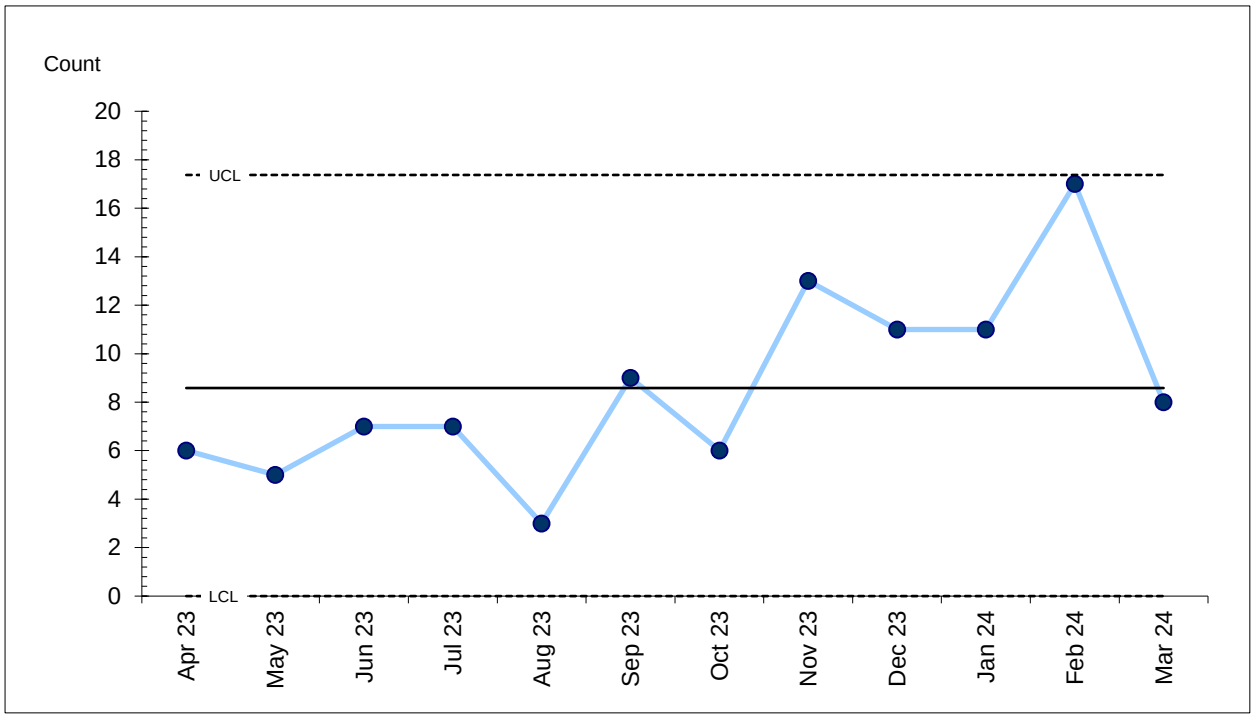
All fire incidents reported are reviewed by the Trust Fire Safety Advisors and, where deemed appropriate, a fire investigation is carried out with a report detailing the details of the occurrence, the cause and any issues relating to building or staff performance. From this, recommendations may arise.

Whilst the number of actual fires in City & Hackney is more than elsewhere in the organisation there is no prominent attributable cause. The number of actual fires in each Directorate varies in subsequent years and can sometimes be accounted for by repeated incidences involving a small number of individual patients.

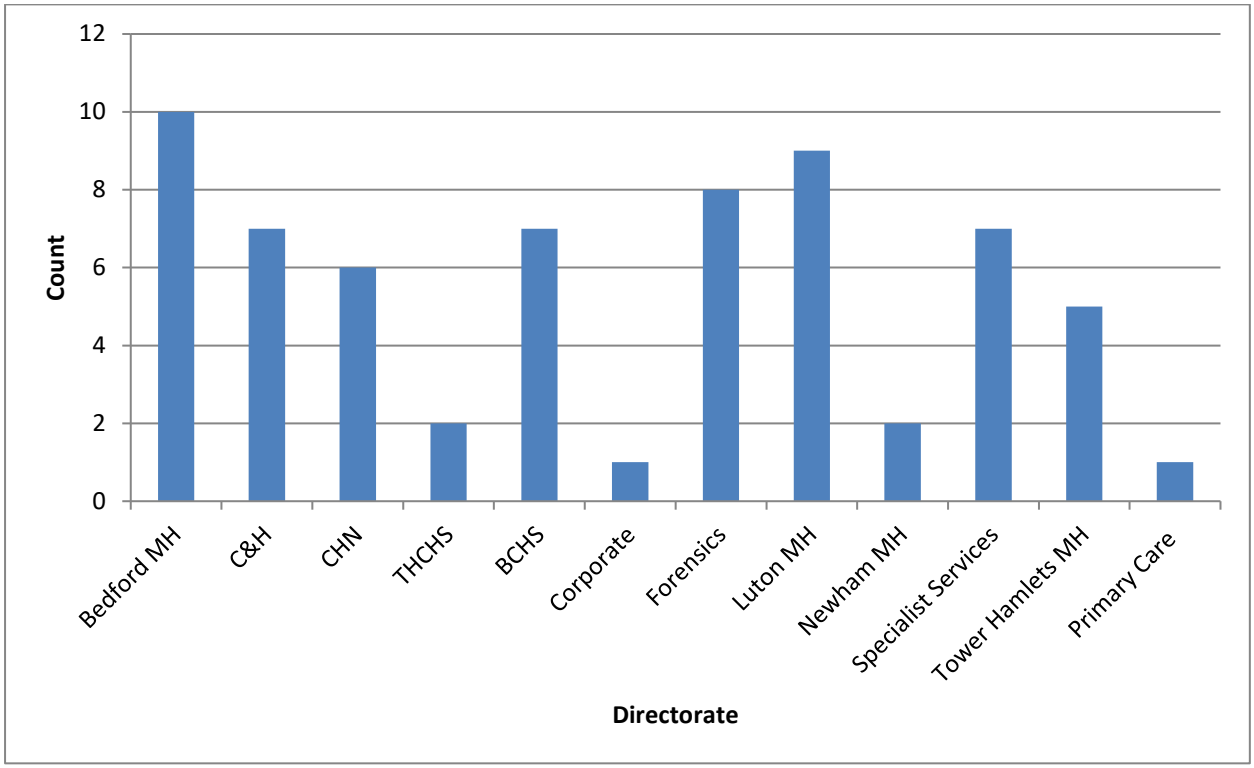
There were no incidents within the category of a 'serious nature' (i.e. resulting in patient or staff injury or damage caused).

Slips, trips and falls – non-clinical (as a result of accident or hazard)

All reported non-clinical slips, trips and falls – Trust-wide:



All reported non-clinical slips, trips and falls by directorate April 23- March 24:



There is no obvious trend with respect to team location or causation of slip or trip.

The statutory health and safety duties of the Trust include an absolute duty to provide floor surfaces and working environments that are safe and without slip and trip hazards. Staff are encouraged to report all slips, trips, and falls to enable the H&S leads locally and corporately to investigate, where practicable and helpful, to look at ways to prevent reoccurrence of such incidents.

RIDDOR

Directorate	2022/23	2023/24
Bedfordshire Community Health Services	**1**	**0**
CAMHS	**4**	**0**
City & Hackney	**5**	**5**
Community Health Newham	**2**	**0**
Corporate	**1**	**0**
Forensic Services	**10**	**9**
Luton & Beds (Mental Health)	**9**	**0**
Newham (Mental Health)	**12**	**4**
Specialist Services	**0**	**2**
Tower Hamlets (Mental Health)	**7**	**3**
Tower Hamlets Community Health Services	**0**	**1**
Primary Care	**0**	**0**
Total	**51**	**24**

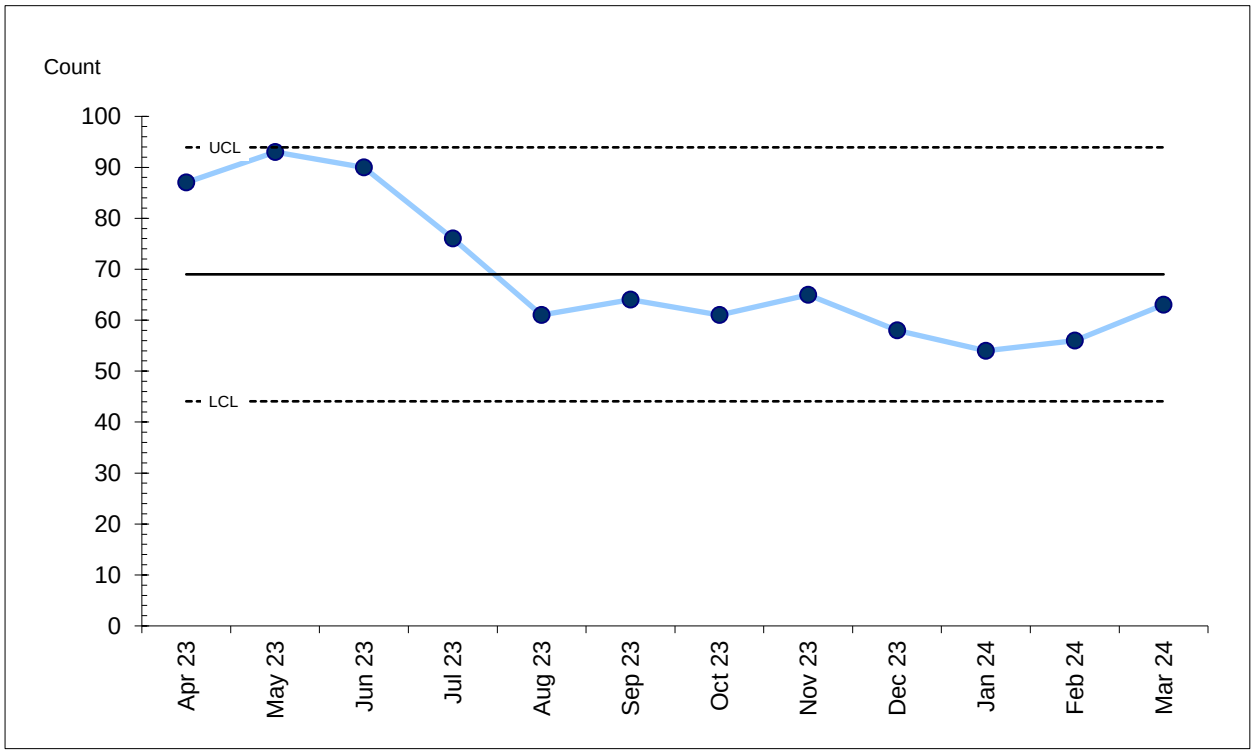
The Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) require the reporting of work-related accidents, diseases and dangerous occurrences to the Health and Safety Executive (HSE). RIDDOR puts duties on employers, the self-employed and people in control of work premises to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences.

Each RIDDOR report that is submitted to the HSE is categorised by type. Physical assaults on staff are the most widely reported H & S related incident and this is reflected by the number of RIDDOR reports for assaults submitted to HSE.

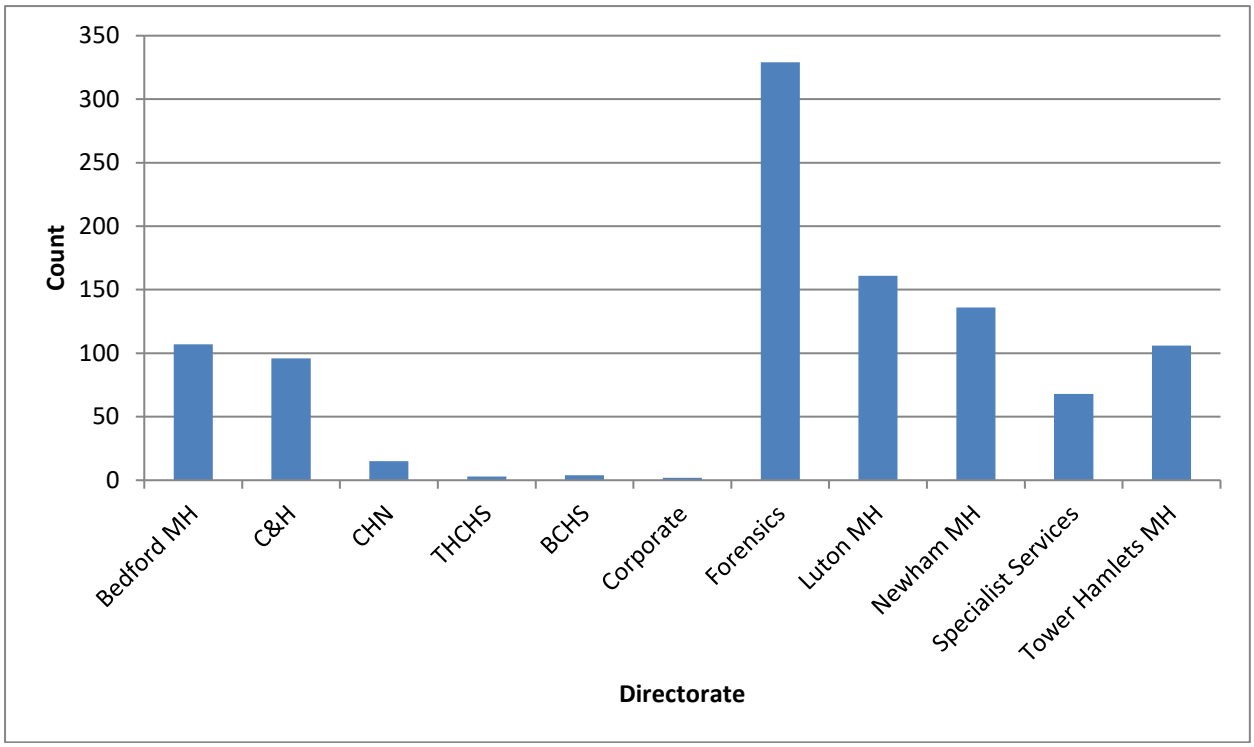
Between 2023/24, there were 38 RIDDOR incidents overall as opposed to 51 in 2022/23 - a decrease of 25%. Assaults accounted for (33) of all RIDDOR reports in 2023/24 – of these, 18 were reported from Newham (Mental Health) and from Forensics. This is not unusual due to the nature of the service and acuity of the wards. The second most common type of H&S related incident reported within the Trust were slips, trips and falls which accounted for 8% (3) of all RIDDOR reports submitted to HSE. The remaining incidents were related to manual handling which accounted for 5% (2).

Security Incidents

All reported security incidents – Trust-wide:



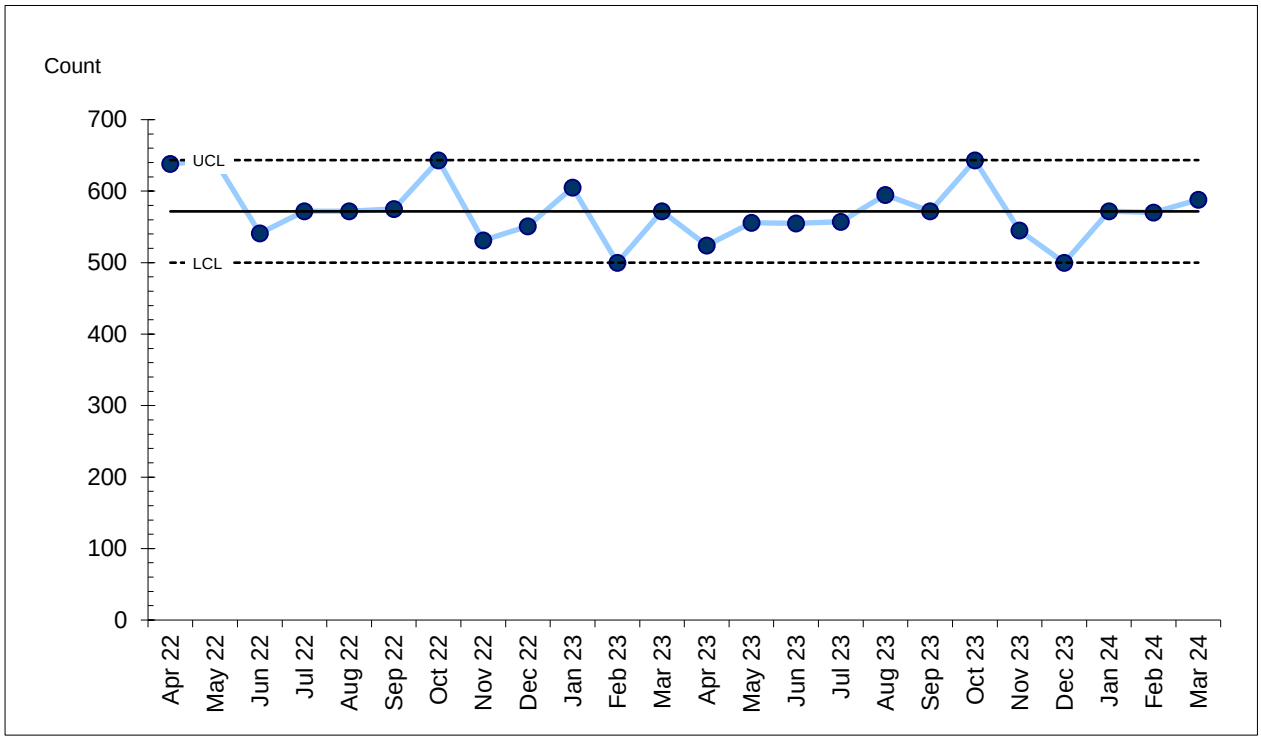
All reported security incidents by directorate April 23- March 24:



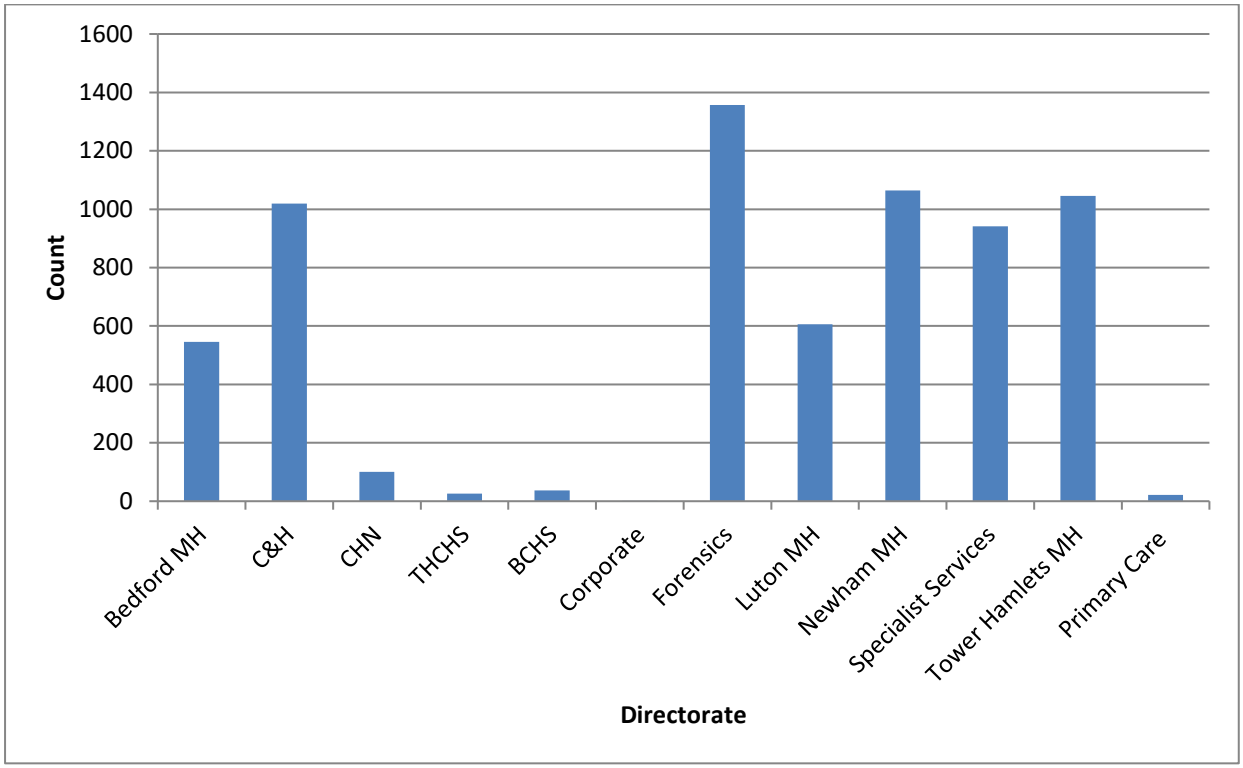
The higher numbers in forensic services reflect security breaches such as reports of the finding of prohibited items, e.g., lighters and tobacco, during both random searches, in line with medium and low security safety procedures and as part of risk management initiatives. Other breaches include internal doors being left unlocked in buildings and associated general housekeeping. There are two fully staffed security teams – located both at the John Howard Centre and at Wolfson House who review and investigate all reported security incidents.

Violence and Aggression

All reported violence and aggression (staff and patients) – Trust-wide:



All reported violence and aggression incidents by directorate April 23 - March 24



All Violence and Aggression Incidents comparison

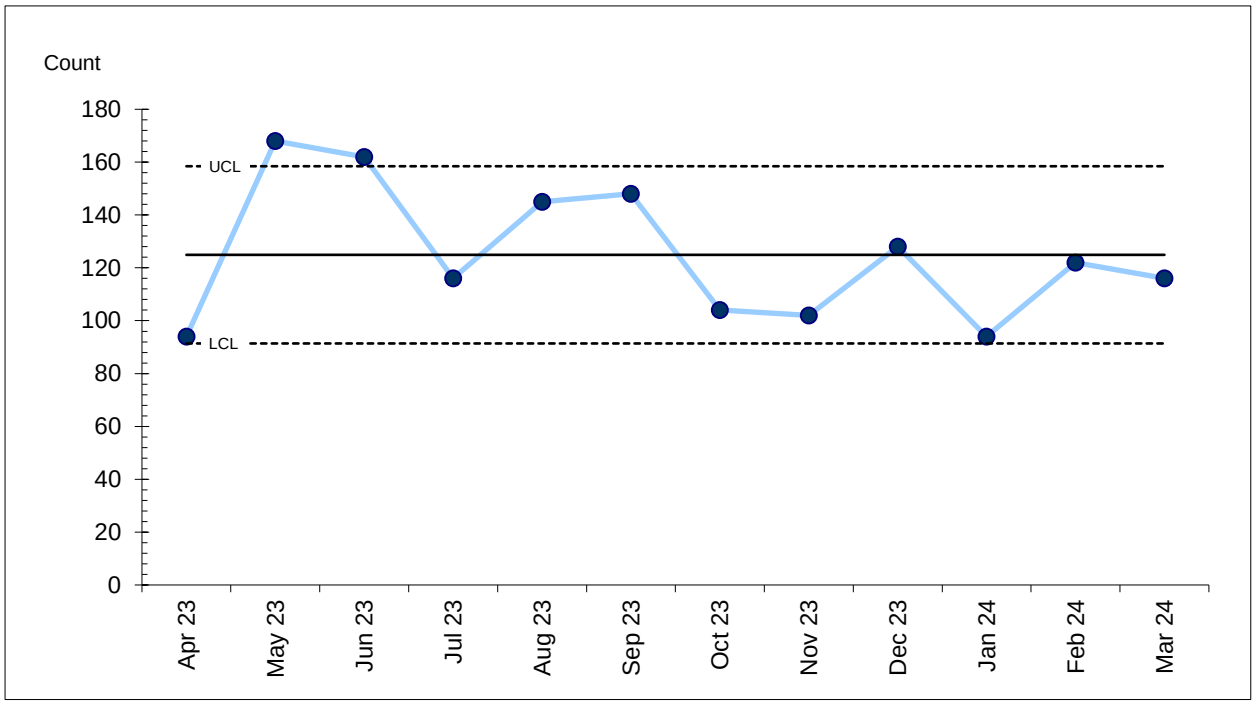
Directorate	Incidents Reported 2022/23	Incidents Reported 2023/24
Bedfordshire Community Health Services	**43**	**37**
Bedford (MH)	**579**	**546**
City & Hackney	**1100**	**1019**
Community Health Newham	**115**	**100**
Corporate	**3**	**1**
Forensic Services	**1502**	**1357**
Luton (MH)	**626**	**606**
Newham (Mental Health)	**1149**	**1064**
Tower Hamlets (Mental Health)	**1147**	**1045**
Tower Hamlets Community Health Services	**52**	**26**
Specialist Services and CHN Children	**619**	**941**
Primary Care Services	**22**	**22**
Total	**6957**	**6764**

Directorates actively report criminal damage and non-physical incidents, such as threatening and verbally abusive behaviours as well as racial aggression. Furthermore, staff are actively encouraged to report all incidents where they, a colleague or a service user has felt threatened or intimidated.

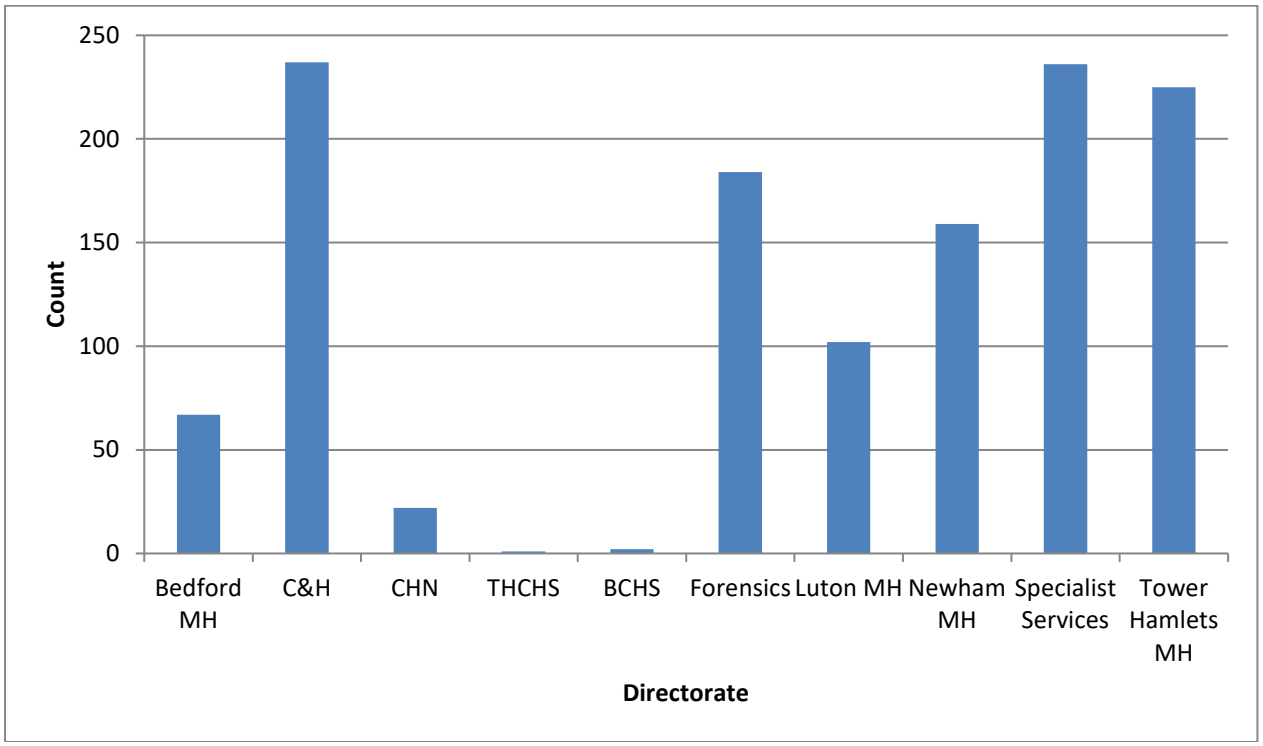
For the period 2023/24 we have seen a decrease in the number of violent and aggressive incidents from2022/23 in all directorates except for Specialist Services which saw arise from 619 to 941. This is mainly attributed to an increase in violence at Evergreen Ward. This ward in particular had been extremely busy by way of the number of admissions, the significant number of patients with challenging behaviours and general acuity on the unit.

Violence and Aggression – Actual Physical Violence towards staff

All reported actual physical violent incidents towards staff – Trust-wide:



All actual physical violence towards staff incidents by directorate April 23- March 24:



The peaks in May and June 2023 is mainly attributed to the increase in violence at Evergreen Ward during those months which was due to admission numbers, patients with challenging behaviours and general acuity.

9.0 Police Liaison

9.1 Police liaison for ELFT

This falls under the role of the Trust's Health, Safety, Security and Emergency Planning Manager, previously the Trust's Police Liaison Advisor. The post holder is both a qualified mental health nurse and ex-police officer from the Metropolitan Police Service – his last post there being Mental Health Liaison officer for Hackney Police.

The post holder is also the Trust's Local Security Management Specialist (LSMS) and sits within the Risk and Governance Department.

Since the appointment of the Trust's Security and Police Liaison Advisor (now called Health, Safety, Security and Emergency Planning Manager) there continues to be a marked increase in reporting of incidents to the police.

For the period of 2023-24, 310 incidents of violence and aggression resulted in some form of contact with the police which is a significant decrease from its peak of 507 in 2021-22 and 360 in 2022-23. It is difficult to attribute this to a particular reason but to address this issue, the Trust will be implementing Operation Cavell (See 9.3) with the full support of both the Metropolitan Police Service and Bedfordshire Police throughout 2024-25.

9.2 Metropolitan Police Mental Health Liaison Teams

The Trust continues to maintain and develop very close collaborative working relationships with the relevant London policing boroughs.

Hackney and Tower Hamlets policing Boroughs have now merged to form the Central East Basic Command Unit (C.E. BCU) whilst Newham and Waltham Forest Police Forces merged to form The Northeast Basic Command Unit (N.E. BCU).

Each BCU attends a bi-monthly police liaison meeting held in each borough where a range of topics are discussed, issues raised and lessons learnt – this would range from section 136 (police) detentions, presentations at A&E, section 135 MHA Assessments, and incidents on our inpatient wards. These meetings provide a forum with which to ensure that any collaborative work between ELFT and the Metropolitan Police Service (MPS) supports both staff and service users.

Currently C.E. BCU consists of a sergeant and two police officers for incidents occurring in Forensics, City & Hackney and Tower Hamlets. They do not investigate any of the crimes but will generally facilitate a response. The investigations would be carried out by the initial response officers – unlike previously when they would have been carried out by a dedicated team of investigators.

N.E. BCU currently has one MH liaison officer who is part of their safeguarding team.

9.3 Operation Cavell

Currently there is no Trust oversight of incidents which are reported to the police often resulting in police investigations becoming elongated and subject to significant delays with victims often not being informed of any outcome – the result is staff then becoming disillusioned with the entire process. Furthermore, staff are finding that police are closing cases with no consultation with either the victim or responsible clinician.

Following a three-month pilot, the NHS, MPS and Crown Prosecution Service (CPS) launched Operation Cavell in May 2021 with the aim to protect NHS staff from risks of both physical and verbal aggression. As well as senior police officer involvement in reviewing all assaults, senior NHS staff will be included to support those who have been a victim of such crimes.

Key changes:

- Promulgating excellent practice across police, NHS and CPS.
- All NHS victims to be treated as priority victims – contact within 24 hours.
- CID to investigate any reports of 'actual bodily harm' and above.
- Linking in with NHS SPOCs to capture best evidence early – including CCTV, statements etc.
- Use of toolkit of 'tried and tested' evidential documents – fitness to be interviewed, loser statement (for use in criminal damage), public interest statement, community impact statement.
- Introduction of single point of contact mailbox at the Trust
- Use of shared resources to save evidential evidence.
- Use of 'Assault on Emergency Workers Act 2018' when seeking a charge
- Use of ward space for interviews (where appropriate)
- Victim/staff satisfaction survey.
- Operation Cavell crime tracker to be discussed at monthly meeting of LSMS, Operation Cavell officers and operational leads

Key benefits:

- Staff retention
- Providing safe environment for both staff and patients
- Improve staff well-being
- Improving overall relationship with police

The Trust will be implementing this throughout 2024-25 with an extensive communications strategy.

9.4 Bedfordshire Police

In July 2019, the Bedfordshire Police Mental Health Hub was formed. This Hub was born from an already excellent relationship between Bedfordshire Police and ELFT who had formed the Mental Health Street Triage Team and Liaison and Diversion services. Bedfordshire's Police and Crime Commissioner supported the Hub with funding to make this happen. The vision was to bring together all mental health practices linked to Police and Mental Health Services under one team to support vulnerable members of our community. The aim was that a more collaborative approach would ultimately result in a better outcome for service users.

The Hub connects a range of services including the Street Triage Team, a mental health nurse in the Force Contact Centre who provides advice to officers attending mental health incidents, and a Mental Health Liaison Officer

Covering Luton and Bedfordshire, there is a joint police and health-led monthly Mental Health Operational Deliver Group and a quarterly Mental Health Strategic Group with service user, third sector, commissioner, ambulance service and emergency department representation. These in turn feeds into the Crisis Care Concordat Strategic Group meetings.

9.5 Joint Mental Health Training (Bedfordshire Police)

ELFT currently support Bedfordshire Police with their two-day mental health training for the Initial Police Learning Development Programme for police recruits. Day one is trainer led with representation from collaborative work streams – Mental Health Street Triage, mental health nurses in the Force Control Centre and Police MH Investigator in mental health settings.

Day two concentrates on improving understanding of those with mental health disorders and how to engage with them as police officers. Bedfordshire and Luton Recovery College support Bedfordshire Police providing an insight into mental health disorders, how to recognise signs and how to open conversations. As we begin to move out of restrictions the People Participation Team at ELFT will be invited to share their lived experiences of mental health with the officers.

ELFT staff within the Bedfordshire Police Mental Health Hub have also supported the police with several bespoke training days for response officers and the Force Contact Centre.

10.0 Lone Working

There has been a drive to improve Lone Worker safety at ELFT, with the development of new safety initiatives and encouragement of improved protocols and practice. Part of this drive has included the dissemination of Peoplesafe Lone Worker Apps across our services which have replaced our previous lone worker devices.

This new app with the latest GPS technology tracks the whereabouts of staff and includes an alarm system to support safe working with patients out in the community. Any alarm calls are sent to controllers at an incident management centre who can use the device to have a two-way conversation with the user or listen to what is happening. They can then decide a course of action, for example calling the emergency services. The application can also be used in conjunction with a Bluetooth Smart Button accessory for an even easier, more discreet personal protection.

Staff identified as a lone worker have been provided with the app and have received the relevant training by the Health & Safety Team in both their use and administration. The chart opposite shows the current percentage compliance by directorate for 2023-2024.

We currently have 1520 lone workers who have uploaded the app, an increase from 1442 during the previous year. In order to continually increase compliance, the Health & Safety team have carried out the following actions:

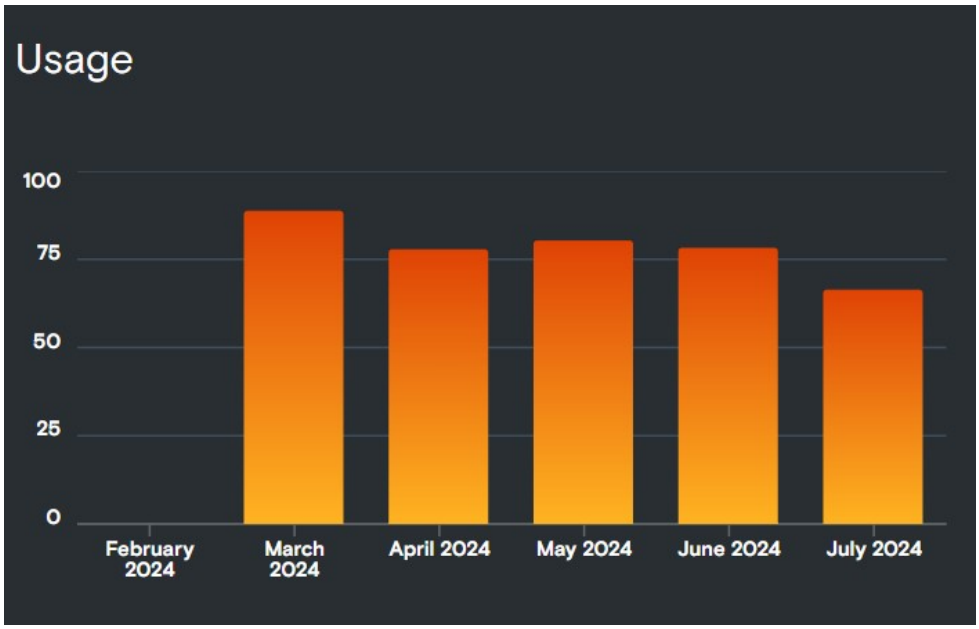
- The H&S team regularly attend local health and safety meetings of all the directorates to raise awareness and to present compliance reports.
- Single points of contact for each directorate have been identified and a series of online training is ongoing to provide localities to access team portals. This enables them to compile reports with a view to further improve uptake and usage of the app – allowing local teams to take ownership.
- The H&S Team have updated the trust's intranet page highlighting and focusing on key features of the Peoplesafe app as well as sharing staff stories and their personal experiences of the risks of loneworking and the benefits of using the app. This page also allows easy access to all training material
- The app has been updated to enable staff to adjust the sensitivity of their phones in order to prevent accidental activations
- Monthly Peoplesafe forums and webinars have been established for staff to discuss any issues they may be having with the lone worker app as well as providing a platform with which to share learning and good practice.

Peoplesafe have also developed a new portal (NEXUS) and the Trust have now migrated over to this new system. This new portal will bring a number of benefits:

- Escalation Plans will be assigned to teams of people rather than individuals to allow instantaneous bulk updates when changes are made.
- A visual overview of the homepage of each account to allow easy monitoring of staff safety.
- Ability to run and schedule reports for users who are not active, making sure managers are always aware of people not using their device or app.
- Allows administrators to select a specific team, user, or app to see activity, listen to voice memos, check battery status and read closed alarm reports.
- Access to training and advice at the click of a button including live chat

Furthermore, a series of webinars for admin leads are taking place throughout February and March which will cover the migration process, how to access Nexus, actions to take and a tour of the Help Centre.

Since the move to the Nexus portal we have also seen a gradual rise in the compliance for the app from 50-60% during 2023-24 to 88% in March 2024.



11.0 Risk Officer Training (NEBOSH endorsed)

ELFT has been working closely with NEBOSH (National Examination Board in Occupational Safety & Health) and have now successfully achieved NEBOSH Endorsed status for our Health and Safety Risk Officers' programme. ELFT is the first Trust within the NHS to have their training endorsed by NEBOSH. Through this training, we should see a positive impact on both the quality and quantity of our workplace risk assessments.

As part of the training each risk officer will be asked to review/complete their site's workplace risk assessment. For learners to be successful and receive a certificate they must:

- Attend the course in full (approx. 2 hours)
- Pass brief course assessment
- Complete feedback form
- Have their workplace risk assessment confirmed as complete

Three training sessions have been carried out to date with more sessions booked throughout 2024-25

13.0 Workplace Risk Assessments

Workplace risk assessments (WPRA) must be carried out under Regulation 3 of Management of Health and Safety Work Regulations 1999. There is a legal requirement for every employer to assess health & safety risks arising out of their work and these must be recorded.

In response to changing guidance especially as regards Covid-19, the Trust's WPRA guidance and template has been updated in consultation with staff side, the infection control team and estates.

Whilst services have completed their workplace risk assessments, work is still required to ensure that there are no gaps and that any risk assessments are indeed reviewed and updated when required. The Health and Safety team are working closely with local services to identify any such gaps.

In addition, the following actions have been taken to address this:

- This has been added as a standing agenda item at local H&S meetings for gaps to be identified and for support to be offered to sites to either complete the WPRA or to assist in any review.
- The WPRAs will be uploaded and audited by the Trust's new Inphase system
- Submission of WPRA by risk officers is required as part of attaining NEBOSH certificate.

14.0 Remote working/Display Screen Equipment (DSE)

As an employer, we must protect our staff from the health risks of working with display screen equipment (DSE), such as PCs, laptops, tablets and smartphones - we have the same health and safety responsibilities for home workers as for any other workers.

The H&S Team has developed a new training package and process for DSE/workstation assessments which has been uploaded to the Learning Academy. This provides guidance for safe working at workstations, a self-assessment and streamlined process with which to order recommended equipment

15.0 People Participation

The Committee now has representation from our People Participation team to allow our service users to contribute and support us in ensuring health & safety on our sites.

In addition, our Service Users' and Carers' Health and Safety Working Group has now been established on a monthly basis with 10-15 in attendance. Its terms of reference has been approved together with an agreed agenda and it provides regular updates to the Trustwide H&S Committee. Its current work plan includes:

- Guest speakers are invited to each meeting and have included our Interim Chief Nurse, Chief Operations Officer and the Estates team
- Reviewing our current health & safety annual audit in preparation for its upload to Inphase.
- Risk officer training has been delivered to the group with a plan for the training to be co-delivered going forward

16.0 Training

16.1 Health & Safety/Security awareness

The Trust provides several e-learning courses for this area via its Learning Academy including H&S Awareness and Display Screen Equipment Use. The courses are determined by the roles the individual staff member carries out and are pre-agreed by their line manager and the Training and Development Team.

16.2 Risk Officer Training (NEBOSH endorsed)

The Health & Safety team have worked collaboratively with NEBOSH (The National Examination Board in Occupational Safety and Health) to attain their endorsement of the trust's Risk Officer training course. As a result, ELFT is now the first NHS Trust to have their health & safety learning programme endorsed by NEBOSH.

The benefits to ELFT of this endorsement are:

- Recognition from NEBOSH of in-house, tailored learning programs
- More cost effective than delivering an accredited qualification
- Customised certification.
- Focus on the Learning Impact to emphasise the Organisational and Learner objectives with a measurable outcome

16.3 Fire training

There are two alternative pathways for fire training dependent on staff responsibilities, namely ward-based and non-ward-based staff

The structure of training is as follows:

Fire Training	Structure	Content
Fire Safety Mandatory for non-ward-based staff)	• Annual requirement • E-learning programme	• Fire awareness • Fire extinguisher (theory)
Fire Warden Designated staff for non-ward areas / departments / out-patient premises	• Two yearly qualifications • At central venue or online • 1 hour • With Fire Safety Advisor	• Fire awareness presentation • Disability equipment familiarisation • Fire extinguisher familiarisation
Fire Competency Assessment (FCA) All ward-based nursing staff	• On induction to the ward then at 6-monthly intervals • With line manager in supervision / appraisal meeting at site of employment	Q & A on all aspects of fire safety: • Fire alarm system and local operational procedures • Duties and responsibilities in relation to fire incidents on the site of employment • Fire extinguisher (theory)

Fire Course (ward staff) All ward-based nursing and OT staff	• Annual qualification • On site or online • 1 hour • With Fire Safety Advisor	• Fire awareness presentation • Local fire procedures • Disability equipment familiarisation • Fire extinguisher familiarisation

Those with direct responsibilities for patient welfare and safety, undergo a higher standard of training in response to the high-risk environment of mental health in-patient facilities. All courses for ward-based staff are site specific and are currently organised locally according to need.

17.0 Progress against workplan during last financial year

KEY ACTION	STATUS AS AT 31/03/2024
Review all policies relating to health & safety to ensure they reflect current guidance and legislation.	Completed – February 2024
Quarterly/exception reports to Quality Committee	Completed – ongoing - quarterly
RIDDOR reports submitted to timescale	Completed - ongoing
Risk facilitators and officers in place	In progress
Risk officer training needs analysis completed, and training completed	In progress
Ensure completion of all annual H&S environmental inspection forms	In progress
Ensure review of all workplace risk assessments considering COVID-19.	Completed – September 2023
Delivery of Peoplesafe smartphone app training and webinars	Completed – March 2024
Co-lead on QI Project to improve reporting of assaults to police	Carried forward

17.1 Key Achievements

- Trust-wide implementation of new Peoplesafe lone working portal.
- Delivering a full health & safety service despite enhanced work of the emergency planning manager and the health and safety advisor seconded to another role
- Providing increased support to services who have a seen a rise in violence and aggression.
- Establishment of Service Users' and Carers' H&S Group
- Risk officer training programme endorsed by NEBOSH - the first NHS Trust to have their health & safety learning programme endorsed by NEBOSH.

17.2 Unfortunately, the QI project to improve reporting of assaults to police was not established which was mainly due to capacity issues when the H&S advisor was seconded to another role. However, it has been decided that the implementation of Operation Cavell will now take precedent over this and will begin when the H&S advisor returns in July 2024

17.4 A further notable risks is that the trust may not be compliant with Health and Safety Regulations if workplace risk assessments are not completed for trust sites. WPRAs are currently saved centrally resulting in significant challenge to quality check and ensure all sites are covered. The H&S team have created a live SharePoint document on MS Teams to provide assurance and governance of completed assessments. The leads of each directorate have been given access to upload and declare when risk assessments have been completed for their sites. However, gaps have still been identified.

To further address this, for risk officers to attain their NEBOSH qualification they are required to submit their site's risk assessment and the WPRA will now be uploaded to the Inphase audit module.

18.0 Workplan for the coming financial year

18.1 Workplan 2024-25

During 2024/25 the Health and Safety team will over-see the implementation of Operation Cavell

Key Action	Outcome measure	TCD	Lead
Review all policies relating to health & safety to ensure they reflect current guidance and legislation.	Approved Trust wide policies in place.	31st December 2024	H&S Manager
Quarterly/exception reports to Quality Committee	Submission of reports	Ongoing	H&S Manager
RIDDOR reports submitted to timescale	Submitted to HSE to timescale	Ongoing	H&S Manager
Risk facilitators and officers in place	All officers in place for the sites	31st September 2024	H&S Manager
Risk officer training delivered trustwide	Training delivered and attendance recorded	30th November 2024	H&S Manager
Ensure review of all workplace risk assessments	Completion of review of all workplace risk assessments	30th September 2024	H&S Manager
Continued implementation of Peoplesafe Smartphone App alarm	Trust wide implementation completed.	30th September 2024	H&S Manager / IT
Delivery of Peoplesafe training Webinars	Delivery of webinar	Ongoing	H&S Manager

Implementation of Operation Cavell	Monthly Cavell meeting established with police service and providing governance	30th September 2024	H&S Manager
Streamline the current DSE Assessment process and procurement of identified equipment	New process in place	30th October 2024	H&S Manager

The H&S team have identified the following key priorities for the coming financial year

- WPRAs completed for each site (Improving population health/improving experience of care)
- Implementation of Operation Cavell (Improving population health/improving experience of care/ improved staff experience)
- Improve awareness, streamline process of and numbers of completed Display Screen Equipment Assessments (Improved value/ improved staff experience)

18.2 In order to deliver our forthcoming plan the Health & Safety team will engage with Staff side, People Participation, Clinical services, Estates, Infection Control Team and People & Culture throughout the year and formally at the Health, Safety & Security Committee.

18.3 The H&S Team will also engage with both the Metropolitan Police Service and Bedfordshire Police especially during Operation Cavell

19.0 Action Being Requested

19.1 The Committee is asked to RECEIVE and APPROVE the report and the associated work plan for 2024/25 set out in section 18

NHS
East London
NHS Foundation Trust

ANNUAL REPORT TO THE QUALITY COMMITTEE

11th July 2024

Title	Annual report on Safe Working Hours: Doctors in Training **2023/ 2024**
Author	Dr Justyna Sierpatowska Consultant Psychiatrist & Guardian of Safe Working Hours (GoSWH)
Accountable Executive Director	Dr David Bridle, Chief Medical Officer

Purpose of the report

The Committee is requested to review the annual report from the ELFT Guardian of Safe Working Hours. This report presents data on the number of junior doctors in training within the Trust, outlines the measures implemented to ensure compliance with the junior doctor contract, and describes the procedures established to identify, assess, and address any potential risks to the organization.

Committees/meetings where this item has been considered

Date	Committee/Meeting
18/07/24	Quality Assurance Committee

Key messages

The Committee is asked to note the annual report from the ELFT Guardian of Safe Working Hours, which provides data about the number of junior doctors in training in the Trust, details arrangements made to ensure Safe Working within the junior doctor contract and arrangements in place to identify, to quantify and remedy any risks to the organisation.
I am assured of junior doctor work schedules at ELFT being compliant with the junior doctor contract, according to data provided by medical staffing department. Reporting of exceptions to work schedules during financial year 2023/2024 was 165 reports including 17 breaches of the rest rules. This is due to doctors remaining late at work due to delays in handover processes and increased workload in both day shifts and out of hours shifts.

In the period, 1114 (without Q3 data for Tower Hamlet and Newham - I don't have data from that period) vacant shifts required locum cover, 8% of which were covered by agency doctors (without data for Q3 for Newham and Tower Hamlet).

Strategic priorities this paper supports

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

Implications

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

1.0 Background/Introduction

1.1 The report has been prepared by the Guardian and covers reporting in financial year 2023 / 2024. The report includes data stipulated in the junior doctor contract to be reviewed by board, including numbers of reported exceptions to work schedules, action taken and response time, in addition to data on numbers of shifts requiring cover.

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

2.0 High level data for ELFT Employed Trainees

2.1 There were 193 junior doctors employed by ELFT across all grades in fianacial year 2023/2024. There were15 junior doctor training vacancies across ELFT.

2.2

Exception reports (fianancial year). There were 165 reports in total. All the reports were for the category hours and rest. There have been 17 breaches of the Junior doctor contract during this budget year.

Majority of the breaches have been on the London rotas, 10 of the breaches were raised by core trainees due to hours and rest (result of doctors remaining late at work after their finishing time to ensure a safe handover for complex patients or to complete urgent admin tasks). 1 was raised by higher trainee from Luton and Bedforshire where the trainee on call was not able to have 5 hours continuous rest whilst on a non-residential rota. 6 of the breaches were raised due to education. These reports are flagged with medical education and the local team to ensure that wherever possible trainees have access to teaching. On a case-by-case basis trainees missing educational opportunities are offered time off in lieu to access missed learning.

The guardian has reminded all junior doctors about the importance of handing over care at the end of their shifts.

All trainees have received a guardian of safe working 2023 induction whilst they rotated to remind them of the importance of exception reporting and to ensure that everyone is aware of the processes to follow.

Exception reports by Directorate				
Directorate	**No. exceptions carried over**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
City and Hackney	0	81	81	0
Tower Hamlets	0	52	52	0
Luton / Beds	0	9	9	0

Newham	0	25	25	
CAMHS	0	0	0	0
Total	**0**	**167**	**167**	**0**

3.1 Reports by grade of doctor – Foundation years 1 and 2, GP trainees, core and higher trainees.

Exception reports by Grade				
Directorate	**No. exceptions carried over**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
FY	0	14	14	0
GP VTS	0	22	22	0
CT1-3	0	78	78	0
ST4-6	0	61	61	0
Total	**0**	**175**	**175**	**0**

3.2 Action taken on reports

Directorate	**Guardian Fine**	**Payment**	**TOIL**	**Not agreed**	**N/A as no action required**
City and Hackney	5	49	14	0	17
Tower Hamlets	5	41	5	1	2
Newham	6	14	10	0	1
Luton + Beds	1	7	0	0	2
CAMHS	0	0	0	0	0
Total	17	111	29	1	22

3.3 Response time on reporting

Exception reports (response time)				
	Addressed within 48 hours	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
FY	5	5	4	0
GPVTS	9	10	3	0
CT1-3	17	25	36	0
ST4-6	16	24	12	0
Total	**47**	**64**	**55**	**0**

3.4 There have been fewer delays in signing off reports during this quarter. Where delays occur this is typically due to a delay in a trainee replying to a guardian email or when the guardian is on leave (as there are no cover arrangements). Whilst clinical supervisors are able to sign off exception reports this is an infrequent occurrence due to lack of familiarity with the DRS system.

3.0 **Locum bookings**

4.1 Locum bookings are made to cover vacant shifts on the on-call rota, the result of vacancies and sickness absence. Most locum shifts are taken by doctors working on the rota already, including staff grade doctors. The table below summarizes the number of locum doctors employed to cover gaps in the junior doctor out of hours rota. The data for Luton/ Beds includes both their first and second on call rotas. There was no data available from the CAMHS rota co-coordinator. There wa sno data avaliable for Quarter 3 from Towe Hamlets and Newham. The Agency spend in some areas was required as a contingency arrangement for the junior doctor strikes.

Directorate	Grade	Year 2023/2024			Agency	Total n. shifts
City and Hackney (incl. Forensics)	**CT**	210			53	263
City and Hackney (incl. Forensics)	**HT**	105			23	128
Tower Hamlets	**CT**	118 (+Q3)			10 (+Q3)	128
Newham	**CT**	178 (+Q3)			25(+Q3)	203
Newham / Tower Hamlets	**HT**	84 (+Q3)			3 (+Q3)	87
Luton / Beds	**CT/HT**	596			0	596
CAMHS	**HT**	0	0	0	0	0

4.0 **Work schedule reviews**

5.1 No Work Schedule Reviews were carried out in the reporting period.

6.0 Fines

6.1 17 fines were raised in this quarter for breaches of the junior doctor contract.

7.0 Qualitative information

7.1 The 2016 junior doctor contract includes safeguards relating to working hours. Work schedules and on call rotas are designed to comply with the contract rules, including rest rules. Trainees report variations to their work schedules by exception reporting. Work schedule reviews can take place if there is a need. In particular circumstances, fines can be levied. The role of Guardian of safe working hours is to ensure compliance with the safeguards, act on issues as they arise, and assure the Trust Committee that working hours are safe (in line with the contract). Guardians are independent of trust management. Exception reporting is considered a sign of a healthy training environment. There have not been any formal work schedule reviews this quarter.

7.2 The Trust runs a Junior Doctor Forum on a bi-monthly basis chaired by the Guardian and including BMA, medical staffing and medical education representation. The purpose of the

forum is to consider any and all issues related to a supportive working environment for junior doctors. The forum was held on the 26th May 2023, 24th of July 2023, 16th Ocotber and 4th December as well as 18th of March.

Separate meetings are also held within each geographical directorate for all trainees. Separate junior senior meetings are also held for CAMHS and Forensic trainees. All meetings have gone ahead as planned and have been positively received. All trainees have access to a variety of channels to report on patient safety issues and training issues.

The Guardian of Safe Working is linked in with Freedom to Speak Up Guardian over any reports from junior doctors on safety or training concerns. There were no concerns raised to the Freedom to Speak up Guardian in Quarter 1.

7.3 In financial year 2023/2024 165 exception reports were raised

Themes of exceptions were:

- Excessive workload in day jobs and on call
- Staying late to address urgent clinical issues and to handover patient care responsibilities.
- Clusters of reports are noted within wards and teams where there are extended sickness and absence in other members of the clinical team.

8.0 Recommendations

8.1 Trainees continue to be actively encouraged to report variation to work schedules. The Guardian has sent all trainees an August 2023 update with regards to the importance of exception reporting. In addition to attending the corporate induction I continue to meet with groups with lower reporting rates in order to address these concerns.

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

8.3 All Clinical Supervisors are being encouraged to respond to and sign off exception reports raised by their trainee in a timely manner to prevent unnecessary delays.

9.0 Action Being Requested

9.1 The Committee is asked RECEIVE and NOTE the report.

East London NHS Foundation Trust

ANNUAL REPORT TO THE QUALITY ASSURANCE COMMITTEE

18 July 2024

Title	Freedom to Speak Up Annual Report 2023-2024
Author	Freedom to Speak Up Guardian, Anita Hynes
Accountable Executive Director	Interim Chief Nurse, Claire McKenna Chief People Officer, Tanya Carter

Purpose of the report

The purpose of the report is to provide an update to the Trust Board as well as to provide assurance on the Freedom to Speak Up activity from 1st April 2023 to 31st March 2024.

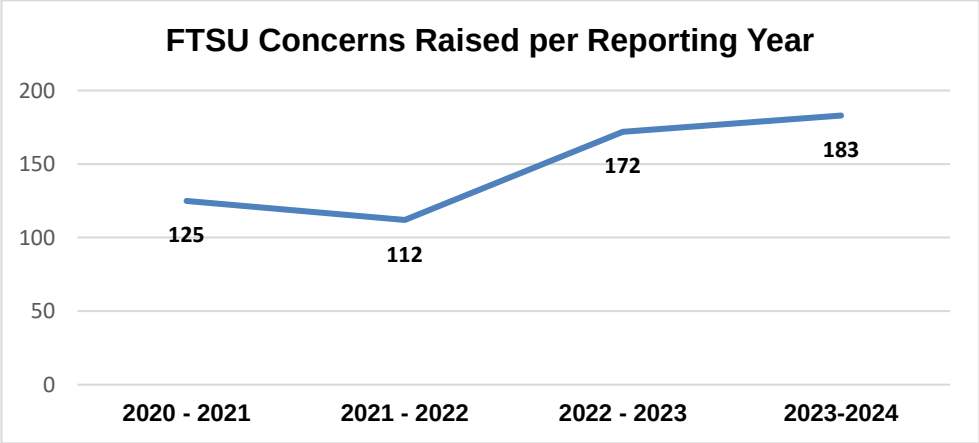
Ensure Freedom to Speak Up is meeting its objectives both locally and nationally, update on progress made against the Freedom to Speak Up Action Plan following the internal review that took place Q3 2023 and set out the proposed work plan for the coming financial year.

Committees/meetings where this item has been considered.

Date	Committee/Meeting
N/A	Regular reports on FTSUG activity are presented to the Service Delivery Board and the Trust Board as part of the People Paper.

Key messages

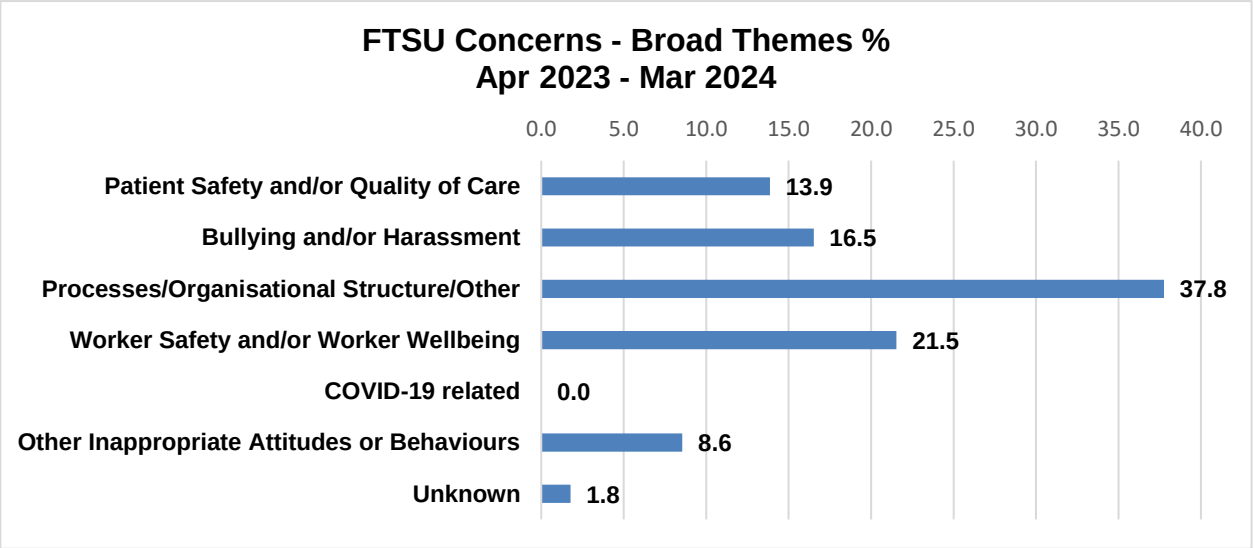
Freedom to Speak Up received 183 concerns from 1st April 2023 to 31st March 2024, which is another increase on the previous reporting year.



The broad themes (reported to the National Guardian's Office (NGO)) under which these concerns fall are:

- Patient Safety/Quality of Care
- Worker Safety and/or Worker Wellbeing
- Bullying or Harassment
- Inappropriate Attitudes or Behaviours
- Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up is indicated.
- Number of cases raised anonymously.

The NGO also requests data on the numbers of cases brought by professional groups.



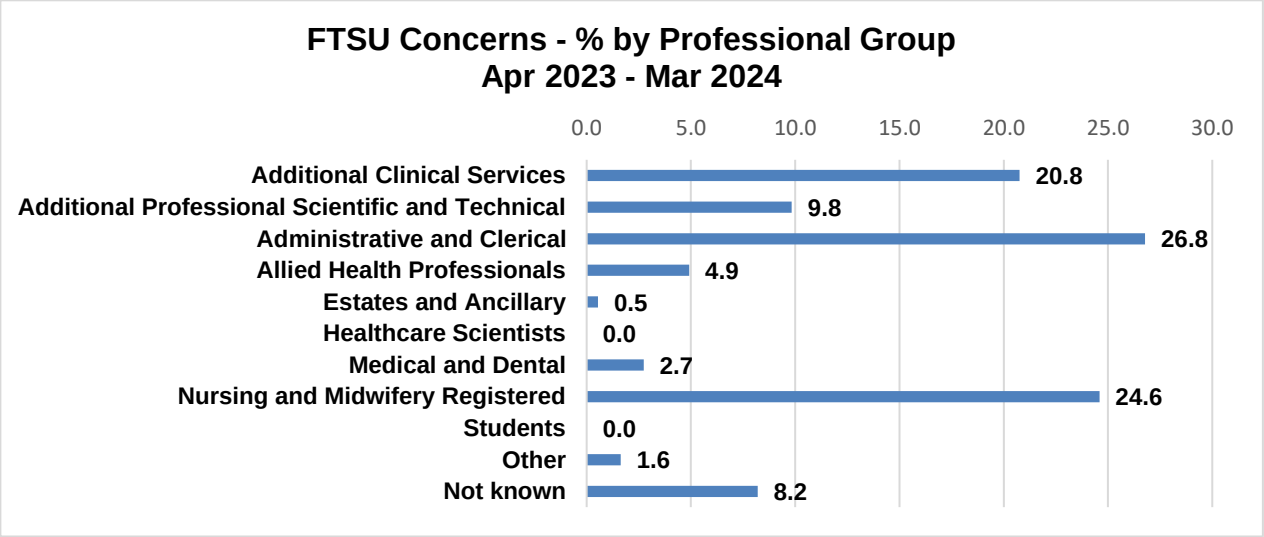
The highest number of cases fall under Processes/Organisational Structure/ Other at 37.8%, with such examples being concerns around work areas, experience with formal People & Culture processes, training/professional development, fraud, service policy, recruitment, and discrimination.

Worker Safety and/or Worker Wellbeing was linked to 21.5% of the concerns raised, with such examples being working/site environment, staffing levels, difficulties with management and impact on staff, unresolved issues with staff, management behaviours and impact on staff, staff conduct and incivility, safety at work, undermining and victimisation.

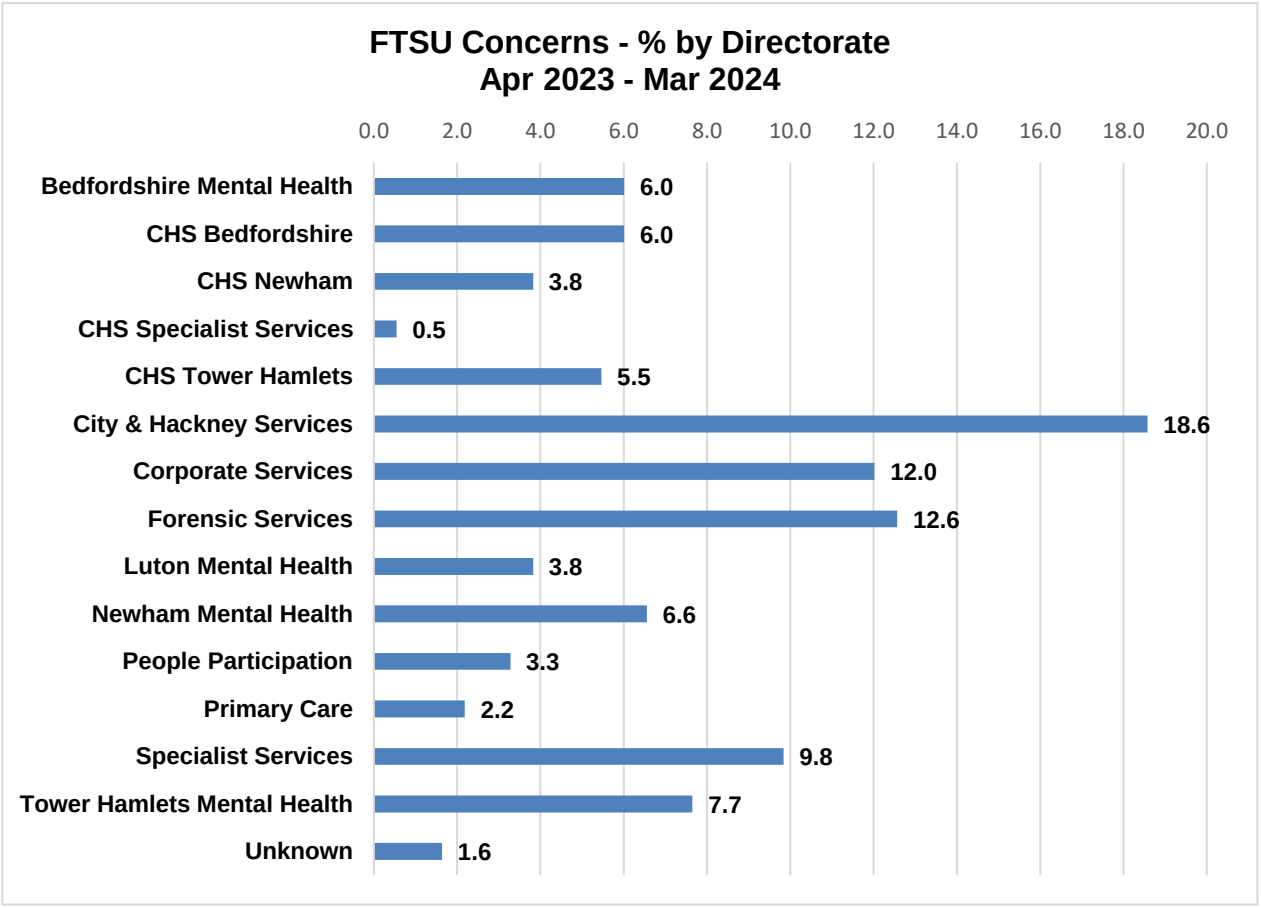
13.9% of concerns raised were linked to Patient Safety/Quality of Care and were around the operational process of services, site facilities and impact on service users and staff, staffing levels and impact on service quality.

All concerns were escalated via the appropriate channels, depending on the nature of the concern. For more details around the FTSU process, please see the Process Guidance & Expected Timelines document here.
Administrative and Clerical staff represent the highest number of concerns raised , at 26.8%. Next were Nursing and Midwifery Registered staff at 24.6% and then Additional Clinical Services

staff at 20.8%.



All directorates raised FTSU concerns this year. The directorates with the highest numbers of FTSU concerns raised were City & Hackney, Forensic Services, Corporate Services and Specialist Services.



Strategic priorities this paper supports.

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

Implications

Equality Analysis	Staff with protected characteristics are impacted by Trust policies, which can result in fear of speaking up. Trends are monitored, with a specific focus on improving the representation and staff experience.
Risk and Assurance	There are some potential risks associated with Freedom to Speak Up cases, including reputational damage, financial risk, and adverse impact on morale. These risks are being managed by corporate and directorate management teams, with oversight of the Executive team.
Service User/ Carer/Staff	FTSU promotes the importance of staff speaking up; providing high quality, cost effective, compassionate services and to continuously improve in partnership with people who use our services, their carers, families, friends, and communities.
Financial	There are potential financial implications associated with Freedom to Speak Up concerns which could include and tribunal claims resulting from organisational change.
Quality	Themes arising from Freedom to Speak Up can act as a driver for quality improvement work.

1.0 Background/Introduction

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015). These recommendations were made as Sir Robert Francis found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result.

The Trust appointed to the FTSU Guardian role in October 2017 and implemented the 'standard integrated policy', which was adopted in keeping with the recommendations of the review by Sir Robert Francis into raising concerns and whistleblowing in the NHS. This policy was updated in line with the FTSU Policy for the NHS (national policy) and implemented in November 2022. All NHS organisations are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of service users and workers. Its aim is to ensure all matters raised are captured and considered appropriately. It was designed to be inclusive and support resolution by managers wherever possible.

The National Guardian's Office (NGO) is an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The NGO is not a regulator but is jointly funded by the Care Quality Commission (CQC) and NHS England. The NGO leads, trains and supports a network of Freedom to Speak Up Guardians in England and provides

support and challenge to the healthcare system in England on speaking up. If you wish to read the National Guardian's Office Priorities for 2023/2024, you will find it here.

The Chief Executive is accountable for ensuring that FTSU arrangements meet the needs of the staff across the Trust. The Deputy Chief Executive is the Executive Lead for FTSU. They provide leadership and oversee the supportive arrangements for speaking up within the Trust. The FTSU independent Non-Executive Director (NED) acts as an independent advisor and is available to the FTSU Guardian and the Deputy Chief Executive to seek second opinions and support as required. The FTSU Guardian has direct access to the Chief Executive and Executive Lead for FTSU and seeks support from the Executive Lead when required.

2.0 Progress

2.1 Key achievements

2.1.1 Progress made against the FTSU Action Plan December 2023.

Most objectives have been completed or achieved. Those outstanding objectives are in section 2.3 below.

2.1.2 Freedom to Speak Up Conference – October 2023

The FTSU Conference was held during Freedom to Speak Up Month in October 2023 and was well attended. The most favoured sessions were the those on psychological safety of staff to support speaking up, civility at work and Helené Donnelly's talk 'Empowering Speaking Up and Challenging the Status Quo', sharing her experiences of speaking up at Stafford Hospital and how we can all empower speaking up.

Some feedback from the day in answer to the question:

What are you taking away from today's conference to share with your team, line manager, service?

- "Importance of civility."
- "Creating space to share concerns before they turn into problems which can compromise wellbeing and care."
- "Thought provoking and informative learning. Feeling empowered. Things I can do better. Not to be a bystander and to continue using my voice with questioning etc."
- "Active listening to understand context".
- "The training sessions available on learning academy. Ensuring we have a safe space in our team to speak up in our weekly meetings. Hopefully senior management has taken away the psychological safety that needs to be built in the department as a whole."
- "That what helps us to feel safe can be different for different people. I will take this to my team and ask colleagues what would support them to feel confident to share their ideas and concerns."
- "Going to speak up more, and compassionately, when I notice those micro-comments and scenarios that contribute to toxic culture."

All resources from the FTSU Conference are available on the FTSU intranet page.

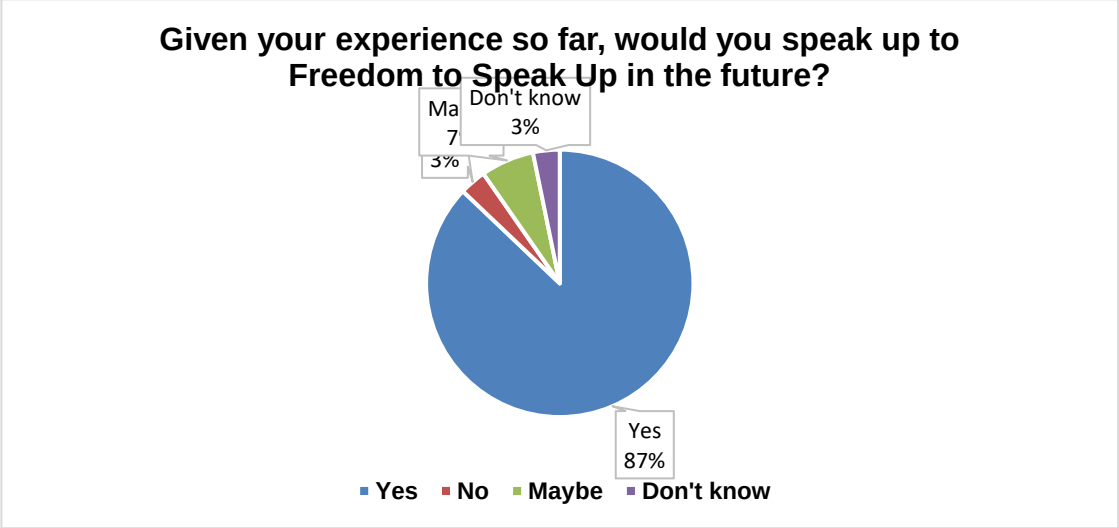
2.1.3 FTSU Training now available on the ELFT Learning Academy

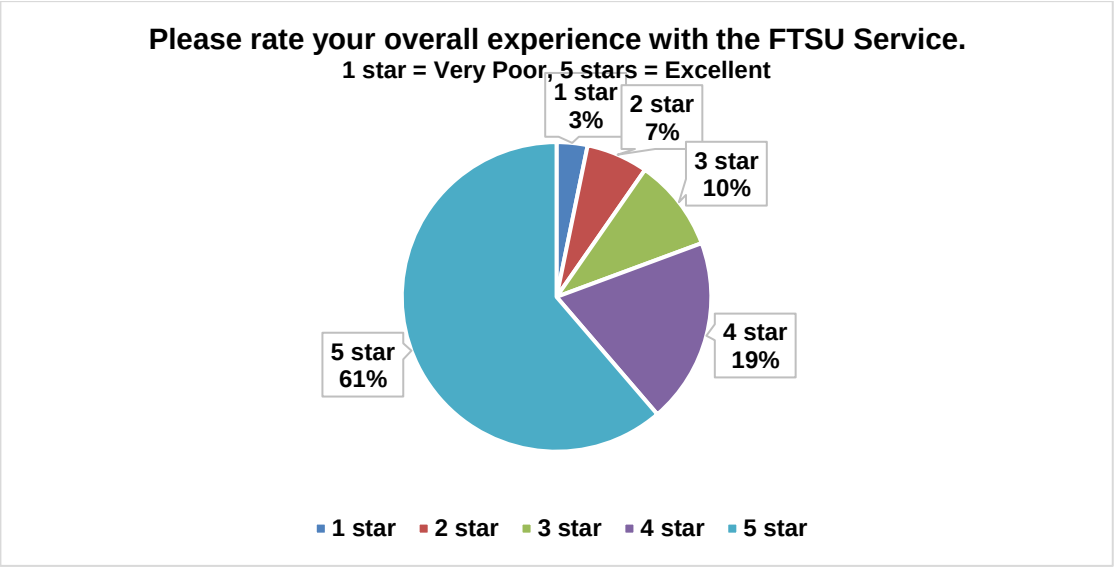
'Speak Up, Listen Up, Follow Up' is Freedom to Speak Up learning and training, divided into three modules. It supports staff with understanding the vital role they can play in a healthy speaking up culture which protects service user safety and enhances worker experience.

This training is for everyone wherever they work in healthcare and explains in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best. It supports staff with understanding the vital role they play and the support available to encourage a healthy speaking up culture for the benefit of service users and workers.

2.1.4 Staff Feedback on using the FTSU Service.

Most staff who completed the FTSU feedback survey after using the service would use the service again if needed and rated the service good/excellent.





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

The increase in the number of staff contacting Freedom to Speak Up to raise their concerns demonstrates that knowledge and awareness of the service is reaching staff. We continue to recruit FTSU Champions and encourage more to join. FTSU sessions continue to be delivered at induction days, away days, service meetings. Focused work and training were completed in the Primary Care Directorate as it was a no reporting area for FTSU. Since this work was completed, there is FTSU reporting from this directorate.

Feedback from staff also indicates that they want more information and training around 'Civility at Work' and 'Psychological Safety in Teams', which are elements that have been incorporate into FTSU sessions, are promoted through resources that are shared via the FTSU intranet page (FTSU Conference resources) and fed back to the People & Culture and Organisational Development Team.

2.3 **What wasn't achieved, and what have we understood about the reasons for this?**

1. **Outstanding objectives to complete in the FTSU Action Plan.**
   - **Freedom to Speak Up InPhase App.**
     Another FTSU concerns reporting avenue to aid with generating a supportive environment where all staff feel safe speaking up. The implementation process has commenced and are hopeful the app will be ready to roll out to staff in July 2024. This app will also support with recording cases (raised via other avenues), improving triangulation of FTSU concerns with incidents, complaints, risks, and generate live reports on FTSU concerns.
   - **Resourcing FTSU.**
     Explore resources required to ensure that the FTSU Service has capacity to continue responding to concerns (given the continued increase in number of concerns raised over the last two years), monitoring, training and strategising.
   - **Freedom to Speak Up Strategy.**
     Develop strategy to include:
   - Long term objectives of FTSU
   - Key roles and responsibilities within FTSU
   - Monitoring and measuring methods of progress within the Trust
   - Dissemination of learnings

- Prioritised actions to deliver the Trust FTSU vision

Freedom to Speak Up actions against the audit have made good progress. Development of the Speaking Up Strategy is the largest piece of work.

Sustained high numbers of Freedom to Speak Up enquiries and cases have delayed this work. This work was prioritised to ensure that:

- the monthly FTSU concerns are captured and raised appropriately.
- following up with those responsible for resolving the FTSU concerns with:
    - feedback on resolution steps
    - feedback on outcomes
    - feedback on the 'learning from' being taken forward and embedded with the team/service/directorate/trust wide as appropriate.
- FTSU following up with those responsible for resolving the FTSU concerns that are still open (from prior months/previous year)

The NGO are updating and launching their strategy July 8th, 2024, and the Trust wants to ensure that the Speaking Up strategy is in line with/complements the NGO strategy.

Progress is being monitored through Quality Committee and supervision with the Chief Nurse and Chief People Officer. Updates on progress work so far includes:

- Looking at best practice across the FTSU Guardian network and partner organisations
- Linking with Stakeholders to co-produce a Speaking Up Strategy

The aim is to have theses objectives completed by 31st August 2024.

2. The Freedom to Speak Up – Reflection and Planning Tool

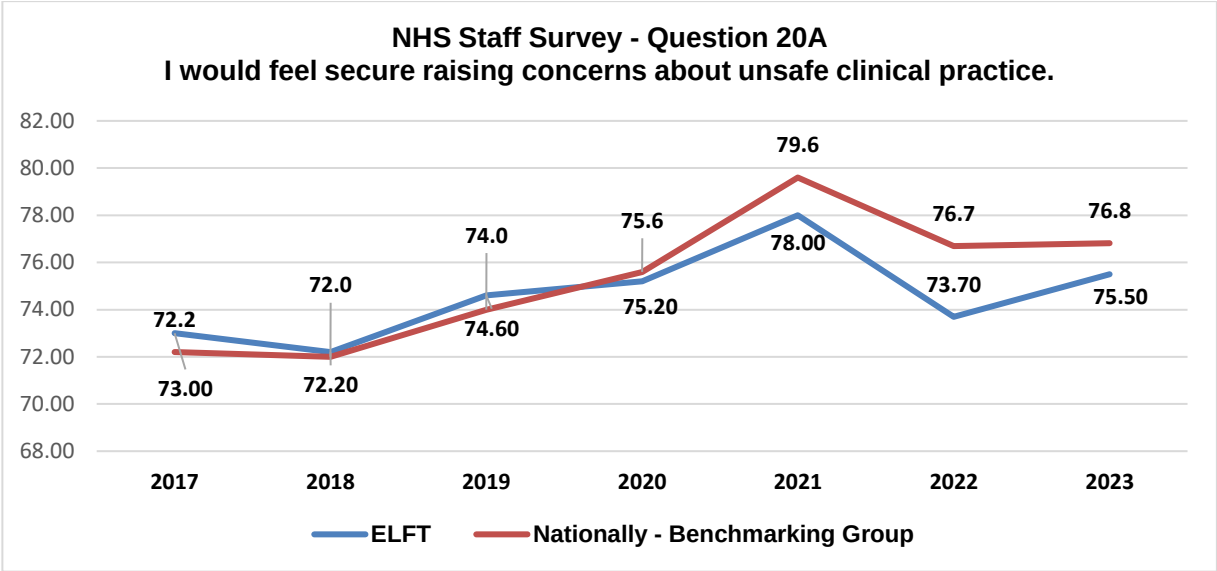
This improvement tool is designed to support Trusts with identifying strengths in the leadership team and the organisation and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.
All principles are reflected upon, evidence gathered (the FTSU Action Plan also feeds into this reflection and planning tool). To complete the summary of the high-level development actions for the next 6 – 24 months. Will be completed by 31st August 2024.

Non-achievement to date is due to prioritising maintaining the rapid response, support, and escalation of FTSU concerns, follow up, feedback on the resolution steps and sharing the outcomes with staff as well as any further follow or action from FTSU up required.

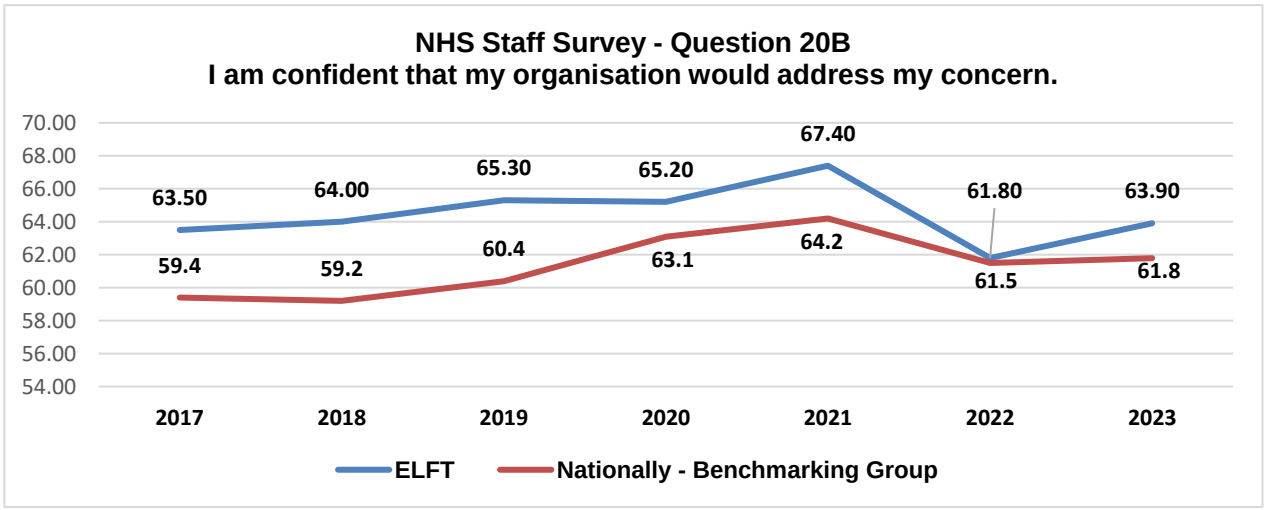
2.4 **Any notable risks further to the above**

2.4.1 NHS 2023 Staff Survey Results – Raising Concerns

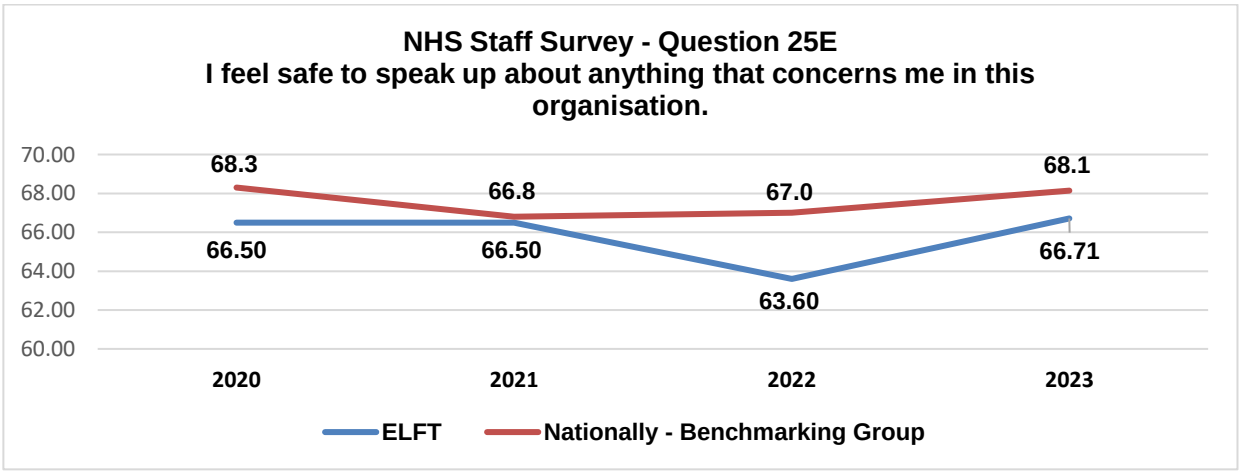
The NHS Staff Survey was complete by 2976 staff, giving a response rate of 42%. ELFT is benchmarked against Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts, of which there are 51 organisations in the group, and the median response rate was 52%.



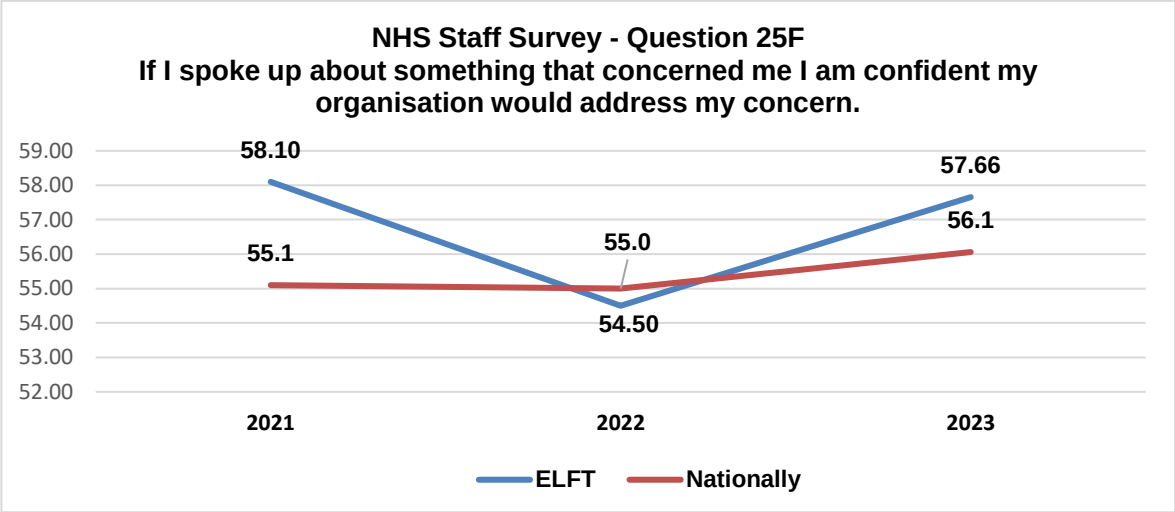
ELFT are below the national benchmarking group but have made slight progress since the previous year. It is important to note that a quarter of staff who completed the survey do not feel secure about raising concerns regarding Insafe clinical practice.



ELFT are slightly above the national benchmarking group. It is worth noting that just over a third of staff (36.1%) who completed the survey are not confident that their concern would be addressed.



ELFT are below the national benchmarking group but have made progress since the previous year. This result tells us that just over two thirds of staff who completed the survey feel safe speaking up about their concerns, one third (33.29%) do not feel safe.



In the raising concerns survey questions, these are the lowest results. There is an increase from last year's result in staff confidence with ELFT addressing their concern. However, 42.34% of staff who completed the survey are not confident that ELFT would address their concern.

"Fear and Futility – What does the Staff Survey tell us about speaking up in the NHS" is a report that was published by the NGO in June 2023, based on the 2022 NHS Staff Survey results. It concludes that there is still much more to be done to ensure that all staff feel it is safe to speak up about concerns or anything that gets in the way of doing their role. The Staff Survey results demonstrate that there is still much work to do to ensure that staff feel safe with speaking up on their concerns. The Trust wide Leadership Programme and the Speaking Up Strategy will support with this work.

3.0 Workplan for the coming financial year

3.1 Key priorities

Priority	Details	How/Why	Lead(s)	Delivery Date
Speaking Up is business as usual.	Reinforcing 'Speaking Up' across the Trust via 'Civility at Work' and 'Psychological Safety in Teams' which will be key elements in the ELFT Speaking Up Strategy.	FTSU training at Corporate Induction, Managers Induction, Away Days, team meetings, and ongoing support for FTSU Champions in localities will continue to increase awareness of the FTSU support available. FTSU is continuously striving towards making 'Speaking Up' business as usual in all teams across the Trust.	Anita Hynes With support from: • Directorate Leads • People & Culture Team • FTSU Champions	March 2025
FTSU InPhase App	Implementation of the Freedom to Speak Up InPhase App**.** The implementation process has commenced and are	The app will provide another avenue for staff to report a FTSU concern. It will also provide an IT system of recording FTSU cases, which will support improved	Anita Hynes With support from the InPhase implementation team	31st July 2024

Priority	Details	How/Why	Lead(s)	Delivery Date
	hopeful the app will be ready to roll out to staff in July 2024.	triangulation with other services and oversights in the Trust.		
Speaking Up Strategy	The Speaking Up strategy is under development and is being informed by stakeholder engagement and review of best practice. The FTSU National NGO Strategy is due to be released in July and will inform ELFT strategy.	Develop strategy by 31st August 2024 to include: • Long term objectives of FTSU • Key roles and responsibilities within FTSU • Monitoring and measuring methods of progress within the Trust • Dissemination of learnings • Prioritised actions to deliver the Trust FTSU vision	Anita Hynes	31st August 2024
Freedom to Speak Up – Reflection and Planning Tool	This improvement tool is designed to support Trusts with identifying strengths in the leadership team and the organisation, and any gaps that need work.	Complete the summary of the high-level development actions for the next 6 – 24 months. Will be completed by 31st August 2024.	Claire McKenna	31st August 2024
Resourcing FTSU	Explore and review the resources necessary to ensure that the FTSU Service has capacity	to continue responding to concerns (given the continued increase in number of concerns raised over the last two years), monitoring, training and strategising.	Anita Hynes	31st August 2024

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

Updates and reports will be shared at:

- Quality Committee
- Quality Assurance Committee
- People & Culture Committee
- People Plan Delivery Board
- DMT Data Dashboard
- Service Delivery Board

4.0 Action Being Requested

4.1 The Committee is asked to: **RECEIVE** and **NOTE** this report.

East London
NHS Foundation Trust

ANNUAL REPORT TO THE QUALITY ASSURANCE COMMITTEE

18 July 2024

Title	Complaints, PALS & Compliments Annual Report 2023/2024
Author	Evah Marufu, Director of Nursing Tribuven Sharma, Head of Complaints and PALS
Accountable Executive Director	Claire McKenna, Chief Nurse

Purpose of the report

To provide the Trust Board with an overview of the Trust's management of complaints & Patient Advice and Liaison Service (PALS) over the past financial year.

To outline the proposed work plan, aims and objectives for the coming financial year.

Summary of key issues

	2022-23 figures	2023-24 figures	Measurement
New formal complaints	427	613	+43%
Total closed	499	370	-25%
Closed within timeframe	213	278	+30%
Total breached complaints	107	151	+41%
Total withdrawn/followed onto next financial year	33	114	+245%
PALS inquiries	988	747	-24%
Compliments	977	1346	+38%

- **613** formal complaints were raised in this reporting period, an increase of **43% (186)** compared with the previous year of **427**.
- The Trust closed **499** formal complaints in total. Out of this **278** were closed on time; this is an increase of **30% (65)** from previous year which was **213**
- **151** complaints were breached (not closed within 25 working days) showing an increase of **41%** from previous year which was **107**.
- The remainder of **114** cases were withdrawn/not pursued or followed onto the next financial year.
- **747** PALS inquiries were received by the Trust, this is a decrease of **-24%** inquires compared to the previous year **988**.
- **1346** compliments were formally recorded, this was an increase of **38%** compliments compared to the previous year **977**

Complaints top 10 themes:

1. Attitude of Staff
2. Communication/Information
3. Access to services
4. Assessment
5. Clinical Management
6. Medication
7. Appointments
8. Care Planning/CPA
9. Discharge/Transfer
10. Arrangements
11. Clinical Management

PALS top 10 themes:

1. Attitude of Staff
2. Communication/Information
3. Assessment
4. Clinical Management
5. Access to services
6. Medication
7. Care Planning/CPA
8. Support in the community
9. Clinical Management
10. Appointments

Strategic priorities this paper supports

Improved population health outcomes	☒	Identifying learning from patient experience that will improve service, improving patient experience by preventing a reoccurrence.
Improved experience of care	☒	Ensuring the Trust meets NHS Regulations 2009, providing timely, fair and quality responses with learning identified where possible.
Improved staff experience	☒	Empowering and supporting staff in providing them with the correct tools, policies, procedures, documentation and training to improve service.
Improved value	☒	Ensuring the Trust meets Statutory regulations and CQC guidelines. Monitoring accidents and incidents. Reducing potential risk where possible by providing robust control measures and in house training.

Committees/meetings where this item has been considered

Date	Committee/Meeting
26 June 2024	Quality Committee Meeting
18 July 2024	Quality Assurance Committee Meeting

Implications

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	This report provides assurance that complaints and PALS are appropriately reported and investigated with learning identified that can be embedded across the Trust.
Service User/Carer/Staff	The recommendations and action plans pertaining to complaints and PALS have implications for service users, carers, staff and services across the organisation.
Financial	There are financial implications regarding resource management & potential for litigation.
Quality	The recommendations and action plans relating to complaints and PALS are proposed with the view of improving the overall quality of the service for the Trust and service users.

Supporting documents and research material

a. ELFT Complaints and PALS Policy Version 9.0 October 2020.
b. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

Glossary

Abbreviation	In full
CAMHS	Child and Adolescent Mental Health Service
CEDS	Community Eating Disorders Service
CHS	Community Health Services
CPA	Care Programme Approach
CQC	Care Quality Commission
Datix	Trust incidents and complaints reporting and management system
ELFT	East London NHS Foundation Trust
MHS	Mental Health Services
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
REGS 2009	The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

1.0 Background/Introduction

1.1 East London NHS Foundation Trust (ELFT) has contractual and statutory obligations to report on and appropriately manage all complaints raised to the Trust. This report fulfils ELFT's obligations under the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 to produce an annual report on all formal complaints raised to the organisation. These regulations are also reflected in the Trust's Complaints Policy.

1.2 The Trust is committed to improving the services and care that we provide. Feedback we receive from patients, their families and carers, helps us to identify the areas where we need to improve and ensure that action is taken to prevent the same things happening again.

1.3 Complaints, compliments and the Patient Advice and Liaison Service (PALS), are one of the ways in which the Trust receives feedback about its services. Information from the complaints and PALS service is also included in the Trust integrated patient safety report, which triangulates information from other sources including serious incidents, legal, care opinion, inquests and incidents.

1.4 This report covers all complaints, PALS and compliments received by the Trust in the period from 1 April 2023 to 31 March 2024

2.0 Trust Activity

- **Complaints**

2.1 Complaints are overseen and supported by a dedicated Corporate Complaints & PALS team to ensure that processes and outcomes are impartial, fair, flexible and conciliatory. This team, which used to be part of the Risk and Governance team, is now a separate team/department within the Trust and reports to a Director of Nursing. This new arrangement aims to raise the profile and focus of complaints as a key source of feedback in the Trust.

2.2 Complaints & PALS team supports those wishing to complain, or provide feedback about the services received, being listened to, and remaining confident that they will not be discriminated against for making a complaint. It also supports staff and managers within the services, to effectively manage and respond appropriately to complaints made about their services.

2.3 Complaints can be managed in two stages. At stage 1, the locality will appoint someone appropriate to review the complaint, conduct a preliminary investigation and contact the complainant to discuss their concerns. At this stage, the service is encouraged to explore the possibility of locally resolving the complaint, and identify any learning without further investigation. If it is not possible (or appropriate) to resolve the complaint under stage 1, or if the complainant is unhappy with the stage 1 outcome, it will then progress to stage 2 where an investigating officer will be appointed from a different service, to provide objectivity. The investigating officer undertakes a thorough investigation with the service, and provides a full response with areas for learning and actions to address any issues identified.

2.4 The Trust's Chief Executive Officer personally oversees and reviews every Stage 2 complaint response. This is to assure service users, carers and families of the importance the Trust places on complaints by having input at the most senior level of the organisation. The Trust also has the support of service users from the People Participation Team overseeing complaint final responses to ensure that the responses are written in a kind and user-friendly and empathetic manner.

2.5 This financial year 2023/2024, we received 613 formal complaints in comparison to 427 complaints in the previous financial year 2022/2023 (please see chart 1 below). This was a 43% increase. The main period for the increase was during April 2023-September 2023. The rising numbers led to the need to investigate the reason behind this. The team carried out deep dive exercises and analysis of the

complaints. We identified that the top three themes were Communication, Attitude of Staff and Access to Services. We shared our analysis and learning by presenting our findings at Trust-wide forums, including the Quality Committee, Quality Assurance Committee, Patient Safety Forum. We also supported and worked closely with the directorates that had the highest number of complaints, with the view of helping them better manage the complaints process, learning and outcomes. In addition, we have sought the assistance of our service user representatives to review, advice and quality assure our processes, learning and responses. As a result, our complaints numbers decreased in the last six months of the financial year, and were closer to the median over the last three years (please see chart 1 below).

- **Patient, Advice and Liaison Service (PALS) inquiries**

2.6 Patient Advice and Liaison Service (PALS) offers confidential advice, support and information on health-related matters.

2.7 PALS inquiries are processed and managed by the Trust's Corporate Complaints & PALS team and come in a variety of methods including email and telephone inquiries. Notably, the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 do not stipulate a time frame to respond to PALS inquiries (or informal complaints), the Trust aims to resolve these within 72 hrs.

2.8 PALS provides help in many ways. For example, it can help with health-related questions help resolve low level concerns or problems. PALS can give you information about the Trust and its' services, the NHS complaints procedure, including how to get independent help if you want to make a complaint. PALS also signposts to support groups outside the NHS.

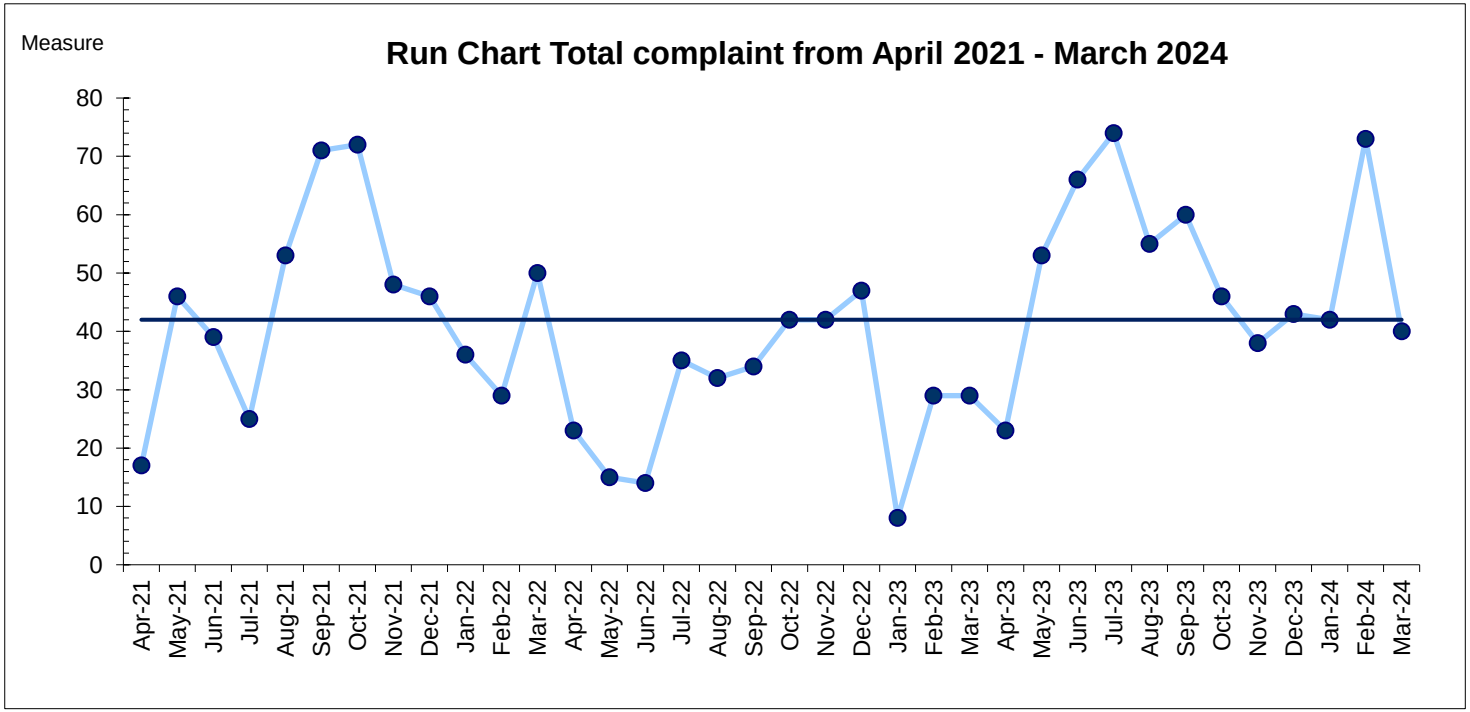
2.9 This financial year 2023/2024, we received 747 PALS inquiries in comparison to 988 in the previous financial year 2022/2023. This was a 24% decrease. Where possible, we encourage concerns to be dealt with via the PALS route, rather than the complaints route, as the PALS process provides our service users with speedier responses and resolutions. To help increase the number of PALS, we have delivered and scheduled several of PALS clinics across the Trust. During these clinics, our team assists service users with their queries and concerns and also promotes our team function and services.

- **Compliments**

2.10 The Trust routinely responds to all reported compliments that are subsequently shared with the relevant teams and publicised in the Trust's news bulletins. The majority of the praise is regarding the care received generally, whilst a high proportion will specifically name staff that have provided excellent service. In addition the complaints team has access to "Care Opinion" where service users and their representatives are encouraged to share their experiences.

2.11 Complaints Data

Chart 1 Complaints over time (1st April 2023 to 31st March 2024)



613

In this financial year the average monthly number of complaints was 51, reflecting a 43% increase compared to the average of 35 complaints per month from April 2022 to March 2023.

NHS
East London
NHS Foundation Trust

Table 1 - Complaints by Directorate

Dirctorates	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Bedfordshire Mental Health Services	5	2	12	10	10	17	9	5	5	12	19	12	**118**
City and Hackney	3	17	8	13	5	10	13	7	9	8	11	10	**114**
Community Health Services	0	3	8	7	7	6	4	0	0	0	0	0	**35**
Corporate	0	0	0	3	0	1	0	0	0	0	3	0	**7**
Forensic Services	0	1	3	5	1	2	2	0	3	0	1	0	**18**
Luton Mental Health Services	2	8	7	9	6	0	2	0	5	4	9	6	**58**
Newham (Mental Health)	3	6	6	9	5	5	7	7	0	4	18	7	**77**
Primary Care Services	0	1	0	0	1	0	4	1	0	5	4	0	**16**
Specialist Services and CHN Children's Services	1	6	9	4	2	9	5	0	0	0	0	0	**36**
Specialists Services	0	0	0	0	0	0	1	6	7	3	7	3	**27**
Tower Hamlets (Mental Health)	6	11	15	9	14	8	7	6	5	12	10	4	**107**
Grand Total	**20**	**55**	**68**	**69**	**51**	**58**	**54**	**32**	**34**	**48**	**82**	**42**	**613**

Table 2 – Complaints by theme and Source

Complaints top 10 themes:

1. Attitude of Staff
2. Communication/Information
3. Access to services
4. Assessment
5. Clinical Management
6. Medication
7. Appointments
8. Care Planning/CPA
9. Discharge/Transfer arrangements
10. Clinical Management

Complaints by Source	Complaint distribution
Email	511
Forwarded by other NHS Trust	12
Letter	17
Phone call	8
Via an advocate	11
Via an MP	18
Via CQC	16
Via Ombudsman	1
Via PALS	13
Other	6
Total	613

Adherence to complaints process and timescales*

The 2009 Complaints Regulations stipulate that all formal complaints must be acknowledged within three working days of receipt.

Table 3- Formal complaints acknowledged within three working days

Period	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Total Complaints	23	53	66	74	55	60	46	38	43	42	73	40
No. Acknowledged in three working days	23	53	66	74	55	60	46	38	43	42	73	40
Percentage	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Chart 2 - Formal complaints acknowledged within three working days

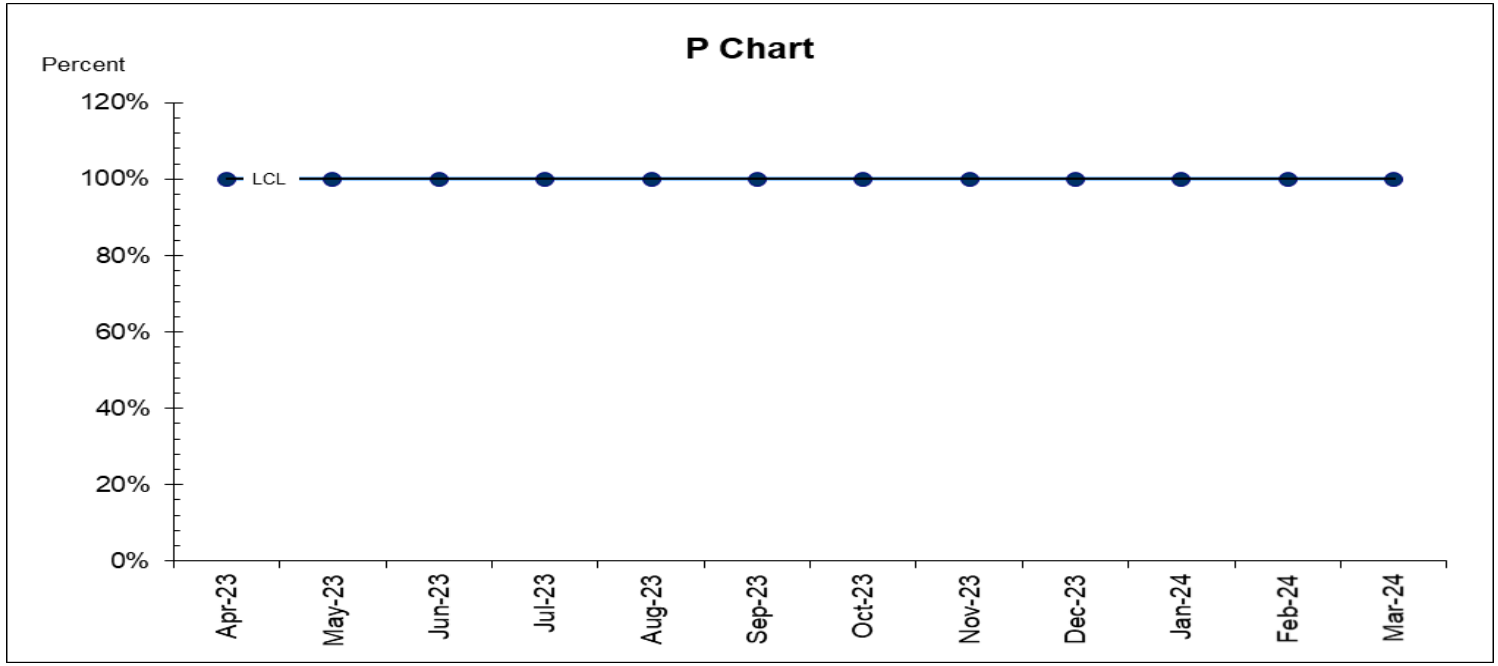
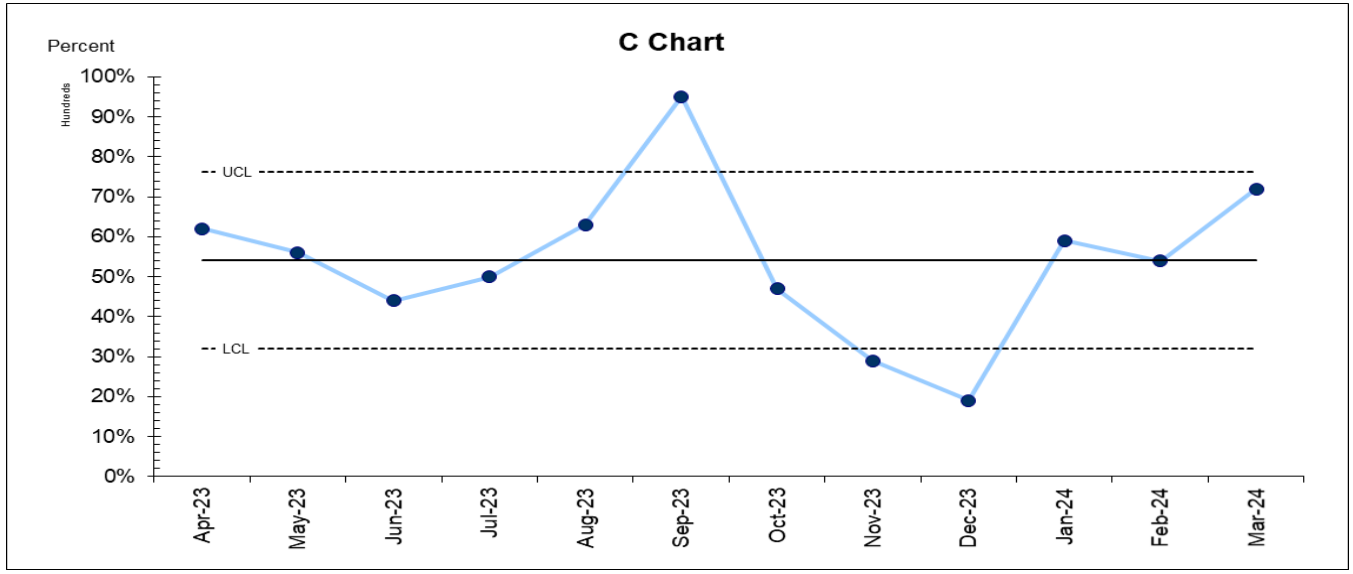


Table 4 – Complaints timescales

The Trust agrees a timescale of response with the complainant, by default this is usually 25 working, the Trust can agree an extension depending on the complexity of the complaint.

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Total complaints closed	21	27	61	54	56	37	51	31	21	34	41	65
No % response sent within agreed timescale	13 62%	15 56%	27 44%	27 50%	35 63%	35 95%	24 47%	9 29%	4 19%	20 59%	22 54%	47 72%
No % response breached agreed timescale	10 48%	9 33%	15 25%	12 22%	35 63%	15 41%	5 10%	4 13%	0 0%	13 38%	17 41%	16 25%

Chart 3 – Complaints produced to timescale



During this reporting period, the Trust responded to/closed **499** formal complaints of which **278 (55%)** were closed within their agreed timescale, compared to **213** (**58%)** the previous year.

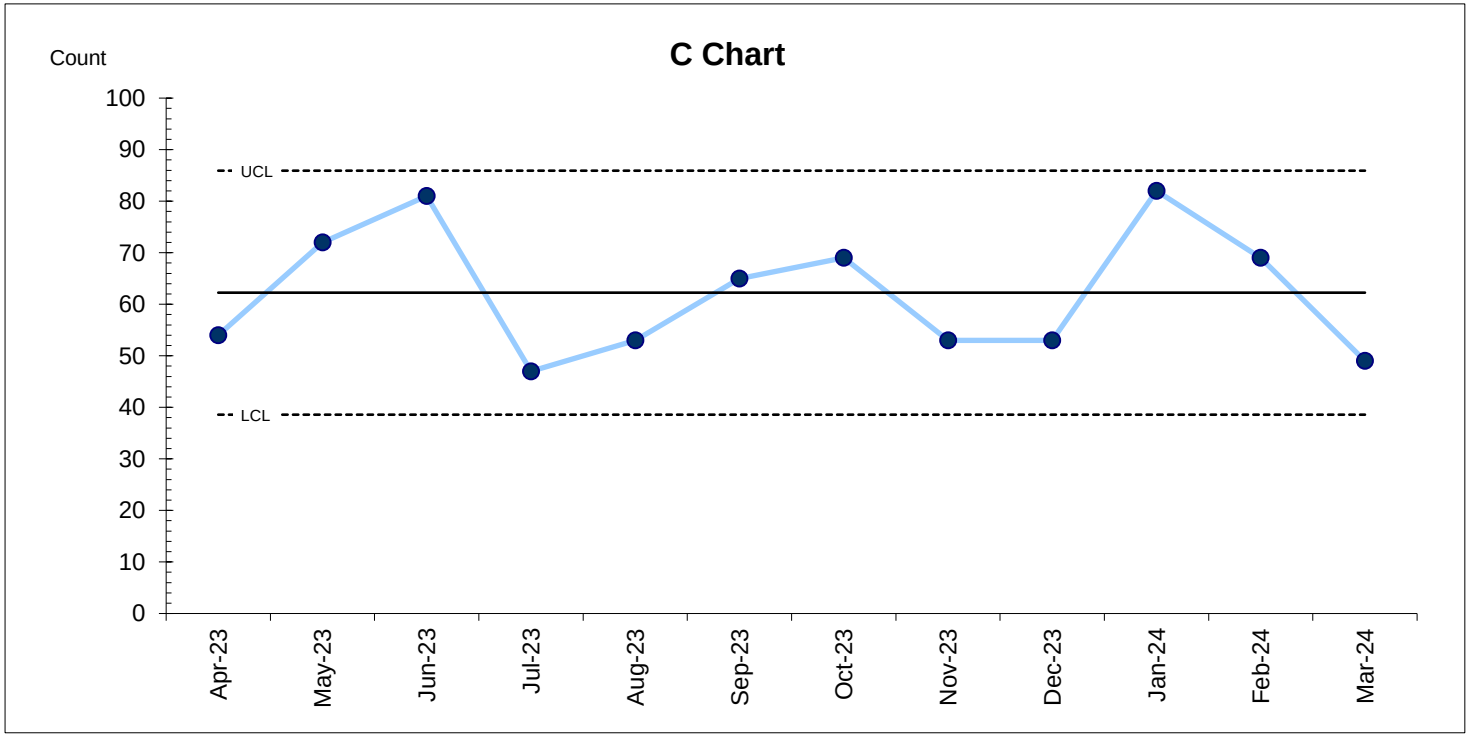
151 (30%) cases breached their agreed timeframe, compared to **107 (29%)** the previous year.

2.12 PALS data

Table 5 - PALS inquiries by Directorate

Directorates	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Bedfordshire Mental Health Services	15	8	8	4	8	9	5	7	10	13	13	18
City and Hackney	11	15	8	8	4	5	3	6	8	12	3	11
Community Health Services	0	0	0	7	13	10	14	8	6	12	0	0
Corporate	6	1	2	0	13	18	2	1	2	0	1	2
Forensic Services	1	1	4	0	2	0	0	0	1	2	0	2
Luton Mental Health Services	8	6	5	6	7	6	5	7	6	8	5	4
Newham (Mental Health)	10	13	7	7	7	8	7	8	6	8	7	5
Primary Care Services	10	11	4	8	6	12	3	7	9	2	10	2
Specialist Services and CHN Children's Services	0	0	0	4	6	8	3	6	11	7	0	0
Specialists Services	5	5	4	0	0	0	0	0	0	0	8	2
Tower Hamlets (Mental Health)	16	9	7	10	6	5	5	3	6	5	6	7

Chart 4 – PALS Inquiries over time



747

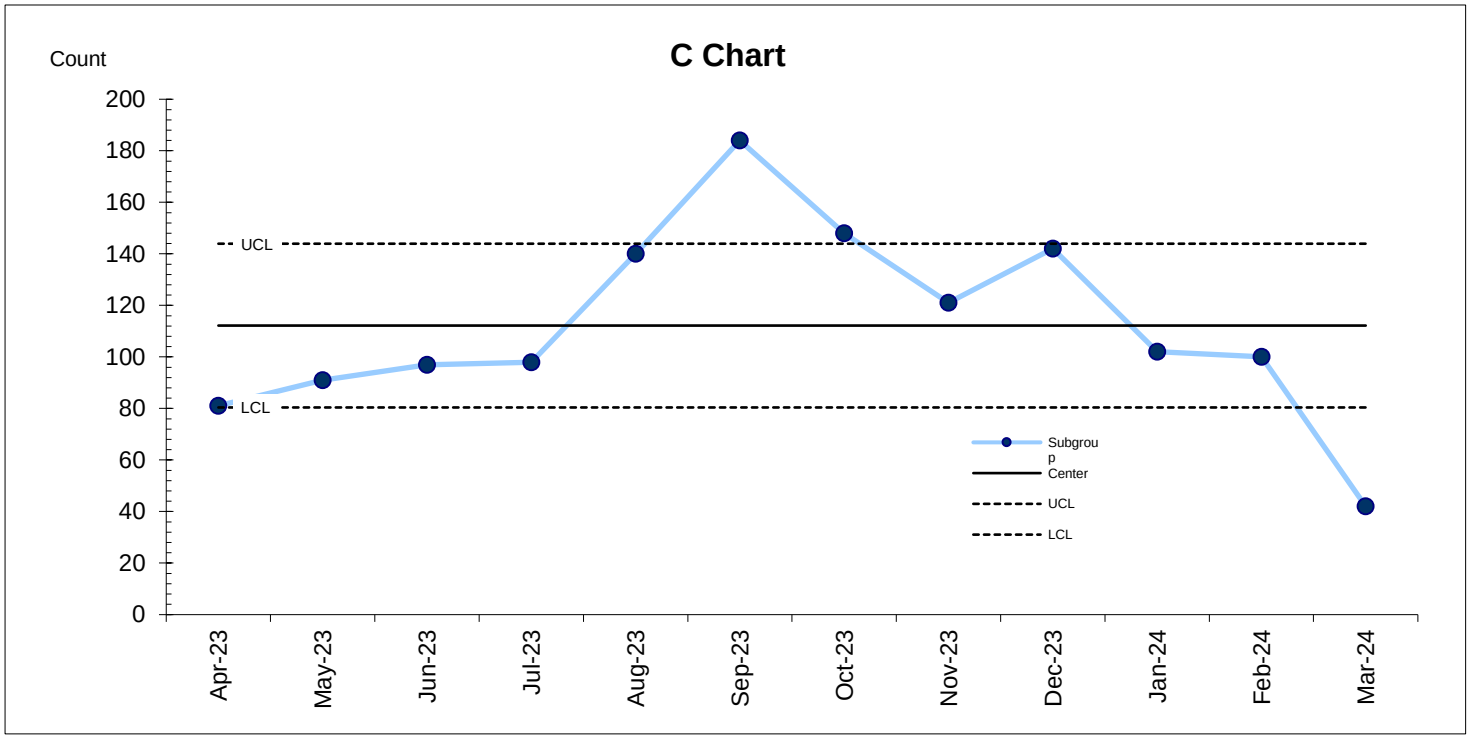
PALS inquiries were logged & handled, an average of 62 inquiries per month

2.13 Compliments data

Table 6- Reported compliments recorded by Directorate

Directorates	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Bedfordshire Mental Health Services	9	19	10	5	31	20	6	9	11	17	14	17
City and Hackney	0	0	2	5	3	0	0	1	0	0	3	0
Community Health Services	19	26	12	18	11	15	14	0	0	0	0	0
Corporate	0	2	0	0	3	0	2	1	0	1	2	0
Forensic Services	0	0	2	2	0	1	0	1	0	1	0	0
Luton Mental Health Services	2	1	3	1	2	3	0	0	0	3	2	1
Newham (Mental Health)	2	0	0	0	0	0	28	73	6	8	8	7
Primary Care Services	12	5	0	5	3	24	23	4	15	8	19	4
Specialist Services and CHN Children's Services	22	16	43	29	39	87	1	0	0	0	0	0
Specialists Services	0	0	0	5	6	4	46	24	61	27	17	0
Tower Hamlets (Mental Health)	15	22	25	28	42	30	28	8	49	37	35	13
Total	**81**	**91**	**97**	**98**	**140**	**184**	**148**	**121**	**142**	**102**	**100**	**42**

Chart 5 Compliments over time



1346

Compliments were recorded by the Trust in this reporting period. It is recognised that many more informal complaints would have been received by individuals and teams across the organisation where they were not formally recorded.

3 Progress against work plan during last financial year

3.1 Key Outcomes

Of the cases investigated and closed in this period the key outcomes were as follows:

244 cases resulted in providing explanations of our services, treatment, plans or processes, this was an increase of **24%** compared to previous year **(196).**

108 complaints resulted in action plans implemented; this showed a notable increase compared to previous year where **6** were recorded.

100 cases recognised errors or gaps in care and full apologies were given **+54%** compared to previous year **(65).**

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

3.2.1 Learning Lessons

Complaints training has continued to be delivered on a bi-monthly basis via Microsoft Teams. The training is well attended and provides staff with the opportunity to discuss and respond to queries about the process and highlight areas of improvement. The training covers local resolution, complaints handling, investigation and response writing. We focus on the latest themes, trends and learning. In addition, there has also been an increase in requests for local and bespoke training which is delivered at the specific service/directorate's offices.

We have carried out two deep dive exercises which focussed on identifying specific themes and trends, and sharing learning from these complaints. The first deep dive reviewed complaints between April 23 – Sept 23 with a focus on complaints concerning staff attitude and communication. The second deep dive reviewed complaints between October 23 – March 24, with a focus on complaints concerning Access to Services, Medication and Clinical Management.

The deep dive findings were presented at the Patient Safety Forum. The finding of both deeps dives were shared via our communications team and incorporated into our complaints training. We have noticed that almost all complaints have an elements of shortfalls regarding communication. Our next deep dive exercise will be focussing on all complaints related to communication, with the view of providing trust-wide learning on how to address this.

There is also a bi-monthly meeting which is attended by the Complaints and PALS team Governance Co-ordinators across the Trust, this meeting picks up on themes identified to ensure learning is followed through, and also to discuss what works well and any gaps or areas requiring improvement.

3.2.2 Complaints pathway

Stage 1 local resolution is always encouraged to resolve a complaint. The team routinely works with governance leads to raise awareness of this. This is explained to the services by the complaints handler and has also been implemented into the complaints training programme. This approach has proved to be received very positive for the services as it still captures key elements such as learnings but in less time consuming and informal manner. Also, as this is dealt within the treating team, it promotes better communication between the service and the service user.

3.2.3 InPhase

We have successfully migrated and transitioned all data from the previous reporting and management system 'Datix' to the new system InPhase. We are still working with the project team to resolve some reporting issues and create extra modules such as action plan monitoring.

3.2.4 Actions Plans

A key priority for the annual plan 2022/23 was and continues to be reviewing and implementing action plans and learning. We are working closely with the Risk & Governance Team to ensure we are meeting the Patient Safety Incident Response Framework (PSIRF). The PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The complaints team, was not previously, but is now, actively collating and monitoring the implementation of action plans. Our processes ensure we are requesting the relevant department to update complainants and provide assurances that actions plan have been implemented and learning has been applied. We received 108 actions plans across the Trust of which 76 (70%) have been implemented. The remainder 33 (30%) are being monitored and managed to ensure they are implemented.

We have started the process of transferring completed actions and learning onto InPhase (the system used to capture complaints and incidents); enabling triangulation with serious incident trends and themes. This is currently work in progress and we are working with the InPhase technical team to have this feature implemented on the system within the coming months.

3.2.5 PALS Clinics

The team has reintroduced face to face PALS clinics to enable patients and their families/carers to directly raise PALs issues with staff. We have delivered 3 clinics which were a success, we provided advice and assistant to both service users and staff. Due to the positive feedback, we have scheduled another 12 clinics over the next 12 months.

3.2.6 Engagement with services and service users

There is a strong focus within the department to continually improve the quality of our systems and processes. We are regularly engaging with our services and service users to obtain feedback, in the last financial year we have:

- Commenced PALS Clinics
- Designed our first complaints newsletter, which includes hints, tips guidance, themes, trends and best practices.
- Our QI project includes colleagues across our directorates and also include two service users.
- As of April 2024 a feedback survey is being sent out to complainants at the end of the process.
- A service user and carer representative from the people participation team, regularly review the quality of responses and work collaboratively with us in reviewing systems and processes.
- Service users are included on our interviewing panels when we recruit staff.
- We have co-produced with our service user colleagues based in Luton and Bedfordshire a bespoke user friendly Complaints and PALS poster/leaflet for our child and adolescent services.

3.2.7 Parliamentary and Health Service Ombudsman (PHSO) contacts and investigations

As part of the complaints regulations 2009 if the complainant is dissatisfied with the way their complaint has been managed by the Trust and local resolution of their complaint is not achievable, the complainant has the option to take their complaint to the PHSO and request an independent review of the Trust's complaint response and investigation.

During 2023/24 the Trust has received 11 new contacts from the PHSO based on complainants expressing dissatisfaction with the Trust's response/outcomes of their complaint. This compares to 16 received in 2022/23. 2 investigations were opened 1 concluded no further action and 1 resulted in financial remedy and recommended action.

3.2.8 Sample of complaints

<u>Long delays in waiting for an appointment</u>
A service user shared that their medical review was cancelled in August and then again in September 2023. It was not rebooked, leaving them concerned about the impact on their health

Reported side effects from medication
A service user had been on Subutex for over 10 years, and had recently been told there were stock shortages therefore their medication must change. After taking the new medication, they shared they could not sleep or relax, and were very worried. They were told that this new medication was the same as Subutex, but they did not agree with this and felt that the service was not listening to them.

Unhappy with involvement in Care Planning and Treatment
The service user reported concerns over her medication as she was given modified release, rather than immediate release tablets of oxycodone 5mg. She also raised concerns that her care plan and paperwork were not completed until her 3rd week as an inpatient.

Poor interaction between the family/representative and service
The service user complained that they had no communication for over a month from the befriending service. This led their condition to worsen.

Staff behaviour
Service user felt they had spoken to rudely by reception staff and then the duty nurse. Their concerns were dismissed and they were sent home without any medication. Two weeks later they were admitted to hospital.

Lack of collaborative working
Complainant thinks that there was a lack of established processes, care coordination, and effective communication. The patient's transfer to the PICU due to unprovoked assaults were not communicated to the family, hindering understanding of incidents and associated risks.

Disagreement with clinical decision
A deceased service user's family requested a formal investigation into why their mother was transferred to x facility, as they believe the medical team were not equipped to manage their mother's complex physical and mental needs.

3.2.9 Sample of PALS

Daughter not happy with mother's consultant
Complainant was very grateful that contact had been made so soon. She said she did not want it logged as a formal complaint but felt that it needed highlighting. Service advised that she is welcome to contact the Team Manager going forward if she has any further concerns. Service offered apologies on behalf of the team.

Patient requested new mattress
Request was sent to the service who confirmed this was already in place. Service contacted patient with update.

Patient wants update on referral
Complainant advised to contact GP to confirm the service that patient was referred to, as she is not under this service.

Patient's mother called to say she is unhappy with medication given to her son.

Service called mother who explained the erratic behaviour displayed by the patient, which she felt was due to the patient not taking his medication and missing appointments. Service explained to mother that an urgent assessment of mental state would be carried to see if section is needed.

Daughter needs financial support
Signposted to the enablement team who the person is under which is not part of ELFT.

Service gives patient injection which causes her leg to be in pain, Dr does not believe her
Patient declined to continue with her treatment until after the medical review which we accepted but discussed concerns regarding past patterns of similar requests and the vulnerability and complications this has generated for her.

3.2.10 Sample of compliments

- The daughter thanked the district nursing team for the support and care provided to her mother and the family

- Thank you so much for the letter. It really worked like gems! As soon as I sent the medical letter to the area manager, he replied saying I would no longer have to relocate and will be put on first priority to be changed to a full time contract. Great news -- thank you so much for yours and Dr A's help & I really really appreciate you both.'

- Every one of the projects, Trusts, teams and individuals who entered this year have truly demonstrated their skills in setting – and delivering – the highest of standards in healthcare excellence, presenting our venerable panel of judges with some difficult decisions.

- I'm looking forward to welcoming our finalists to the awards ceremony in September, where we'll have a fantastic opportunity to come together and celebrate some really impressive achievements, whilst sharing experiences, best practice and learning from our colleagues working in a diverse range of roles across the healthcare sector.

- Thank you for being our hope and making everything ok in the end. Thank you for empowering us with everything we to needed to know.

- Thank you to all the staff for making me well again which I appreciate very much. God bless you all, you are all so wonderful. Glad to be able to back home with my loving family again.

- Hello, I recently spoke on the phone Bedfordshire Talk therapies. The person was absolutely fantastic and extremely friendly and helpful and I feel very glad I contacted the service to get help. I just wanted to say thank you to her and your service

3.3. What wasn't achieved, and what have we understood about the reasons for this?

3.3.1 Response times/breaches

Some directorates are consistently exceeding the number complaints closed within 25 working days/ agreed timeframe. There is also concerns that a number of cases are breaching the statutory response time of 6 months (as stipulated in the NHS Complaints Regulations 2009). Much of the delay has been attributed to staff shortages and clinical pressures. The corporate complaints team has initiated communications with directorates in relation to this, and will be looking at how to best support these directorates to avoid unnecessary and avoidable delays. This continues to be the trend this year and work is underway to establish key points of contact in the directorates, to ensure complaints are being managed in an effective and timely manner.

3.3.2 Quality of complaints

Many complaint responses produced by services are not of the highest standard and this is leading to a lower number of complaints being completed within agreed timescales. Currently, senior staff along with the complaints team are having to make heavy edits during their QA of the responses. The QA process is taking up too much time and leads to delays and us breaching agreed timelines with complainants.

In addition, compared to the previous year there has been an increase in the number of complaints, including those that are being re-opened. For those re-opened the majority of complainants were not satisfied with the quality of the responses.

3.3.3 Action taken and planned in response to gaps in implementation or other risks identified

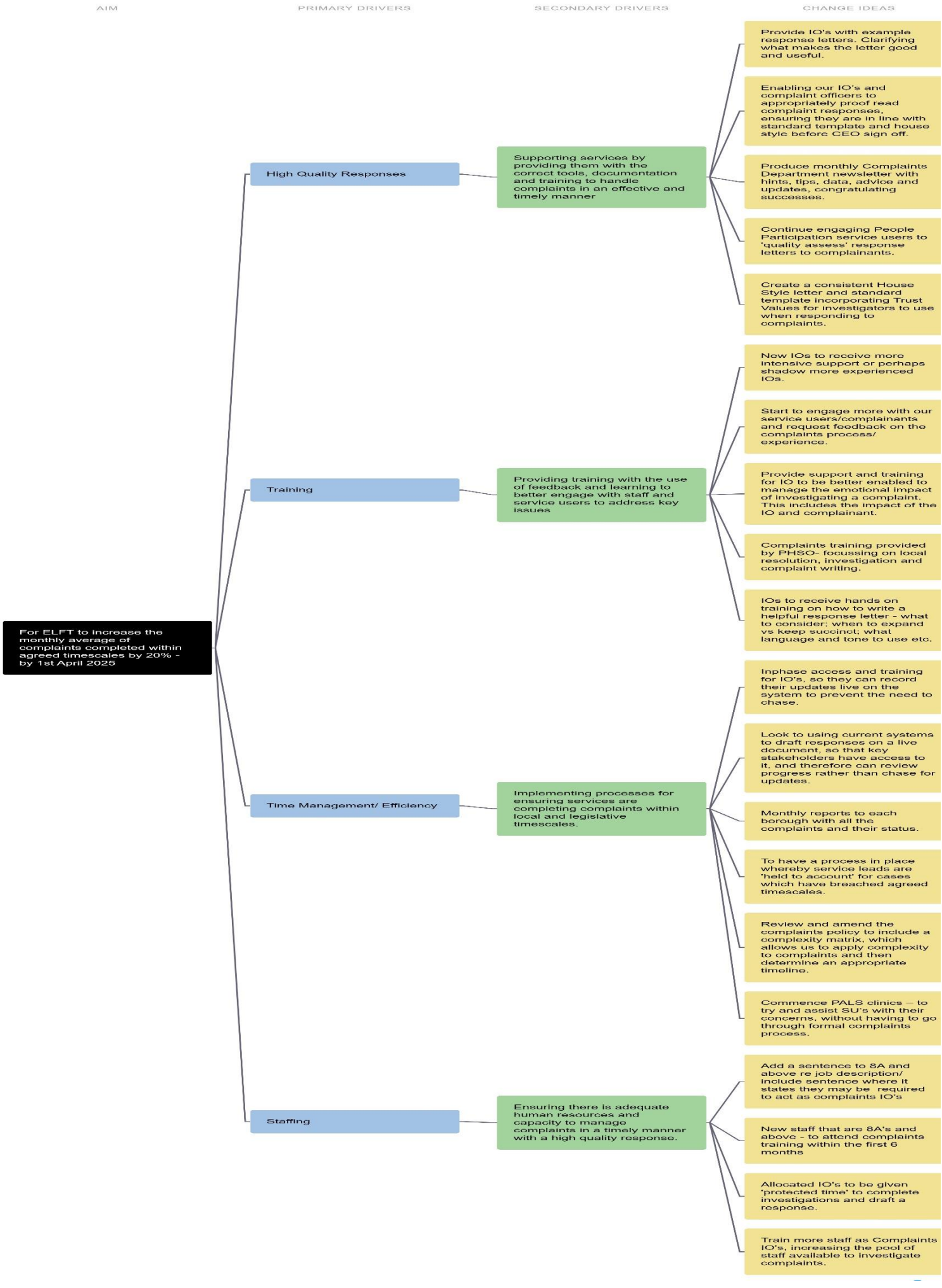
3.3.4 QI project to address quality of complaints and response times

We started a QI project in February 2024 which has the aim of increasing the monthly average of complaints completed to the agreed time scales by 20%, by the end of March 2025. By using QI we hope to make our processes and policies more efficient and enable and train staff to carry out investigations and write good standard responses at the outset. As a result, higher quality responses will ensure less time will be taken up during the QA process, which in turn should increase the number of complaints responded to within agreed timelines. The QI team also involves representatives from the Directorates who are from clinical and non-clinical backgrounds. They are also key stakeholders as they are familiar with complaint investigations. A service user representative and carer are currently helping us with QA of responses, and are part of this project.

We are of the view that the QI project change ideas and drivers will:

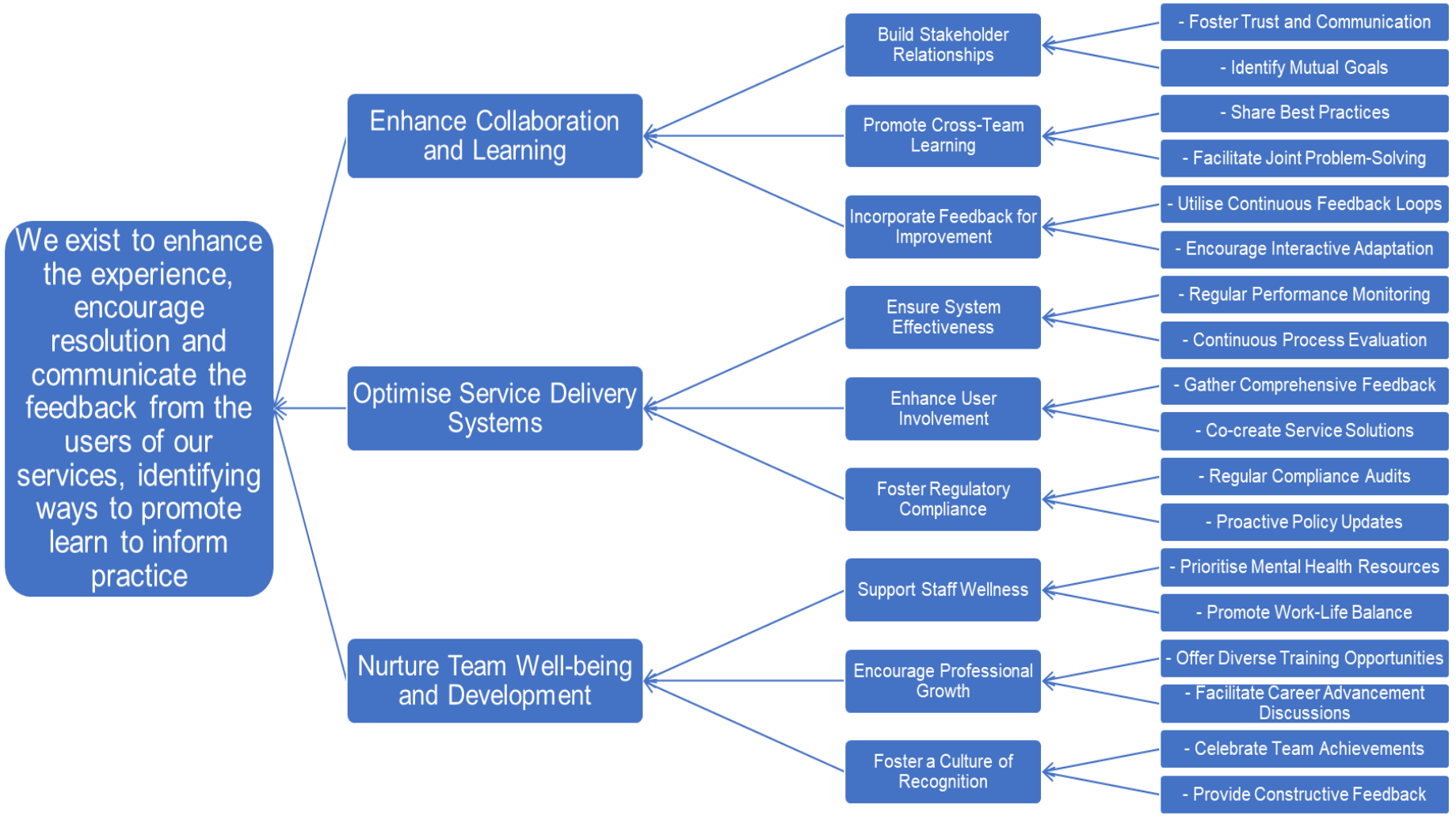
- Increase number of complaints resolved via local resolution.
- Increase number of complaints responded to within agreed timelines.
- Decrease number of complaints that are re-opened.
- Decrease number of average number of complaints received per month.

QI Project Driver Diagram (Please see page below)


AIM
PRIMARY DRIVERS
SECONDARY DRIVERS
CHANGE IDEAS
For ELFT to increase the monthly average of complaints completed within agreed timescales by 20% - by 1st April 2025
High Quality Responses
Supporting services by providing them with the correct tools, documentation and training to handle complaints in an effective and timely manner
Provide IO's with example response letters. Clarifying what makes the letter good and useful.
Enabling our IO's and complaint officers to appropriately proof read complaint responses, ensuring they are in line with standard template and house style before CEO sign off.
Produce monthly Complaints Department newsletter with hints, tips, data, advice and updates, congratulating successes.
Continue engaging People Participation service users to 'quality assess' response letters to complainants.
Create a consistent House Style letter and standard template incorporating Trust Values for investigators to use when responding to complaints.
Training
Providing training with the use of feedback and learning to better engage with staff and service users to address key issues
New IOs to receive more intensive support or perhaps shadow more experienced IOs.
Start to engage more with our service users/complainants and request feedback on the complaints process/ experience.
Provide support and training for IO to be better enabled to manage the emotional impact of investigating a complaint. This includes the impact of the IO and complainant.
Complaints training provided by PHSO- focussing on local resolution, investigation and complaint writing.
IOs to receive hands on training on how to write a helpful response letter - what to consider; when to expand vs keep succinct; what language and tone to use etc.
Time Management/ Efficiency
Implementing processes for ensuring services are completing complaints within local and legislative timescales.
Inphase access and training for IO's, so they can record their updates live on the system to prevent the need to chase.
Look to using current systems to draft responses on a live document, so that key stakeholders have access to it, and therefore can review progress rather than chase for updates.
Monthly reports to each borough with all the complaints and their status.
To have a process in place whereby service leads are 'held to account' for cases which have breached agreed timescales.
Review and amend the complaints policy to include a complexity matrix, which allows us to apply complexity to complaints and then determine an appropriate timeline.
Commence PALS clinics – to try and assist SU's with their concerns, without having to go through formal complaints process.
Staffing
Ensuring there is adequate human resources and capacity to manage complaints in a timely manner with a high quality response.
Add a sentence to 8A and above re job description/ include sentence where it states they may be required to act as complaints IO's
New staff that are 8A's and above - to attend complaints training within the first 6 months
Allocated IO's to be given 'protected time' to complete investigations and draft a response.
Train more staff as Complaints IO's, increasing the pool of staff available to investigate complaints.

4 Work plan for the coming financial year

4.1 Driver Diagram- Key priorities



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

We will be using the new InPhase system to collect the following data:

- Complaints received
- Complaints acknowledged within three working days
- Number of stage 1 complaints
- Number of stage 2 complaints
- Number of PALS inquires
- Number complaints closed within 25 working days/ agreed timeframe
- Number of complaints which have breached the agreed timeframe
- Common themes and trends
- Learning implemented by the directorates following outcomes action plans.

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

The complaints team will be providing the data outlined above; monthly to the Quality Assurance department; quarterly to the Patient Safety department; and quarterly to the Risk and Governance department.

The complaints management team will regularly review progress against the work plan, ensuring it continues to be achievable. If we detect key priorities may not be met and/or other priorities have been identified, this will then be reviewed with the corporate senior leadership team to assess how the plan can be adapted to try and achieve these priorities.

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

We will arranging both face to face and virtual meetings with the following stakeholders:

- Service users and/or their representatives
- Past complainants
- The People Participation Group
- Complaints leads across all directorates
- Learning leads across all directorates
- Performance leads across all directorates

4.5 Resourcing requirements or other risks to implementation.

A Head of Complaints and PALS Band 8a was appointed to the team on 3rd May 2023. As of January 2024 the department has been overseen and supported by a newly appointed Director of Nursing. There is a Band 7 Complaints manager; four Band 6 complaints officers; two Band 5 Assistant Complaints and PALS Officers (one

of which is fixed term maternity cover); Band 5 Governance Coordinator; and there are two PALS and Complaints Band 4 administrative support in place.

5 Action Being Requested

5.1 The Board/Committee is asked to receive, discuss and approve this report.

NHS
East London
NHS Foundation Trust

PALS & Complaints Policy

Version number :	9.0
Consultation Groups	Complaints and PALS Teams
Approved by (Sponsor Group)	Governance and Risk SMT
Ratified by:	Quality Committee
Date ratified:	October 2020
Name and Job Title of author:	Charlotte Walton Deputy Incidents and Complaints Manager Carole Shackleton, Complaints Manager
Executive Director lead :	Lorraine Sunduza Chief Nurse
Implementation Date :	November 2020
Last Review Date	November 2020
Next Review date:	November 2023

Services	Applicable to
Trust wide	√
Mental Health and LD	
Community Health Services	

Version Control Summary

Version	Date	Author	Status	Comment
1.0	07/12/00		Draft	
2.0	23/01/01		Final	
3.0	10/11/03		Revised draft	Updated in accordance with Risk Pooling Scheme for Trusts requirements and national guidance on investigating complaints.
4.0	15/11/04		Revised	Updated in accordance with reform of the NHS Complaints Procedure 2004
5.0	01/09/08		Revised	Updated to reflect NHSLA standards for complaints management process 2008
6.0	21/09/11	Claire McElwee – Complaints Manager	Revised	Updated in accordance with the Local Authority Social Services and NHS Complaints (England) Regulations 2009.
7.0	09/03/16	Claire McElwee – Complaints Manager	Revised - Final	Updated to reflect current practice, including the move of the Complaints to the Assurance Department.
8.0	16/03/18	Duncan Hall - Incidents and Complaints Manager	Revised	Updated to reflect current practice, changes to roles and responsibilities and recommendations made following Internal Audit Review
9.0		Charlotte Walton - Deputy Incidents and Complaints Manager	Revised	Updated to reflect new complaints handling process and changes to roles and responsibilities.

Contents

Executive Summary

- The policy emphasises that its guiding principle is that the process should be complainant-led and collaborative in approach.

- The policy describes the framework setting out how staff should deal with complaints about patient care and its services under the Regulations.

- The policy describes the specific duties and responsibilities of various staff groups.

- The policy sets out the principles for staff to follow along with specific guidance on complaint handling.

- The policy includes details of the various stages of the complaints process including local resolution and the process for escalation to independent review by the Parliamentary and Health Service Ombudsman (PHSO).

- The policy outlines how the organisation aims to improve its services by learning from complaints.

- The policy also details the Patient Advice and Liaison Services (PALS) within the Trust.

1 Introduction

East London Foundation Trust is committed to continually improving the quality of the care and services it provides. As part of this commitment it invites and welcomes the views of service users, carers and the local community. The guiding principle of its complaints procedure is that it is led by the complainant who will be fully consulted at each stage of the process. No complainant or the patient they represent will be treated less favourably on the grounds of age, creed, colour, disability, ethnic or national origin, medical condition or marital status, nationality, race, gender (at birth or reassigned), or sexuality, nor will a complainant be placed at a disadvantage by making a complaint.

Any complaint must be seen as an opportunity to continuously improve the quality of the services that we provide and to learn lessons from mistakes that may have occurred. Knowledge from handling complaints will be shared and applied across the Trust, to support service user experience, better risk management and effective clinical governance. In addition to this, the Trust is required to comply with the procedures for complaints handling in line with the Local Authority Social Services and NHS Complaints (England) Regulations 2009.

Complaints, comments or suggestions, whether oral or written made by service users or their representative, as well as information and subject access requests should be taken seriously, handled appropriately and sensitively. The Trust should always make every attempt to resolve complaints within the spirit of the Local Resolution principle. Service users should feel able to approach the staff that provided the service and staff should make every attempt to resolve complaints at an early stage.

The process should be fair, open, flexible and conciliatory and should be easy to access for all service users. It is essential that the service user, relative or carer is treated with respect and confident that there will be no adverse consequences as a result of raising concerns. Rigid, bureaucratic and legalistic approaches must be avoided.

As part of its commitment to accessibility, the Trust widely distributes posters and leaflets about the complaints procedures and PALs service within its clinical areas and on its website and provides a Freephone contact number and Freepost address.

2 Purpose

This purpose of this policy is to provide a robust framework for all staff involved with informal and formal complaints within the Trust, in line with the objectives of the Local Authority Social Services and NHS Complaints (England) Regulations 2009 (The Regulations) and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16.

This policy and the processes followed by the Trust are also underpinned by the Parliamentary and Health Service Ombudsman (PHSO) Principles of Good Complaint Handling and the Department of Health – Listening, Responding, and Improving: A guide to Better Customer Care (2009) and Healthwatch - Shifting the Mindset January 2020.

3 Scope

This policy is concerned with the handling of complaints and enquires about the staff and services of East London Foundation Trust and the procedures for local resolution. Staff concerns at work and complaints raised by professionals from within or outside the Trust will be dealt with via separate procedures. It will also uphold the framework that supports patients in meeting their information needs regarding all Trust services.

3.1 Complainants can be current or former service users, individuals referred to the Trust, or any person who is affected by or likely to be affected by the action, omission or decision of the Trust.

3.2 Other people may complain on behalf of an existing or former service user such as carers and relatives. However, their suitability to act as a representative will depend on a service user's explicit knowledge and written consent that a specific person may act on their behalf in relation to the

complaint. All complaints from third parties where the patient does not provide consent will be carefully considered and a decision taken about whether an investigation can proceed without the patient's consent. In responding, care will be taken not to disclose personal health information without the express consent of the service user. All complaints relating to patient safety and/or quality of care issues will be investigated irrespective of consent.

3.3 Where an existing or former service user has died, or where an existing or former service user lacks the capacity to consent, any person may complain on their behalf. Confidential clinical information relating to deceased patients falls under the Access to Health Records Act 1990. Therefore careful consideration must be given about whether the complainant is a suitable representative under this legislation. However, the Complaints Manager has the right not to accept a person as a suitable representative.

3.4 If it is decided that the complainant is not a suitable representative of a service user who is unable to give consent, or who has died, the Complaints Manager will inform them in writing, stating why the Trust has reached this decision.

3.5 Complainants also have a right to request access to their complaints file. These requests should be handled in accordance with the Trust's Access to Records Policy.

3.6 If the Trust receives any complaints about a member of staff allegedly causing harm to a person under the age of eighteen years, they will be investigated under a separate procedure, Management of Child Abuse Allegations Made Against Employees of ELFT. Following the completion of this investigation, a response will be provided under the complaints procedure.

3.7 Similarly, if the Trust receives any complaints about a member of staff allegedly causing harm to a vulnerable adult, the Trust will consider whether they should be dealt with under a separate policy, Management of Safeguarding Vulnerable Adult Allegations Made Against Employees of East London Foundation Trust and a response will be provided as detailed above.

3.8 In certain circumstances, it will be appropriate for concerns raised via complaints and PALS to be investigated under the Trust's Incident Policy. Following the completion of this investigation, a response will be provided under the complaints procedure. The complainant will be advised of the incident investigation and invited to contribute to that process as appropriate. They will also be given the choice to have their concerns fully included in the incident investigation or for the complaint to be investigated separately to any other investigation.

3.9 All individuals (service users, carers, relatives, stakeholders or staff) will be treated in an equitable manner, with respect for their views. They will have a right to comment on all services provided by the Trust and for their views to be properly considered.

3.10 Staff will always be polite and responsive to patients and people that they liaise with in order to address concerns.

3.11 Staff will not be judgemental when concerns and issues are raised.

3.12 Staff will not raise expectations by giving undertakings that might not be possible to meet.

3.13 All those that use the service have a right to privacy and confidentiality.

3.14 Staff will endeavour to keep individuals informed of progress and any actions taken or proposed.

4 Duties

Applying the principles contained within this policy is the responsibility of all staff. However, specific duties and responsibilities rest with designated groups and individuals:

4.1 The Trust Board

Has a duty to ensure there is a complaints policy and procedures in place and that these are widely publicised and available to all patients and staff and any persons who may be involved in the care of a patient on a personal or professional level. The Trust Board also has a responsibility to regularly review complaints data in order to make service improvements where necessary and ensure that any identified risks are effectively managed.

4.2 The Chief Executive

Has overall responsibility for the effective implementation of this policy and for responding to all formal complaints in writing. The Chief Executive is also the person with responsibility for ensuring that the Trust meets its obligations under the Regulations.

4.3 The Chief Nurse

Is the Trust Executive Lead for Complaints and has responsibility for presenting regular complaint reports to the Board and for ensuring that action is taken in light of the outcomes of any investigation.

4.4 Service/Borough Directors

Have responsibility for the investigation of all complaints relating to their areas of service and for ensuring that they are completed within the required time frame. Service directors have responsibility for ensuring that appropriately trained staff within their service are assigned to investigate complaints bearing in mind the need for objectivity, seniority, understanding and knowledge necessary to carry out a thorough investigation. Service directors also have a responsibility to ensure that any staff member identified in the complaint/complaints investigation is given the opportunity to participate in the investigation and is given a copy of the original complaint letter and a copy of the final response.

4.5 Associate Director of Governance and Risk Management

Has responsibility for providing the Chief Nurse and the service directors with regular complaints monitoring reports and for monitoring the actions taken by services in light of outcomes of investigations. The Associate Director of Governance and Risk has responsibility for reporting compliance to the Service Delivery Board and reporting on a regular basis to the Quality Committee and Trust Board.

4.6 The Incidents & Complaints Manager

Has day to day corporate responsibility in the direction and management of the Trust's integrated incident and complaints processes. The Incidents and Complaints Manager will ensure effective systems are in place for reporting, investigating and managing incidents and complaints and will provide credible, visible and effective leadership.

4.7 The Deputy Incidents & Complaints Manager

Has responsibility to support the Incidents and Complaints Team Manager in the management of the Trust's integrated incident and complaints processes and oversight of the complaints process through the provision of monthly reporting and monitoring, investigating and managing incidents and complaints, training and supporting all Trust staff.

4.8 The Complaints Team Manager

Has responsibility for managing the complaints function of the Trust, which includes ensuring that all staff have the appropriate training and support to enable them to respond to informal and formal complaints. The Complaints Team Manager is responsible for monitoring the quality of information recorded on DATIX, investigations and action plans. The Complaints Team Manager is responsible for monitoring the quality of investigations to ensure that remedial action is taken and in the event of

an incomplete investigation escalate concerns to the appropriate Service Director and Deputy Incidents & Complaints Manager.

5 Definitions

Formal Complaints
A concern raised by a complainant which it has not been possible to resolve informally, or where after discussion, the complainant has expressed a wish for their concerns to be subject to a formal investigation. Formal complaints can be made verbally or by written means (postal or electronically). Staff will provide the complainant with clear and comprehensive information about the range of complaint handling options, to enable them to make an informed decision as to whether they would like the complaint to be handled.

5.1 PALS (Patient Advice and Liaison Service) Enquiries
Informal concerns, complaints and enquiries can be received from patients/service users and/or their families where the preference of the complainant is for these concerns to be resolved informally.

The Regulations provide that an inquiry, suggestion, comment or issue of concern made orally and resolved to the complainant's satisfaction by the next working day does not need to be dealt with as a formal complaint. It should be normal practice for staff to communicate directly with the complainant, and staff should feel empowered to resolve issues without the need for them to go through the complaints process.

In all cases, staff should provide the complainant with clear and comprehensive information about the range of complaint handing options, to enable them to make an informed decision as to whether they wish for the complaint to be handled informally or formally. In all instances, staff must clarify with the complainant what their concerns are and what the desired outcome is. Where the complainant accepts the response as being satisfactory and appropriate there will usually be no need for further action. However, it is important for staff to recognise that there may be issues that need to be brought to the attention of senior managers in the organisation such as issues of patient safety.

PALS enquiries should be resolved within 48 hours to the individual's satisfaction. If this is not achievable the formal complaints route may be pursued in accordance with the individual's wishes.

Please see section 10 for further details of the PALS interface and functions.

5.2 Complaints not required to be dealt with (Regulation exemptions)
Under the Regulations 2009, there are types of complaints that the Trust is not required to investigate under a formal complaints procedure; please see **appendix 5** for details.

6 Principles of Complaints Handling

The guiding principle of all complaint handling is that it should be complainant-led and collaborative in approach. This should involve the complaints department actively seeking out the views of the complainant at each stage of the process. In handling complaints, the Trust endeavours to adhere to the Ombudsman's Principles of Good Complaint Handling including:

- Getting it right by acting in accordance with the law and relevant guidance
- Being customer focused
- Listening to the complainant to understand their concerns and the outcome they are seeking
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

6.1 Time Limits for Formal Complaints

Under the aforementioned regulations, complaints must be made within twelve months of the event complained about or twelve months of the complainant becoming aware of the issues. The Trust has the power to exercise its discretion to investigate complaints outside of this time frame. In such cases, a desktop review will be undertaken to establish whether a viable investigation may be undertaken.

6.2 Confidentiality

It is essential when dealing with complaints that employees of the Trust observe the legal obligation not to release information relating to the patient to a third party without appropriate consent.

6.3 Protecting Complainants and Patients

The Trust is committed to ensuring that patients, their relatives and their carers are not treated differently as a result of making a complaint. It is Trust procedure that all records relating to the complaint and its investigation are held separately from the patient's clinical records. Information about the complaint should only be disclosed between members of staff on a need to know basis and where it has a direct bearing on the patient's clinical care.

6.4 A Comprehensive Duty of Care

When handling and investigating complaints the Trust has an obligation to address all issues of concern, including those expressly stated in the complaint, as well as any other concerns which are identified during the process of complaints handling and investigation e.g. safeguarding and equality issues.

6.5 Consent

Where a complaint is raised by a third party, the complaints department will seek consent from the patient for the complaint to be investigated under the complaints process, and for confidential clinical information to be disclosed. However, as stated above, any concerns relating to patient safety will be investigated by the Trust. This section will not apply where the patient lacks capacity; the patient is a child or has died which are dealt with under separate headings.

6.6 Capacity

Where a patient lacks capacity to make a decision about whether their personal information is disclosed to another party, the Trust will assess whether the complainant is an appropriate representative e.g. holds Power of Attorney for Health and / or is the identified Next of Kin. Additionally, where appropriate, in cases where a patient's capacity is uncertain, a clinician's view on capacity will be sought before any personal information is disclosed. In these circumstances a complaint may be put on hold if it is deemed to be in the patient's best clinical interests.

6.7 Complaints received about a child

In line with the regulations, where a representative makes a complaint on behalf of a child, the Trust will consider whether it is satisfied that it is reasonable for the complaint to be made by the representative instead of the child. If the Trust is not satisfied, it will notify the representative in writing, stating reasons for its decision.

6.8 Complaints relating to the care of deceased service users

When dealing with complaints regarding the care of a deceased service user, careful consideration must be given to what information can be disclosed to the complainant. In such circumstances staff should be guided by principals of the Access to Health Records Act 1990 (deceased patients only) where applications for records or personal information can only be granted to legal representatives of the estate or to someone having a claim arising out of the death.

6.9 Appropriate Representation

With reference to consent, capacity and representation, the complaints department will consider whether the complainant is a suitable representative of the patient and if it is not satisfied it will notify the representative in writing and state the reason for its decision. In doing so, the complaints department will take account of relevant legislation such as the Data Protection Act, Access to Health

Records Act and the Mental Capacity Act. In any event the Trust will review the concerns raised and report internally on its finding and apply learning as necessary.

6.10 Interagency Complaints

When the Trust receives a complaint which appears to span more than one organisation, including the local authority, the complaints department will contact the complainant to establish whether they require a single or joint response, or where appropriate, a meeting. The complainant's agreement to share the complaint with the other organisation(s) must be obtained.

The complaint will then follow the usual process for ELFT's input and the complaints team will work with the complaints departments of the other organisation(s) to ensure co-ordinated handling and to provide the complainant with a single response which covers all aspects of the complaint. This might not apply to integrated services.

6.11 Complaints from external bodies directly into Trust Services

Complaints received into the Trust from the Care Quality Commission (CQC), Member of Parliament (MP), Councillor, Parliamentary and Health Service Ombudsman (PHSO), Healthwatch, and any other external organisation must be forwarded to the complaints department immediately on receipt.

6.12 Transferred services

Where ELFT acquire a new service, a specific member of staff will be allocated to liaise with the other organization about every complaint that requires handover, and support the complainants who are affected by the transition of services, advising them of the organisational transfer, and which organisation will have overall responsibility for the continued handling of their complaint. All new complaints received after the date of this handover will be managed by ELFT.

6.13 Information for the complainant

The Trust is committed to ensuring that information about how to access the complaints procedure is widely available in an accessible form. On receipt of a complaint, the complaints department will ensure that any additional information required by the complainant is provided.

6.14 Support for the complainant

The support needs of the complainant should be established at the outset in order for the complaint process to be as accessible as possible. This should take into the potential need for involvement of PALS, Advocacy, and Interpreting and Translation Services. Details of advocacy services are provided to every complainant when acknowledging their complaint.

6.15 Being Open/Duty of Candour

Open effective communication with service users, their relatives and carers is central to the process of complaint handling and addressing negative experiences of the care and service provided. It is important that the Trust acknowledges where mistakes have been made and apologises. The Trust must also explain what happened in terms of care and service delivery problems, any remedial response and longer term action required in order to minimise the likelihood of recurrence.

In cases where moderate and above harm has been or is suspected to have been caused, the Trust will undertake its responsibilities under Duty of Candour in accordance with the applied statutory framework, in line with the incident reporting policy. Complaints pertaining to harm being caused will be cross referenced against the Trust's incident management system to ensure an incident report has been raised.

6.16 Support for Staff

It is important that staff who are subject to a complaints investigation, have confidence in the Trust's complaints procedures and experience it as being fair and objective. The Trust will provide general training for its staff on the complaints procedure as part of its induction, as well as specific training session on its complaints policy and procedure. Staff can access advice about the complaints procedures and how they might be supported, from their line manager and the complaints department. In addition, as noted, staff will be provided with a copy of any complaint where they are named and a copy of the Trust's response. Regular reports are provided to each Directorate to enable

managers to ensure that staff are adequately supported. As part of the support process the line manager must ensure that all staff are aware of how to seek additional support. If the staff member is experiencing difficulties associated with the complaint, then a referral to Occupational Health services should be made. The Trust has an 'Employee Assistance Programme' in place. The scheme is a 24 hour, 7 days a week, free and confidential support service available to all Trust employees.

Employee Assistance Programme Tel: 0800 282 193.

6.17 Dealing with Aggressive/Threatening or Vexatious and Persistent Complainants

On rare occasions despite the best efforts of staff, complainants may be aggressive, threatening, vexatious or persistent. This may negatively impact both on their own and or other's investigations, health & wellbeing and the Trust's resources.

Where complainants repeatedly contact the complaints department or the clinical services where they are being treated with the same issues, where the substance of a complaint continually changes or the complainant continually raises new issues, a discussion will take place between the Complaints Team Manager and Deputy Incidents and Complaints Manager, and other senior staff as required to agree an appropriate management plan.

If the actions of the complainant are considered to be inappropriate, the complainant will be informed via email or letter of the Trust's consideration to implement the Persistent Complainants procedure. If this procedure is implemented, a letter signed by the Chief Executive will be sent to the complainant outlining the plan; please see **appendix 5.**

6.18 Conflict of Interest

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role, is or could be impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur.

Any member of staff directly involved with a complaint investigation should declare to the Complaints Manager if there is a conflict of interest as soon as they become aware, in line with the Trust's Standards of Business Conduct Policy and will be required to sign a declaration, to that affect, at the point at which that they begin their investigation.

7 Complaints Process

Complaints should, whenever possible, be resolved at the time by front line staff. If the complaint is resolved to the complainant's satisfaction it does not need to be handled via the Trust's formal complaints procedures. In situations where front line staff are unsure about the seriousness of the complaint or if it is felt that issues of patient safety are involved, advice should always be sought from the complaints department.

7.1 On receipt of a complaint, the complaints department will establish whether the complaint falls within the remit of the regulations and record the complaint on DATIX (the Trust complaints database). The complaints department will acknowledge receipt of the complaint in writing within three working days.

7.2 Complaints will be graded according to seriousness (high, medium and low). The investigation of any complaint that has an initial 'high' grading will be brought to the attention of the Chief Nurse and Chief Medical Officer via the Trust's serious incident grading panel where a decision will be made as to whether this case will be subject to a serious incident review.

The complaints process will be put on hold until a serious incident investigation has been completed. Any concerns not covered in the serious incident review will be addressed through the complaints process.

7.3 A Complaints Higher Level Committee meet on a weekly basis to review complex complaints providing oversight on progress and learning outcomes.

7.4 Any complaint that fulfils the criteria of an incident (see the Trust's Incident Policy) should be searched for on the incident module on DATIX. The complaint record should be linked to the incident record and the incident details forwarded to the directorate to assist in their investigation.

7.5 All information relating to the complaint will be forwarded to the locality, along with supporting documents, including guidance on investigations and responding to a complaint. The locality will appoint someone appropriate to review the complaint, conduct a preliminary investigation and contact the complainant to discuss their concerns – stage 1. At this stage it might be possible to resolve the complaint and identify any learning without further investigation. This will then be agreed with the complainant and a written response offered summarising the outcome. The complaints department will be updated accordingly and the complaint will be closed.

7.6 If it is not possible to resolve the complaint under stage 1, an investigating officer will be appointed and it will progress to stage 2. An investigating officer will be appointed, whose day-to-day function sits outside that of the team subject to the investigation. They will contact the complainant to discuss how they would like their complaint handled and establish the preferred method of communication, timescale and any other requirements, including support needs or interpreting or translating needs. The investigating officer will update the complaints department accordingly.

7.7 The Regulations stipulate that a complaint must be responded to within six months. The Trust aims to respond to those that are considered straightforward in 25 working days. However, in circumstances where complaints are complex, being investigated under other procedures, involve other agencies or where the witnesses are not available, the investigation will take longer. Time scales will therefore be negotiated by the investigating officer with the complainant.

7.8 There may be times when extensions to an investigation time scale are required. All extension requests must be made by the investigating officer to the Complaints Manager. Where it becomes evident that a response will not be sent within the agreed time scale, the investigating officer will contact the complainant to apologise, provide reasons for the expected delay and provide a new timescale for the response. Please see **appendix 3** for extension process.

7.9 After investigating the complaint, the investigating officer will write a draft response that addresses the issues contained within the complaint and aim to satisfy the complainant that their concerns have been taken seriously. It should offer an explanation and an appropriate apology, and refer to any recommendations and/or remedial action that has and will be taken. The response will be reviewed by the complaints department before being personally signed by the Chief Executive. A copy of the signed final response, together with any attachments will be recorded on DATIX. Please see **appendix 1**, complaints handling process chart.

7.10 The response will provide details of how to seek an independent review by the PHSO and encourage the complainant to contact the Trust if they are dissatisfied with the content, or require clarification. In such a case, the Trust will undertake further action as necessary to resolve any outstanding issues and to bring about a more satisfactory resolution for the complainant. If the Trust reaches the view that nothing further may be achieved, the complainant will be advised of this and provided again with details of the PHSO.

7.11 Any formal complaint which includes a request for compensation or reimbursement (made by any source i.e. the complainant, legal representation, PHSO) should be copied to the Legal Services Team immediately on receipt. Once the draft response is completed and compensation/reimbursement is recommended, the response will be sent to the Legal Services Team outlining the outcome of the investigation.

7.12 In the case of PHSO investigations, if compensation is recommended then this should be forwarded to the Legal Services Team to see if they approve the award.

7.13 When a compensation/reimbursement request that was made as part of the formal complaints process is approved, an ex-gratia form should be completed by the locality along with their budget code. This form will be processed by the Legal Services Team who will then notify the complaints department when the cheque is ready for collection. The cheque will be sent to the complainant via recorded/special delivery.

When a compensation/reimbursement request is made outside of the formal complaints process (i.e. via PALS), this will be forwarded to the Legal Service Team and the relevant locality.

In the rare event that a complaint has been escalated and is being dealt with via the Chair's office, the complainant will no longer liaise with the complaints department and will be redirected to the Chair's PA.

8 Improvement through learning from complaints

Effective complaint handling is an important driver for service improvement. The Trust welcomes complaints as an opportunity to learn and improve its services and seeks to adopt a non-defensive approach to complaints.

Where complaint investigations result in recommendations and actions, these must be SMART (specific, measurable, achievable, realistic and timely). These actions will be documented on DATIX with allocated leads and completion timelines. They will be monitored locally by the directorate's governance department and centrally by the complaints department. If actions have not been completed, the reasons for this should be explored and every effort should be made to implement the necessary changes. Once an action plan has been completed, the complaints department will write to the complainant with details of the improvements that have been made within the service.

8.1 The Trust collates complaints data, including the number of complaints received and timeliness in responding, as well as themes, trends and actions implemented. This data forms part of regular integrated governance reports which are considered at Trust wide committee level and is used to inform the Training Needs Analysis and high level discussion about identified themes and issues relating to Trust wide quality and safety issues.

8.2 The Trust holds twice yearly learning from complaints events with a focus on evaluating the complaints processes within the Trust and improving patient safety and experience. A range of stakeholders are invited to attend the events including complainants, commissioners, health watch, service representatives and local advocacy groups.

8.3 Individual teams are expected to regularly review outcomes of complaints about their service, to gain insight into shortcomings in service delivery, with a view to identifying wider areas for improvement.

8.4 Where a staff member is named in a complaint, it is a requirement that the staff member's supervisor and/or line manager supports them through the investigation process and discusses the outcome with the staff member, to ascertain whether or not there are any individual practice issues that need to be addressed or from which learning can be derived.

9 Monitoring and Control

This document will be ratified by the Quality Committee and any review of it will be agreed and signed off by the Quality Committee.

9.1 This document will be disseminated to all staff via the Trust e-mail system and will be accessible to all staff via the Trust intranet and members of the public via the Trust website. Implementation of this document is detailed in the policy implementation plan that will accompany it at the review stage.

9.2 Monitoring of compliance with the procedures and principles within this policy is done via the quarterly Integrated Governance Report provided to the Quality Committee, by local directorate governance

reporting and day to day oversight by the Complaints Manager and Deputy Incidents & Complaints Manager.

9.3 Complaints data is recorded using the DATIX complaints module and reports are regularly produced that capture the numbers of complaints received, the category of complaint and the outcome of the complaint.

9.4 The Trust will have regard to the number of cases referred to the PHSO. In addition, the Trust will take account of the outcome of the PHSO's review of its complaints handling and any lessons that can be applied to increase compliance with the regulations thereby improving the experience of its services users.

10 Patient Advice and Liaison Service (PALS)

The PALS service is designed to act as an independent facilitator in addressing the informal concerns, with the power to negotiate immediate solutions or resolutions of issues as speedily as possible. It provides accurate information on all aspects of the Trust, including how to make a formal complaint about Trust services.

10.1 As a result of early intervention, PALS expects to reduce the number of concerns that escalate into a formal complaint. However, there is no requirement for individuals to use the PALS before they can make a formal complaint and it is the choice of the individual to use either the formal complaints process, or the PALS.

PALS does not aim to reduce complaints to the Trust but to work with individuals to obtain the best possible outcome for them and to ensure the Trust learns from the persons experience. This may involve a significant amount of signposting to other services and agencies, both internally and externally.

10.2 It is important that details of the enquiries dealt with by the PALS are recorded and monitored. PALS data is recorded on DATIX and reports are regularly produced that capture the numbers and category of the enquiries received.

10.3 PALS operate an open referral system by which anyone can self-refer or refer someone to PALS. As such, individuals may contact PALS:

- In person (by drop-in* or appointment*).
- By telephone
- Through Trust staff
- By returning a completed PALS card.
- By referral of an external source.
- By email

*PALS clinics where applicable

The service is accessible Monday to Friday from 9.00am to 5.00pm via a Freephone facility to ensure free and easy access to the service. Outside these times, an answer machine will be available where individuals can leave brief details and they will be contacted as soon as the message has been retrieved. In addition, the Trust has a postal free address for surface mail and an electronic mail address for users to contact over the Internet.

PALS FREEPHONE: 0800 783 4839

PALS FREEPOST:
FREEPOST RTXT-HJLG-XEBE
Complaints Department
The Green

1 Roger Dowley Court
Russia Lane
London E2 9NJ

PALS Email: elft.pals@nhs.net

11 References

1. The Local Authority Social Services and National Health Services Complaints (England) Regulations 2009

2. The Health Service Ombudsman - Principles of Good Complaints Handling (2009)

3. Department of Health - Listening, Responding, Improving: A Guide to Better Customer Care (2009)

4. Secretary of State for Health – Government Response to the House of Commons Health Select Committee Sixth Report of Session 2010-2011: Complaints and Litigation (2011)

5. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 16

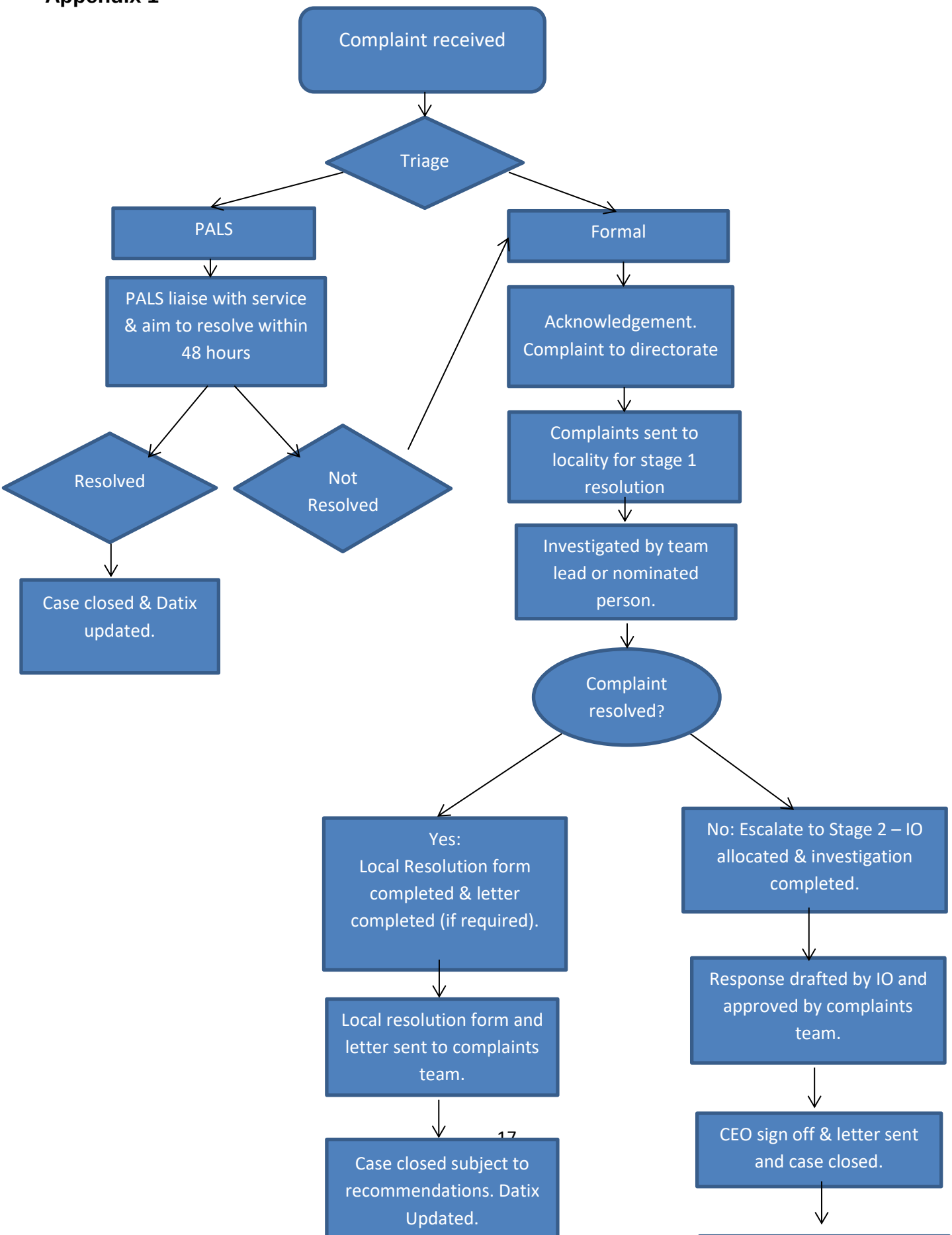
6. East London NHS Foundation Trust Standards of Business Conduct Policy.

7. Healthwatch - Shifting the Mindset January 2020.

Appendices

Appendix 1	Complaints process
Appendix 2	Complaint Review (comeback) process
Appendix 3	Complaint Investigation Extensions process
Appendix 4	Persistent Complainant process
Appendix 5	Complaints not required to be dealt with under a formal process

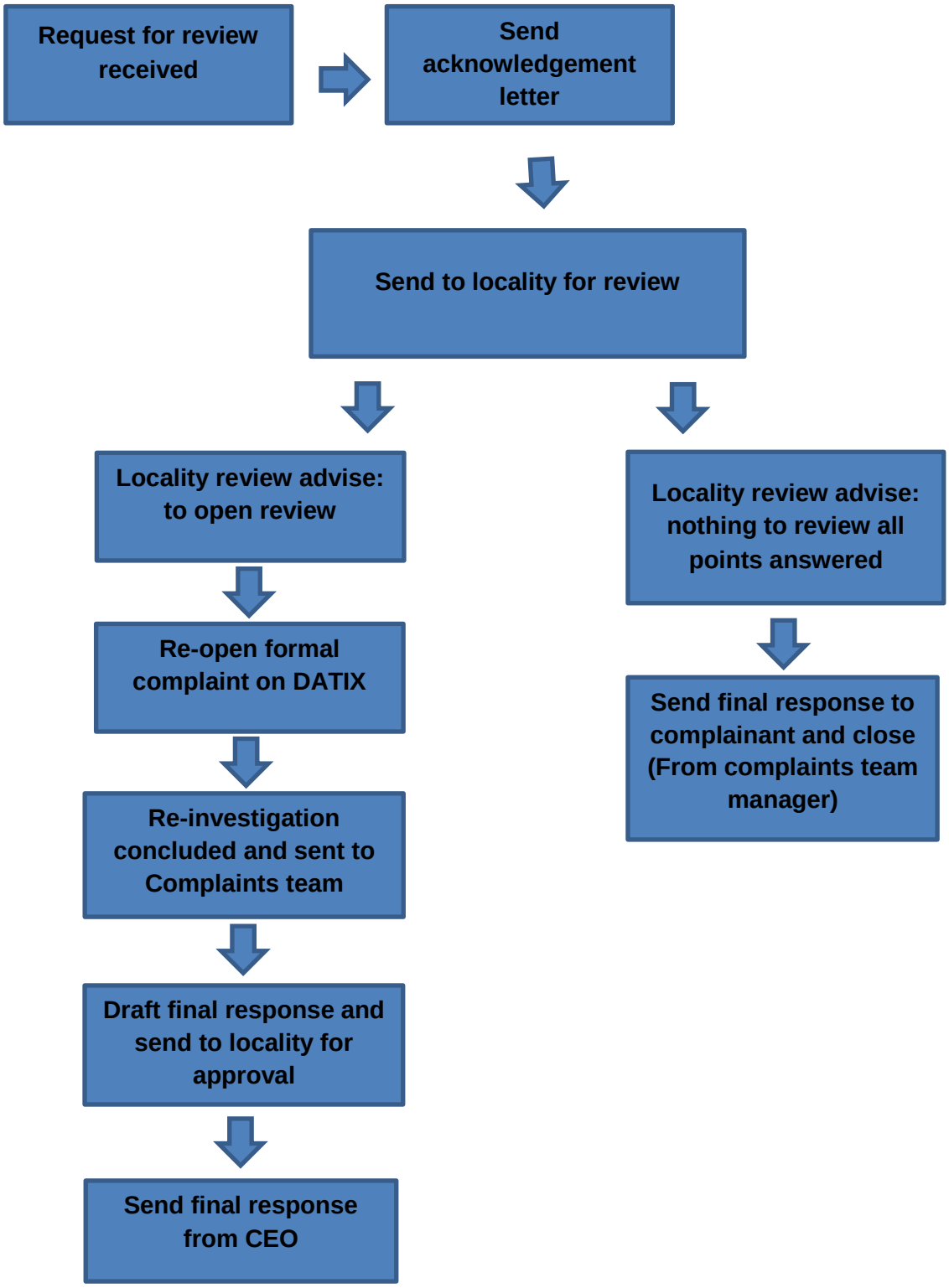
Appendix 1


Complaint received
Triage
PALS
PALS liaise with service & aim to resolve within 48 hours
Resolved
Not Resolved
Case closed & Datix updated.
Formal
Acknowledgement. Complaint to directorate
Complaints sent to locality for stage 1 resolution
Investigated by team lead or nominated person.
Complaint resolved?
Yes: Local Resolution form completed & letter completed (if required).
Local resolution form and letter sent to complaints team.
Case closed subject to recommendations. Datix Updated.
No: Escalate to Stage 2 – IO allocated & investigation completed.
Response drafted by IO and approved by complaints team.
CEO sign off & letter sent and case closed.

Appendix 2

Complaint response review/comeback process

If a complainant is unhappy with the response to the complaint, then the case can be reviewed.



Appendix 3

Complaint investigation extensions process

There are occasions where an extension is required to complete the investigation.

All extension requests must be forwarded to the Complaints Manager for approval.

Valid reasons for an extension include:

- Complexity – once an investigation commences it may become apparent that additional time is needed to undertake a thorough investigation
- Number and type of points raised by complainant – sometimes these include in excess of twenty points. Where there is a high number or the concerns raised cover several areas it may be necessary to grant an extension
- Absence of key witnesses/interviewees (where it is not possible to meet/interview within the timescale)
- Investigation report does not capture all the points raised and further investigation is required

Circumstances where an extension will not be granted:

- Acknowledgement not completed on time
- Inability to keep to agreed timescales for no valid reason
- Annual leave of investigating officer

Following the outcome decision, the investigating officer should contact the complainant and advise them of the planned extension and rationale and the revised completion date. If an extension has not been granted and there is an expected delay in responding, the complainant should be informed of the expected delay in providing their response. In all cases, DATIX must be updated by the complaints department with the outcome decision and summary of contact with the complainant.

Extensions should be obtained as soon as possible and not left to the last minute, and the timeframes must account for the time required by the investigating officer and the internal quality assurance process.

Appendix 4

Persistent Complaints procedure

Introduction

Unreasonable persistent complainants, although they are a small part of the complaints the Trust receives, they represent a particular problem in the resolution of complaints. The difficulty in handling such complainants places a significant strain on time and resources and can be demoralising for staff. The Trust's staff are trained to respond sensitively to the needs of all complainants, but there are times when there is nothing further that can be done to assist them or to rectify a real or perceived problem. This procedure has been created to ensure a joint understanding of what is considered as acceptable and unacceptable behavior.

Implementing this procedure should be a last resort and after all reasonable measures have been taken to try to resolve complaints following the Trust policy and procedure.

The procedure is also designed to protect and support staff who are the subject of persistent complainants and to maintain the integrity of the complaints procedure.

Definition of unreasonably persistent behavior

Complainants may be deemed to be unreasonably persistent where current or previous contact with them shows that they have met two or more (or are in serious breach of one) of the following criteria:

- Persisting in pursuing a complaint where the NHS complaints process has been fully and properly implemented and exhausted. For example, where investigation is deemed to be 'out of time' or where the PHSO has declined a request for independent review.

- Persisting in pursuing a complaint with the Trust in preference to contacting the PHSO for independent resolution

- Repetition of a previous complaint where the Trust Complaints procedures has been implemented and exhausted.

- The substance of a complaint is changed or new issues are raised persistently or complainants seek to prolong contact by unreasonably raising further concerns or questions during the complaints process or upon receipt of a response whilst the complaint is being dealt with. Care must be taken not to disregard new issues which differ significantly from the original complaint – these may need to be addressed as separate complaints.

- Complainants who are unwilling to accept documented evidence of treatment given as being factual or deny receipt of an adequate response despite correspondence specifically answering their questions/concerns. This could also extend to complainants who do not accept that facts can sometimes be difficult to verify after a long period of time has elapsed.

- Complainants do not identify clearly the precise issues they wish to be investigated despite reasonable efforts to help them do so by Trust staff and/or other agencies, e.g. by referral to Independent Complaints Advocacy, conciliation/mediation.

- The concerns identified are not within the remit of the Trust to investigate.

- Complaints focus on a trivial matter to an extent which is out of proportion to its significance and continue to focus on this point. It should be recognized that determining what is trivial can be subjective and careful judgement must be used in applying the criterion.

- Aggressive, rude or physical violence has been used or threatened towards staff or their families/associates at any time. This will in itself cause personal contact with complainant and/or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication. All such incidents should be documented on DATIX and reported, as appropriate, to the police.

- Complainants have, in the course of pursuing a registered complaint, had an excessive number of contacts with the Trust placing unreasonable demands on staff. Such contacts may be in person, by telephone, letter, fax or electronically. Discretion must be exercised in deciding how many contacts are required to qualify as excessive, using judgement based on the specific circumstances of each individual case.

- Complainants have harassed or been abusive, including racist, sexist or homophobic abuse, or verbally aggressive on more than one occasion towards staff dealing with their complaint. If the nature of the harassment or aggressive behavior is sufficiently serious, this could, in itself, be sufficient reason for classifying the complaint as unusual. Staff must recognize that complainants may sometimes act out of character at times of stress, anxiety or distress and should make reasonable allowances for this. All incidents of harassment or aggression must be documented on DATIX and dated.

- Requests may be considered unreasonable by the nature and scale of service expected. Examples of which are requesting responses within an unreasonable timescale or insisting on speaking with only certain members of staff or by contacting many staff members and third parties which could be detrimental to investigating the complaint.

- Complainants have been known to have electronically recorded meetings or conversations without the prior knowledge and consent of the other parties involved. It may be necessary to explain to a complainant at the outset of any investigation into their complaint(s) that such behavior is unacceptable and can, in some circumstances, be illegal.

- Complainants have made defamatory comments about staff to the media (local, national and or social media.

Options for dealing with unreasonable, persistent complainants

When the complainant is deemed to be considered as an unreasonable, persistent complainant, the Complaints Team in consultation with the Incidents & Complaints Manager and the Associate Director of Governance and Risk Management will write to the complainant advising them that their behaviour may be considered to be unreasonable and or excessively persistent. They will be asked to consider their further contact with the Trust. The letter will advise the complainant that if there is no change in their behaviour the Persistent Complaints Procedure will be invoked.

This procedure maybe implemented at any time during a complaint investigation; however the implementation will not stop the complaint investigation.

This notification must be copied promptly for the information of others already involved in the complaint. A record must be kept, for future reference, of the reasons why a complainant has been classified as unreasonable or excessively persistent and the actions taken. All supporting evidence in dealing with this type of complaint must be documented and retained on the complaint file for future reference.

The Trust may decide to deal with persistent complainants in one of the following ways:

- Where complainants have been identified in accordance with the above criteria, the chief executive, in consultation with the complaints manager and the clinical team will determine what action to take.

- Try to resolve matters before invoking this procedure, and/or the sanctions detailed within it, by drawing up a signed agreement with the complainant setting out a code of behavior for the parties involved if the Trust is to continue dealing with the complaint. If this agreement is breached consideration would then be given to implementing other actions as outlined below. Clinicians should be consulted and involved in drawing up such an agreement.

- Decline further contact with the complainant either in person, by telephone, fax, letter or electronically or any combination of these, provided that one form of contact is maintained. Alternatively, further contact could be restricted to liaison through a third party.

- Inform complainants that in extreme circumstances the Trust reserves the right to refer persistent complainants to the Trust's solicitors and/or, if appropriate, the police.

- Temporarily suspend all contact with complainant(s), or investigation of a complaint, whilst seeking legal advice or guidance from the NHS England or the Department of Health. However, this must not intervene with the provision of care and service delivery to any individuals involved in the complaint who are in direct receipt of care from the Trust.

Withdrawing persistent complainant status

Once complainants have been classified as unreasonably persistent, there needs to be a mechanism for withdrawing this status if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which the normal complaints procedures would be appropriate.

When recommending that such status should be revoked, discussions will be held with the chief executive, the clinical team and the complaints department and, subject to approval, normal contact with complainants and application of the NHS complaints procedures will be resumed.

Implementation of the policy will be kept under review and a decision will be made on the continuation/cessation of the status. Clinical teams and front line staff should work closely with the chief executive and complaints department in reviewing the policy.

Appendix 5

Complaints not required to be dealt with under a formal process

(As taken from the Regulations 2009)

The following complaints are not required to be dealt with in accordance with these Regulations:

(a) a complaint by a responsible body;

(b) a complaint by an employee of a local authority or NHS body about any matter relating to that employment;

(c) a complaint which:

(i) is made orally; and

(ii) is resolved to the complainant's satisfaction not later than the next working day after the day on which the complaint was made;

(d) a complaint the subject matter of which is the same as that of a complaint that has previously been made and resolved in accordance with sub-paragraph (c);

(e) a complaint the subject matter of which has previously been investigated under:

(i) these Regulations;

(ii) the 2004 Regulations, in relation to a complaint made under those Regulations before1st April 2009;

(iii) the 2006 Regulations, in relation to a complaint made under those Regulations before1st April 2009; or

(iv) a relevant complaints procedure in relation to a complaint made under such a procedure before 1st April 2009;

(f) a complaint the subject matter of which is being or has been investigated by:

(i) a Local Commissioner under the Local Government Act 1974(19); or

(ii) a Health Service Commissioner under the 1993 Act;

(g) a complaint arising out of the alleged failure by a responsible body to comply with a request for information under the Freedom of Information Act 2000(20); and

(h) a complaint which relates to any scheme established under section 10 (superannuation of persons engaged in health services, etc.) or section 24 (compensation for loss of office, etc.) of the Superannuation Act 1972(21), or to the administration of those schemes.

(2) Where a responsible body decides that a complaint is a complaint specified in paragraph (1):

(a) it is not required to consider the complaint, or consider it further, under these Regulations; and

(b) except where the complaint is a complaint specified in paragraph (1)(c), it must as soon as reasonably practicable notify the complainant in writing of its decision and the reason for the decision.

(3) Where a complaint specified in paragraph (1) is part of, or is connected with, another complaint which is not so specified, nothing in this regulation prevents that other complaint being handled in accordance with these Regulations.

STATUTORY INSTRUMENTS

2009 No. 309

NATIONAL HEALTH SERVICE, ENGLAND
SOCIAL CARE, ENGLAND

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

Made - - - - 23rd February 2009

Laid before Parliament 27th February 2009
Coming into force in accordance with regulation 1(2) and (3)

The Secretary of State, in exercise of the powers conferred by sections 113(1), (3) and (4), 114(1), (2) and (5), 115(1), (2), (4) and (5) and 195(1) and (2) of the Health and Social Care (Community Health and Standards) Act 2003(**1**), makes the following Regulations:

PROSPECTIVE

Citation, commencement, effect and application

1.—(1) These Regulations may be cited as the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

(2) These Regulations, except for regulations 2(3) and 11, come into force on 1st April 2009.

(3) Regulations 2(3) and 11 come into force on 1st April 2010.

(4) The following provisions shall cease to have effect on 1st April 2010—

(a) regulation 2(2); and

(b) regulation 10.

(5) These Regulations apply in relation to England.

Commencement Information

I1 Reg. 1 in force at 1.4.2009, see **reg. 1(2)**

(**1**) 2003 c. 43.

Interpretation

2.—(1) In these Regulations—

"the 1993 Act" means the Health Service Commissioners Act 1993(**2**);

"the 2004 Regulations" means the National Health Service (Complaints) Regulations 2004(**3**);

"the 2006 Act" means the National Health Service Act 2006(**4**);

"the 2006 Regulations" means the Local Authority Social Services Complaints (England) Regulations 2006(**5**);

"adult" means an individual who has attained the age of 18;

"adult social care" means social care within the meaning of Part 1 of the Health and Social Care Act 2008(**6**) which is provided to an adult;

"adult social care provider" means a person or body who carries on an activity which—

(a) involves, or is connected with, the provision of adult social care; and

(b) is a regulated activity within the meaning of Part 1 of the Health and Social Care Act 2008;

"child" means an individual who has not attained the age of 18;

"complaints manager" means the person designated in accordance with regulation 4(1)(b);

"local authority" means—

(a) a county council in England;

(b) a metropolitan district council;

(c) a non-metropolitan district council for an area for which there is no county council;

(d) a London borough council;

(e) the Common Council of the City of London; or

(f) the Council of the Isles of Scilly;

"general dental services contractor" means a person or body who has entered into a general dental services contract with a Primary Care Trust in accordance with section 100 of the 2006 Act;

"general medical services contractor" means a person or body who has entered into a general medical services contract with a Primary Care Trust in accordance with section 84 of the 2006 Act;

"general ophthalmic services contractor" means a person or body who has entered into a general ophthalmic services contract with a Primary Care Trust in accordance with section 117 of the 2006 Act;

"Health Service Commissioner" means the person appointed Health Service Commissioner for England in accordance with section 1 of, and Schedule 1 to, the 1993 Act;

"independent provider" means a person or body who—

(a) provides health care in England under arrangements made with an NHS body; and

(b) is not an NHS body or primary care provider;

"NHS body", except in regulation 6(1)(a)(ii), means—

(**2**) 1993 c. 46.
(**3**) S.I. 2004/1768, amended by S.I. 2006/552, 562 and 2084, 2007/1898 and 2008/528.
(**4**) 2006 c. 41.
(**5**) S.I. 2006/1681.
(**6**) 2008 c.14.

(a) a Strategic Health Authority;

(b) a Special Health Authority which does not exercise functions only or mainly in Wales and to which section 2 of the 1993 Act applies;

(c) a Primary Care Trust;

(d) an NHS trust managing a hospital, or other establishment or facility, in England;

(e) NHS Direct National Health Service Trust; or

(f) an NHS foundation trust;

"primary care provider" means a person or body who—

(a) is a general medical services contractor;

(b) provides primary medical services in accordance with arrangements made under section 83(2)(b) or 92 of the 2006 Act;

(c) is a general dental services contractor;

(d) provides primary dental services in accordance with arrangements made under section 107 of the 2006 Act;

(e) is a general ophthalmic services contractor;

(f) provides pharmaceutical services in accordance with arrangements made under section 126 of the 2006 Act;

(g) provides additional pharmaceutical services in accordance with arrangements made under section 127 of the 2006 Act; or

(h) provides local pharmaceutical services in accordance with an LPS scheme established under paragraph 1 of Schedule 12 to the 2006 Act;

"registered person" has the meaning given in regulation 10;

"relevant complaints procedure" means—

(a) any arrangements for the handling and consideration of complaints that may at any time be or have been required respectively by any of the following provisions—

(i) paragraph 32 of Schedule 1 to the National Health Service (Pharmaceutical Services) Regulations 2005(**7**);

(ii) paragraph 19 of Schedule 3 to the National Health Service (Pharmaceutical Services) Regulations 2005(**8**) ; or

(iii) paragraph 25 of Schedule 2 to the National Health Service (Local Pharmaceutical Services etc.) Regulations 2006(**9**); or

(b) any complaints procedure that may at any time be or have been required respectively by any of the following provisions—

(i) paragraph 92 of Schedule 6 to the National Health Service (General Medical Services Contracts) Regulations 2004(**10**);

(**7**) S.I. 2005/641, relevant amendments are made by paragraph 1 of the Schedule to these Regulations. A new paragraph 32 of Schedule 1 is substituted with effect from 1st April 2009 by paragraph 1(2) of the Schedule to these Regulations.

(**8**) S.I. 2005/641. A new paragraph 19 of Schedule 3 is substituted with effect from 1st April 2009 by paragraph 1(4) of the Schedule to these Regulations.

(**9**) S.I. 2006/552. A new paragraph 25 of Schedule 2 is substituted with effect from 1st April 2009 by paragraph 2 of the Schedule to these Regulations.

(**10**) S.I. 2004/291, amended by S.I. 2004/2694 and 2007/3491, and paragraph 3 of the Schedule to these Regulations. A new paragraph 92 of Schedule 6 is substituted with effect from 1st April 2009 by paragraph 3(2) of the Schedule to these Regulations.

(ii) paragraph 86 of Schedule 5 to the National Health Service (Personal Medical Services Agreements) Regulations 2004(**11**);

(iii) paragraph 47 of Schedule 3 to the National Health Service (General Dental Services Contracts) Regulations 2005(**12**);

(iv) paragraph 47 of Schedule 3 to the National Health Service (Personal Dental Services Agreements) Regulations 2005(**13**); or

(v) paragraph 22 of Schedule 1 to the General Ophthalmic Services Contracts Regulations 2008(**14**);

"responsible body" means a local authority, NHS body, primary care provider or independent provider;

"responsible person" means the person designated in accordance with regulation 4(1)(a);

"working day" means any day except a Saturday, a Sunday, Christmas Day, Good Friday or a day which is a bank holiday in England under section 1 of the Banking and Financial Dealings Act 1971(**15**).

(2) "Care standards complaint" means a complaint which—

(a) relates to services provided by an establishment or agency in respect of which a person is required to be registered under section 11 of the Care Standards Act 2000(**16**); and

(b) does not relate to the exercise by a local authority of—

(i) its social services functions (as defined in section 148 of the Health and Social Care (Community Health and Standards) Act 2003(**17**); or

(ii) any function discharged by it under arrangements made under section 75 of the 2006 Act.

(3) "Social care provider complaint" means a complaint which—

(a) relates to action taken by an adult social care provider in connection with the provision of adult social care; and

(b) does not relate to the exercise by a local authority of—

(i) its social services functions; or

(ii) any function discharged by it under arrangements made under section 75 of the 2006 Act.

Commencement Information

I2 Reg. 2(1)(2) in force at 1.4.2009, see **reg. 1(2)**

I3 Reg. 2(3) in force at 1.4.2010, see **reg. 1(3)**

(**11**) S.I. 2004/627, amended by S.I. 2004/2694 and 2007/3491, and paragraph 4 of the Schedule to these Regulations. A new paragraph 86 of Schedule 5 is substituted with effect from 1st April 2009 by paragraph 4(2) of the Schedule to these Regulations.

(**12**) S.I.2005/3361, amended by paragraph 5 of the Schedule to these Regulations. Paragraph 47 of Schedule 3 is amended with effect from 1st April 2009 by paragraph 5(3) of the Schedule to these Regulations.

(**13**) S.I.2005/3373, amended by paragraph 6 of the Schedule to these Regulations. Paragraph 47 of Schedule 3 is amended with effect from 1st April 2009 by paragraph 6(3) of the Schedule to these Regulations..

(**14**) S.I. 2008/1185, amended by paragraph 7 of the Schedule to these Regulations. Paragraph 22 of Schedule 1 is amended with effect from 1st April 2009 by paragraph 7(3) of the Schedule to these Regulations.

(**15**) 1971 c.80.

(**16**) 2000 c.14.

(**17**) 2003 c.43.

Arrangements for the handling and consideration of complaints

3.—(1) Each responsible body must make arrangements ("arrangements for dealing with complaints") in accordance with these Regulations for the handling and consideration of complaints.

(2) The arrangements for dealing with complaints must be such as to ensure that—

(a) complaints are dealt with efficiently;

(b) complaints are properly investigated;

(c) complainants are treated with respect and courtesy;

(d) complainants receive, so far as is reasonably practical—

(i) assistance to enable them to understand the procedure in relation to complaints; or

(ii) advice on where they may obtain such assistance;

(e) complainants receive a timely and appropriate response;

(f) complainants are told the outcome of the investigation of their complaint; and

(g) action is taken if necessary in the light of the outcome of a complaint.

Commencement Information

I4 Reg. 3 in force at 1.4.2009, see **reg. 1(2)**

Responsibility for complaints arrangements

4.—(1) Each responsible body must designate—

(a) a person, in these Regulations referred to as a responsible person, to be responsible for ensuring compliance with the arrangements made under these Regulations, and in particular ensuring that action is taken if necessary in the light of the outcome of a complaint; and

(b) a person, in these Regulations referred to as a complaints manager, to be responsible for managing the procedures for handling and considering complaints in accordance with the arrangements made under these Regulations.

(2) The functions of the responsible person may be performed by any person authorised by the responsible body to act on behalf of the responsible person.

(3) The functions of the complaints manager may be performed by any person authorised by the responsible body to act on behalf of the complaints manager.

(4) The responsible person is to be—

(a) in the case of a local authority or NHS body, the person who acts as the chief executive officer of the authority or body;

(b) in the case of any other responsible body, the person who acts as the chief executive officer of the body or, if none—

(i) the person who is the sole proprietor of the responsible body;

(ii) where the responsible body is a partnership, a partner; or

(iii) in any other case, a director of the responsible body, or a person who is responsible for managing the responsible body.

(5) The complaints manager may be—

(a) a person who is not an employee of the responsible body;

(b) the same person as the responsible person;

(c) a complaints manager designated by another responsible body under paragraph (1)(b).

Commencement Information

I5 Reg. 4 in force at 1.4.2009, see **reg. 1(2)**

Persons who may make complaints

5.—(1) A complaint may be made by—

(a) a person who receives or has received services from a responsible body; or

(b) a person who is affected, or likely to be affected, by the action, omission or decision of the responsible body which is the subject of the complaint.

(2) A complaint may be made by a person (in this regulation referred to as a representative) acting on behalf of a person mentioned in paragraph (1) who—

(a) has died;

(b) is a child;

(c) is unable to make the complaint themselves because of—

(i) physical incapacity; or

(ii) lack of capacity within the meaning of the Mental Capacity Act 2005(**18**); or

(d) has requested the representative to act on their behalf.

(3) Where a representative makes a complaint on behalf of a child, the responsible body to which the complaint is made—

(a) must not consider the complaint unless it is satisfied that there are reasonable grounds for the complaint being made by a representative instead of the child; and

(b) if it is not so satisfied, must notify the representative in writing, and state the reason for its decision.

(4) This paragraph applies where—

(a) a representative makes a complaint on behalf of—

(i) a child; or

(ii) a person who lacks capacity within the meaning of the Mental Capacity Act 2005; and

(b) the responsible body to which the complaint is made is satisfied that the representative is not conducting the complaint in the best interests of the person on whose behalf the complaint is made.

(5) Where paragraph (4) applies—

(a) the complaint must not be considered or further considered under these Regulations; and

(b) the responsible body must notify the representative in writing, and state the reason for its decision.

(6) In these Regulations any reference to a complainant includes a reference to a representative.

(**18**) 2005 c.9.

Commencement Information

I6 Reg. 5 in force at 1.4.2009, see **reg. 1(2)**

Duty to handle complaints

6.—(1) This regulation applies to a complaint made on or after 1st April 2009 in accordance with these Regulations to—

(a) a local authority about the exercise by the local authority of the following functions—

(i) its social services functions; or

(ii) any function discharged or to be discharged by it under arrangements made between it and an NHS body under section 75 of the 2006 Act in relation to the functions of an NHS body;

(b) an NHS body about—

(i) the exercise of its functions; or

(ii) the exercise of any function discharged or to be discharged by it under arrangements made between it and a local authority under section 75 of the 2006 Act in relation to the exercise of the health-related functions of a local authority;

(c) a primary care provider about the provision of services by it under arrangements with an NHS body; or

(d) an independent provider about the provision of services by it under arrangements with an NHS body.

(2) This regulation does not apply to a complaint specified in regulation 8(1).

(3) In paragraph (1)(a)(ii), "NHS body" has the meaning given in section 28 of the 2006 Act, but does not include a Special Health Authority.

(4) Where this regulation applies to a complaint, the responsible body to which the complaint is made must handle the complaint in accordance with these Regulations.

(5) This paragraph applies where—

(a) a responsible body ("the first body") receives a complaint on or after 1st April 2009;

(b) it appears to the first body that the complaint, if it had been made to another responsible body ("the second body"), would be a complaint which would fall to be handled in accordance with these Regulations by the second body; and

(c) the first body sends the complaint to the second body.

(6) Where paragraph (5) applies, the complainant is deemed to have made the complaint to the second body under these Regulations.

Commencement Information

I7 Reg. 6 in force at 1.4.2009, see **reg. 1(2)**

Complaints about the provision of health services

7.—(1) This regulation applies to a complaint which is—

(a) made to a Primary Care Trust in accordance with these Regulations on or after 1st April 2009;

(b) about the services provided by a provider under arrangements with the Primary Care Trust; and

(c) not specified in regulation 8(1).

(2) In this regulation, "provider" means an NHS body, primary care provider or independent provider.

(3) Where a Primary Care Trust receives a complaint to which this regulation applies—

(a) the Primary Care Trust must ask the complainant whether the complainant consents to details of the complaint being sent to the provider; and

(b) if the complainant so consents, the Primary Care Trust must as soon as reasonably practicable send details of the complaint to the provider.

(4) If the Primary Care Trust considers that it is appropriate for the Primary Care Trust to deal with the complaint—

(a) it must so notify the complainant and the provider; and

(b) it must continue to handle the complaint in accordance with these Regulations.

(5) If the Primary Care Trust considers that it is more appropriate for the complaint to be dealt with by the provider, and the complainant consents—

(a) the Primary Care Trust must so notify the complainant and the provider;

(b) when the provider receives the notification given to it under sub-paragraph (a)—

(i) the provider must handle the complaint in accordance with these Regulations; and

(ii) the complainant is deemed to have made the complaint to the provider under these Regulations.

Commencement Information

I8 Reg. 7 in force at 1.4.2009, see **reg. 1(2)**

Complaints not required to be dealt with

8.—(1) Subject to paragraph (2), the following complaints are not required to be dealt with in accordance with these Regulations—

(a) a complaint by a responsible body;

(b) a complaint by an employee of a local authority or NHS body about any matter relating to that employment;

(c) a complaint which—

(i) is made orally; and

(ii) is resolved to the complainant's satisfaction not later than the next working day after the day on which the complaint was made;

(d) a complaint the subject matter of which is the same as that of a complaint that has previously been made and resolved in accordance with sub-paragraph (c);

(e) a complaint the subject matter of which has previously been investigated under—

(i) these Regulations;

(ii) the 2004 Regulations, in relation to a complaint made under those Regulations before 1st April 2009;

(iii) the 2006 Regulations, in relation to a complaint made under those Regulations before 1st April 2009; or

(iv) a relevant complaints procedure in relation to a complaint made under such a procedure before 1st April 2009;

(f) a complaint the subject matter of which is being or has been investigated by—

(i) a Local Commissioner under the Local Government Act 1974(**19**); or

(ii) a Health Service Commissioner under the 1993 Act;

(g) a complaint arising out of the alleged failure by a responsible body to comply with a request for information under the Freedom of Information Act 2000(**20**); and

(h) a complaint which relates to any scheme established under section 10 (superannuation of persons engaged in health services, etc.) or section 24 (compensation for loss of office, etc.) of the Superannuation Act 1972(**21**), or to the administration of those schemes.

(2) Where a responsible body decides that a complaint is a complaint specified in paragraph (1)—

(a) it is not required to consider the complaint, or consider it further, under these Regulations; and

(b) except where the complaint is a complaint specified in paragraph (1)(c), it must as soon as reasonably practicable notify the complainant in writing of its decision and the reason for the decision.

(3) Where a complaint specified in paragraph (1) is part of, or is connected with, another complaint which is not so specified, nothing in this regulation prevents that other complaint being handled in accordance with these Regulations.

Commencement Information

I9 Reg. 8 in force at 1.4.2009, see **reg. 1(2)**

Duty to co-operate

9.—(1) This regulation applies where—

(a) a responsible body ("the first body") is considering a complaint made in accordance with these Regulations; and

(b) it appears to the first body that the complaint contains material which, if it had been sent to another responsible body ("the second body"), would be a complaint which would fall to be handled in accordance with these Regulations by the second body.

(2) The first body and the second body must co-operate for the purpose of—

(a) co-ordinating the handling of the complaint; and

(b) ensuring that the complainant receives a co-ordinated response to the complaint.

(3) The duty to co-operate under paragraph (2) includes, in particular, a duty for each body—

(a) to seek to agree which of the two bodies should take the lead in—

(i) co-ordinating the handling of the complaint; and

(ii) communicating with the complainant;

(**19**) 1974 c. 7.
(**20**) 2006 c.36.
(**21**) 1972 c.11.

(b) to provide to the other body information relevant to the consideration of the complaint which is reasonably requested by the other body; and

(c) to attend, or ensure it is represented at, any meeting reasonably required in connection with the consideration of the complaint.

Commencement Information

I10 Reg. 9 in force at 1.4.2009, see **reg. 1(2)**

Care standards complaints

10.—(1) This regulation applies where it appears to a local authority considering a complaint that the complaint is wholly or in part a care standards complaint.

(2) The local authority must—

(a) ask the complainant whether the complainant consents to details of the complaint being sent to the registered person; and

(b) if the complainant so consents, send such details to the registered person as soon as reasonably practicable.

(3) Where a complaint is in part a care standards complaint and in part for the local authority to consider, the local authority must—

(a) as soon as reasonably practicable notify the complainant which part of the complaint will be handled by the local authority in accordance with these Regulations; and

(b) where the local authority has sent details of the complaint to the registered person under paragraph (2)(b), co-operate as much as is reasonable and practicable with the registered person for the purpose of ensuring that the complainant receives a co-ordinated response to the complaint.

(4) In this regulation, "registered person" means the person registered under section 11 of the Care Standards Act 2000 in respect of the establishment or agency complained about.

Commencement Information

I11 Reg. 10 in force at 1.4.2009, see **reg. 1(2)**

Social care provider complaints

11.—(1) This regulation applies where it appears to a local authority considering a complaint that the complaint is wholly or in part a social care provider complaint.

(2) The local authority must—

(a) ask the complainant whether the complainant consents to details of the complaint being sent to the relevant adult social care provider; and

(b) if the complainant so consents, send such details to the relevant adult social care provider as soon as reasonably practicable.

(3) Where a complaint is in part a social care provider complaint and in part for the local authority to consider, the local authority must—

(a) as soon as reasonably practicable notify the complainant which part of the complaint will be handled by the local authority in accordance with these Regulations; and

(b) where the local authority has sent details of the complaint to the relevant adult social care provider under paragraph (2)(b), co-operate as much as is reasonable and practicable with the relevant adult social care provider for the purpose of ensuring that the complainant receives a co-ordinated response to the complaint.

(4) In this regulation, "relevant adult social care provider" means the adult social care provider in relation to whom the social care provider complaint was made.

Commencement Information

I12 Reg. 11 in force at 1.4.2010, see **reg. 1(3)**

Time limit for making a complaint

12.—(1) Except as mentioned in paragraph (2), a complaint must be made not later than 12 months after—

(a) the date on which the matter which is the subject of the complaint occurred; or

(b) if later, the date on which the matter which is the subject of the complaint came to the notice of the complainant.

(2) The time limit in paragraph (1) shall not apply if the responsible body is satisfied that—

(a) the complainant had good reasons for not making the complaint within that time limit; and

(b) notwithstanding the delay, it is still possible to investigate the complaint effectively and fairly.

Commencement Information

I13 Reg. 12 in force at 1.4.2009, see **reg. 1(2)**

Procedure before investigation

13.—(1) A complaint may be made orally, in writing or electronically.

(2) Where a complaint is made orally, the responsible body to which the complaint is made must—

(a) make a written record of the complaint; and

(b) provide a copy of the written record to the complainant.

(3) Except where regulation 6(5) or 7(1) applies in relation to a complaint, the responsible body must acknowledge the complaint not later than 3 working days after the day on which it receives the complaint.

(4) Where paragraph (5) of regulation 6 applies, and a responsible body ("the recipient body") receives a complaint sent to it by another responsible body in accordance with that paragraph, the complaint must be acknowledged by the recipient body not later than 3 working days after the day on which it receives the complaint.

(5) Where regulation 7(1) applies to a complaint—

(a) the Primary Care Trust which receives the complaint must acknowledge the complaint not later than 3 working days after the day on which it receives it; and

(b) where a responsible body receives notification given to it under regulation 7(5)(a), it must acknowledge the complaint not later than 3 working days after the day on which it receives the notification.

(6) The acknowledgement may be made orally or in writing.

(7) At the time it acknowledges the complaint, the responsible body must offer to discuss with the complainant, at a time to be agreed with the complainant—

(a) the manner in which the complaint is to be handled; and

(b) the period ("the response period") within which—

(i) the investigation of the complaint is likely to be completed; and

(ii) the response required by regulation 14(2) is likely to be sent to the complainant.

(8) If the complainant does not accept the offer of a discussion under paragraph (7), the responsible body must—

(a) determine the response period specified in paragraph (7)(b); and

(b) notify the complainant in writing of that period.

Commencement Information

I14 Reg. 13 in force at 1.4.2009, see **reg. 1(2)**

Investigation and response

14.—(1) A responsible body to which a complaint is made must—

(a) investigate the complaint in a manner appropriate to resolve it speedily and efficiently; and

(b) during the investigation, keep the complainant informed, as far as reasonably practicable, as to the progress of the investigation.

(2) As soon as reasonably practicable after completing the investigation, the responsible body must send the complainant in writing a response, signed by the responsible person, which includes—

(a) a report which includes the following matters—

(i) an explanation of how the complaint has been considered; and

(ii) the conclusions reached in relation to the complaint, including any matters for which the complaint specifies**,** or the responsible body considers, that remedial action is needed; and

(b) confirmation as to whether the responsible body is satisfied that any action needed in consequence of the complaint has been taken or is proposed to be taken;

(c) where the complaint relates wholly or in part to the functions of a local authority, details of the complainant's right to take their complaint to a Local Commissioner under the Local Government Act 1974(**22**); and

(d) except where the complaint relates only to the functions of a local authority, details of the complainant's right to take their complaint to the Health Service Commissioner under the 1993 Act.

(**22**) 1974 c.7.

(3) In paragraph (4), "relevant period" means the period of 6 months commencing on the day on which the complaint was received, or such longer period as may be agreed before the expiry of that period by the complainant and the responsible body.

(4) If the responsible body does not send the complainant a response in accordance with paragraph (2) within the relevant period, the responsible body must—

(a) notify the complainant in writing accordingly and explain the reason why; and

(b) send the complainant in writing a response in accordance with paragraph (2) as soon as reasonably practicable after the relevant period.

Commencement Information
I15 Reg. 14 in force at 1.4.2009, see **reg. 1(2)**

Form of communications

15.—(1) Any communication which is required by these Regulations to be made to a complainant may be sent to the complainant electronically where the complainant—

(a) has consented in writing or electronically; and

(b) has not withdrawn such consent in writing or electronically.

(2) Any requirement in these Regulations for a document to be signed by a person is satisfied, in the case of a document which is sent electronically in accordance with these Regulations, by the individual who is authorised to sign the document typing their name or producing their name using a computer or other electronic means.

Commencement Information
I16 Reg. 15 in force at 1.4.2009, see **reg. 1(2)**

Publicity

16. Each responsible body must make information available to the public as to—

(a) its arrangements for dealing with complaints; and

(b) how further information about those arrangements may be obtained.

Commencement Information
I17 Reg. 16 in force at 1.4.2009, see **reg. 1(2)**

Monitoring

17. For the purpose of monitoring the arrangements under these Regulations each responsible body must maintain a record of the following matters—

(a) each complaint received;

(b) the subject matter and outcome of each complaint; and

(c) where the responsible body informed the complainant of—

(i) the response period specified in regulation 13(7)(b); or

(ii) any amendment to that period**,**

whether a report of the outcome of the investigation was sent to the complainant within that period or any amended period.

Commencement Information

I18 Reg. 17 in force at 1.4.2009, see **reg. 1(2)**

Annual reports

18.—(1) Each responsible body must prepare an annual report for each year which must—

(a) specify the number of complaints which the responsible body received;

(b) specify the number of complaints which the responsible body decided were well-founded;

(c) specify the number of complaints which the responsible body has been informed have been referred to—

(i) the Health Service Commissioner to consider under the 1993 Act; or

(ii) the Local Commissioner to consider under the Local Government Act 1974; and

(d) summarise—

(i) the subject matter of complaints that the responsible body received;

(ii) any matters of general importance arising out of those complaints, or the way in which the complaints were handled;

(iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints.

(2) In paragraph (1), "year" means a period of 12 months ending with 31st March.

(3) Each responsible body must ensure that its annual report is available to any person on request.

(4) This paragraph applies to a responsible body which is—

(a) an NHS body other than a Primary Care Trust; or

(b) a primary care provider or an independent provider,

and which in any year provides, or agrees to provide, services under arrangements with a Primary Care Trust.

(5) Where paragraph (4) applies to a responsible body, the responsible body must send a copy of its annual report to the Primary Care Trust which arranged for the provision of the services by the responsible body.

(6) Each Primary Care Trust must send a copy of its annual report to the Strategic Health Authority whose area includes any part of the area of the Primary Care Trust.

(7) The copy of the annual report required to be sent in accordance with paragraph (5) or (6) must be sent as soon as reasonably practicable after the end of the year to which the report relates.

Commencement Information

I19 Reg. 18 in force at 1.4.2009, see **reg. 1(2)**

Transitional provision: complaints to local authorities

19.—(1) This paragraph applies to a complaint where, immediately before 1st April 2009—

(a) the complaint falls to be handled under the 2006 Regulations; and

(b) the complaint is not a complaint which, under regulation 5 of those Regulations, is not to be considered or further considered.

(2) Where paragraph (1) applies, the 2006 Regulations shall continue to have effect in relation to the complaint.

(3) References in this regulation to a complaint include—

(a) any investigation of the complaint which has been requested under regulation 8 of the 2006 Regulations; and

(b) any complaint in respect of which a review panel has been established, or has been requested to be established, in accordance with those Regulations.

Commencement Information

I20 Reg. 19 in force at 1.4.2009, see **reg. 1(2)**

Transitional provision: complaints to NHS bodies, primary care providers and independent providers, and investigation by Health Service Commissioner

20.—(1) This paragraph applies to—

(a) a complaint which—

(i) immediately before 1st April 2009 falls to be handled under the 2004 Regulations; and

(ii) is not a complaint which, under regulation 7 of those Regulations, is excluded from the scope of the arrangements required under Part 2 of those Regulations; or

(b) a complaint which before 1st April 2009 a complainant has requested the Healthcare Commission to consider under regulation 14 of the 2004 Regulations.

(2) Where paragraph (1) applies to a complaint—

(a) the 2004 Regulations, except for regulations 14 to 22 of those Regulations, shall continue to have effect in relation to the complaint;

(b) regulation 13 of those Regulations shall have effect in relation to the complaint as if, in paragraph (4), the words "Health Service Commissioner under the Health Service Commissioners Act 1993" were substituted for the words "Healthcare Commission in accordance with regulation 14"; and

(c) any request made under regulation 14 before 1st April 2009 for the Healthcare Commission to consider the complaint shall have effect as a request to the Health Service Commissioner to consider the complaint under the 1993 Act.

Commencement Information

I21 Reg. 20 in force at 1.4.2009, see **reg. 1(2)**

Transitional provision: investigation by Health Service Commissioner in relation to complaints about NHS foundation trusts

21.—(1) This paragraph applies where a person has made a complaint before 1st April 2009 to an NHS foundation trust and either—

(a) the complainant is not satisfied with the outcome of any investigation of that complaint by the NHS foundation trust in accordance with any procedures it may have; or

(b) the NHS foundation trust has no complaints procedures.

(2) Where paragraph (1) applies, any request made under regulation 15 of the 2004 Regulations before 1st April 2009 for the Healthcare Commission to consider the complaint shall have effect as a request to the Health Service Commissioner to consider the complaint under the 1993 Act.

Commencement Information
I22 Reg. 21 in force at 1.4.2009, see **reg. 1(2)**

Revocations

22.—(1) Subject to regulations 20 and 21, the 2004 Regulations are revoked.

(2) Subject to regulation 19, the 2006 Regulations are revoked.

Commencement Information
I23 Reg. 22 in force at 1.4.2009, see **reg. 1(2)**

Consequential and transitional provisions

23. The Schedule (consequential and transitional provisions) has effect.

Commencement Information
I24 Reg. 23 in force at 1.4.2009, see **reg. 1(2)**

Signed by authority of the Secretary of State for Health.

Ann Keen
Parliamentary Under-Secretary of State,
Department of Health

23rd February 2009

PROSPECTIVE

SCHEDULE

CONSEQUENTIAL AND TRANSITIONAL PROVISIONS

Amendment of the National Health Service (Pharmaceutical Services) Regulations 2005

1.—(1) The National Health Service (Pharmaceutical Services) Regulations 2005(**23**) are amended as follows.

(2) In Schedule 1 (terms of service of pharmacists), for paragraph 32 (complaints) substitute—

"**Complaints**

32.—(1) A pharmacist must have in place—

(a) arrangements which are essentially the same as those set out in Part 2 of the National Health Service (Complaints) Regulations 2004(**24**), for the handling and consideration of any complaints—

(i) which were made on or before 31st March 2009; and

(ii) in respect of which the complaints process has not yet been concluded; and

(b) arrangements which comply with the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009(**25**), for the handling and consideration of any complaints made on or after 1st April 2009.

(2) The reference in sub-paragraph (1)(a) to the National Health Service (Complaints) Regulations 2004 is a reference to those Regulations as they had effect on 31st March 2009 and as if they had not been revoked.

(3) In this paragraph, "complaint" means a complaint about a matter connected with the provision of pharmaceutical services by the pharmacist.".

(3) In Schedule 2 (terms of service of dispensing doctors), in paragraph 9(1)(c) (complaints procedures), after "relevant APMS contract" add ", in accordance with any obligation imposed on the APMS contractor by the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009,".

(4) In Schedule 3 (terms of service of suppliers of appliances), for paragraph 19 (complaints) substitute—

"**Complaints**

19.—(1) A supplier of appliances must have in place—

(a) arrangements which are essentially the same as those set out in Part 2 of the National Health Service (Complaints) Regulations 2004, for the handling and consideration of any complaints—

(i) which were made on or before 31st March 2009; and

(**23**) S.I. 2005/641, to which there are amendments not relevant to these Regulations.
(**24**) S.I. 2004/1768.
(**25**) S.I. 2009/309.

(ii) in respect of which the complaints process has not yet been concluded; and

(b) arrangements which comply with the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009(**26**), for the handling and consideration of any complaints made on or after 1st April 2009.

(2) The reference in sub-paragraph (1)(a) to the National Health Service (Complaints) Regulations 2004 is a reference to those Regulations as they had effect on 31st March 2009 and as if they had not been revoked.

(3) In this paragraph, "complaint" means a complaint about a matter connected with the provision of pharmaceutical services by the supplier of appliances.".

Commencement Information
I25 Sch. para. 1 in force at 1.4.2009, see **reg. 1(2)**

Amendment of the National Health Service (Local Pharmaceutical Services etc.) Regulations 2006

2. In Schedule 2 to the National Health Service (Local Pharmaceutical Services etc.) Regulations 2006(**27**) (contract terms), for paragraph 25 (complaints) substitute—

"**Complaints**

25.—(1) A contractor must have in place—

(a) arrangements which are essentially the same as those set out in Part 2 of the National Health Service (Complaints) Regulations 2004, for the handling and consideration of any complaints—

(i) which were made on or before 31st March 2009; and

(ii) in respect of which the complaints process has not yet been concluded; and

(b) arrangements which comply with the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009(**28**), for the handling and consideration of any complaints made on or after 1st April 2009.

(2) The reference in paragraph (1)(a) to the National Health Service (Complaints) Regulations 2004 is a reference to those Regulations as they had effect on 31st March 2009 and as if they had not been revoked.

(3) In this paragraph, "complaint" means a complaint about a matter connected with the provision of local pharmaceutical services by the contractor.".

Commencement Information
I26 Sch. para. 2 in force at 1.4.2009, see **reg. 1(2)**

(**26**) S.I. 2009/309.
(**27**) S.I. 2006/552, to which there are amendments not relevant to these Regulations.
(**28**) S.I. 2009/309.

Amendment of the National Health Service (General Medical Services Contracts) Regulations 2004

3.—(1) Schedule 6 to the National Health Service (General Medical Services Contracts) Regulations 2004(**29**) (other contractual terms) is amended as follows.

(2) For paragraph 92 (complaints procedure) substitute—

"**Complaints procedure**

92.—(1) The contractor shall establish and operate a complaints procedure to deal with any complaints in relation to any matter reasonably connected with the provision of services under the contract.

(2) In respect of complaints made on or after 1st April 2009, the complaints procedure required by sub-paragraph (1) shall comply with the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009(**30**).

(3) In respect of complaints received by the contractor prior to 1st April 2009 which have not been resolved by that date, the contractor shall continue to deal with such complaints in accordance with the complaints procedure that it was required to establish and operate prior to 1st April 2009.".

(3) In paragraph 97 (co-operation with investigations)—

(a) in sub-paragraph (1)(a)(ii), for "the Commission for Healthcare Audit and Inspection" substitute "the Health Service Commissioner";

(b) at the end of sub-paragraph (2), add—

""Health Service Commissioner" means the person appointed Health Service Commissioner for England in accordance with section 1 of, and Schedule 1 to, the Health Service Commissioners Act 1993(**31**).".

(4) Paragraphs 93 to 96 and 98 are omitted.

Commencement Information

I27 Sch. para. 3 in force at 1.4.2009, see **reg. 1(2)**

Amendment of the National Health Service (Personal Medical Services Agreements) Regulations 2004

4.—(1) Schedule 5 to the National Health Service (Personal Medical Services Agreements) Regulations 2004(**32**) (other contractual terms) is amended as follows.

(2) For paragraph 86 (complaints procedure) substitute—

""**Complaints procedure**

86.—(1) The contractor shall establish and operate a complaints procedure to deal with any complaints in relation to any matter reasonably connected with the provision of services under the agreement.

(**29**) S.I. 2004/291, amended by S.I. 2004/2694 and 2007/3491.
(**30**) S.I. 2009/309.
(**31**) 1993 c. 46.
(**32**) S.I. 2004/627, amended by S.I. 2004/2694 and 2007/3491.

(2) In respect of complaints made on or after 1st April 2009, the complaints procedure required by sub-paragraph (1) shall comply with the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009(**33**).

(3) In respect of complaints received by the contractor prior to 1st April 2009 which have not been resolved by that date, the contractor shall continue to deal with such complaints in accordance with the complaints procedure that it was required to establish and operate prior to 1st April 2009.".

(3) In paragraph 91 (co-operation with investigations)—

(a) in sub-paragraph (1)(b), for "the Commission for Healthcare Audit and Inspection" substitute "the Health Service Commissioner";

(b) in sub-paragraph (3), for "In sub-paragraph (2)" substitute "In this paragraph";

(c) at the end of sub-paragraph (3), add—

""Health Service Commissioner" means the person appointed Health Service Commissioner for England in accordance with section 1 of, and Schedule 1 to, the Health Service Commissioners Act 1993(**34**).".

(4) Paragraphs 87 to 90 and 92 are omitted.

Commencement Information

I28 Sch. para. 4 in force at 1.4.2009, see **reg. 1(2)**

Amendment of the National Health Service (General Dental Services Contracts) Regulations 2005

5.—(1) Schedule 3 to the National Health Service (General Dental Services Contracts) Regulations 2005(**35**) (other contractual terms), is amended as follows.

(2) Before Part 6 (complaints) insert—

"PART 5A

Complaints received on or after 1st April 2009

46B. As regards complaints relating to any matter reasonably connected with the provision of services under the contract which are received on or after 1st April 2009, the contractor must have in place a complaints procedure which meets the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009(**36**).".

(3) In Part 6 (complaints)—

(a) in paragraph 47 (complaints procedure), in sub-paragraph (1) for the words from "The contractor" to "the contract" substitute—

"As regards complaints relating to any matter reasonably connected with the provision of services under the contract which are received before 1st April 2009, the contractor shall operate a complaints procedure";

(**33**) S.I. 2009/309.
(**34**) 1993 c. 46.
(**35**) S.I. 2005/3361.
(**36**) S.I. 2009/309.

(b) in paragraph 51 (co-operation with investigations)—

(i) in sub-paragraph (1)(a)(ii), for "the Commission for Healthcare Audit and Inspection" substitute "the Health Service Commissioner";

(ii) at the end of sub-paragraph (2), add—

""Health Service Commissioner" means the person appointed Health Service Commissioner for England in accordance with section 1 of, and Schedule 1 to, the Health Service Commissioners Act 1993(**37**).".

Commencement Information

I29 Sch. para. 5 in force at 1.4.2009, see **reg. 1(2)**

Amendment of the National Health Service (Personal Dental Services Agreements) Regulations 2005

6.—(1) Schedule 3 to the National Health Service (Personal Dental Services Agreements) Regulations 2005(**38**) (other contractual terms) is amended as follows.

(2) Before Part 6 (complaints) insert—

"PART 5A

Complaints received on or after 1st April 2009

46B. As regards complaints relating to any matter reasonably connected with the provision of services under the agreement which are received on or after 1st April 2009, the contractor must have in place a complaints procedure which meets the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009(**39**).".

(3) In Part 6 (complaints)—

(a) in paragraph 47 (complaints procedure), in sub-paragraph (1) for the words from "The contractor" to "the agreement" substitute—

"As regards complaints relating to any matter reasonably connected with the provision of services under the agreement which are received before 1st April 2009, the contractor shall operate a complaints procedure";

(b) in paragraph 51 (co-operation with investigations)—

(i) in sub-paragraph (1)(a)(ii), for "the Commission for Healthcare Audit and Inspection" substitute "the Health Service Commissioner";

(ii) at the end of sub-paragraph (2), add—

""Health Service Commissioner" means the person appointed Health Service Commissioner for England in accordance with section 1 of, and Schedule 1 to, the Health Service Commissioners Act 1993(**40**).".

(**37**) 1993 c. 46.
(**38**) S.I. 2005/3373.
(**39**) S.I. 2009/309.
(**40**) 1993 c. 46.

Commencement Information
I30 Sch. para. 6 in force at 1.4.2009, see **reg. 1(2)**

Amendment to the General Ophthalmic Services Contracts Regulations 2008

7.—(1) Schedule 1 to the General Ophthalmic Services Contracts Regulations 2008(**41**) (other contractual terms) is amended as follows.

(2) Before Part 5 (complaints) insert—

"Part 4A

Complaints received on or after 1st April 2009

21A. As regards complaints relating to any matter reasonably connected with the provision of services under the contract which are received on or after 1st April 2009, the contractor must have in place a complaints procedure which meets the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009(**42**).".

(3) In Part 5 (complaints), in paragraph 22 (complaints procedure)—

(a) for sub-paragraph (1) substitute—

"(1) As regards complaints relating to any matter reasonably connected with the provision of services under the contract which are received before 1st April 2009, the contractor shall operate a complaints procedure and that complaints procedure shall comply with the requirements of paragraphs 23 to 25 and 27.";

(b) in paragraph 26 (co-operation with investigations)—

(i) in sub-paragraph (1)(a)(ii), for "the Commission for Healthcare Audit and Inspection" substitute "the Health Service Commissioner";

(ii) at the end of sub-paragraph (2), add—

""Health Service Commissioner" means the person appointed Health Service Commissioner for England in accordance with section 1 of, and Schedule 1 to, the Health Service Commissioners Act 1993(**43**).".

Commencement Information
I31 Sch. para. 7 in force at 1.4.2009, see **reg. 1(2)**

Transitional provision: the Primary Ophthalmic Services Amendment, Transitional and Consequential Provisions Regulations 2008, and the General Dental Services, Personal Dental Services and Abolition of the Dental Practice Board Transitional and Consequential Provisions Order 2006

8.—(1) This sub-paragraph applies to a complaint which—

(a) was made before 1st April 2009; and

(**41**) S.I. 2008/1185.
(**42**) S.I. 2009/309.
(**43**) 1993 c. 46.

(b) falls to be investigated by a Primary Care Trust under—

(i) regulation 4(2) or 5(2) of the Primary Ophthalmic Services Amendment, Transitional and Consequential Provisions Regulations 2008(**44**); or

(ii) article 5(5), 6(2), 21(2) or 22(2) of the General Dental Services, Personal Dental Services and Abolition of the Dental Practice Board Transitional and Consequential Provisions Order 2006(**45**).

(2) Where sub-paragraph (1) applies to a complaint, the investigation of the complaint shall be carried out in accordance with the 2004 Regulations as if—

(a) notwithstanding their revocation, the 2004 Regulations, except for regulations 14 to 22 of those Regulations, continued to have effect;

(b) in paragraph (4) of regulation 13, the words "Health Service Commissioner under the Health Service Commissioners Act 1993" were substituted for the words "Healthcare Commission in accordance with regulation 14"; and

(c) any request made under regulation 14 before 1st April 2009 for the Healthcare Commission to consider the complaint shall have effect as a request to the Health Service Commissioner to consider the complaint under the 1993 Act.

Commencement Information

I32 Sch. para. 8 in force at 1.4.2009, see **reg. 1(2)**

PROSPECTIVE

EXPLANATORY NOTE

(This note is not part of the Regulations)

These Regulations make provision for complaints made on or after 1st April 2009 in relation to local authority social services and the National Health Service.

Regulation 3 requires "responsible bodies" to make arrangements for the handling and consideration of complaints. "Responsible bodies" are defined (in regulation 2) to mean local authorities, NHS bodies and certain other providers who provide services under arrangements with NHS bodies.

Regulation 4 requires responsible bodies to designate a person to be responsible for ensuring compliance with the arrangements, and a complaints manager to be responsible for managing the complaints procedure.

Regulation 5 makes provision as to who may make a complaint. Regulations 6 and 7 specify the complaints which are to be handled by responsible bodies in accordance with the Regulations.

(**44**) S.I. 2008/1700.
(**45**) S.I. 2006/562.

Regulation 8 specifies certain types of complaint that are not required to be dealt with in accordance with these Regulations.

Regulation 9 provides for responsible bodies to co-operate in relation to complaints being considered by one body which also fall to be handled by another body. Regulations 10 and 11 make provision for disclosure and co-operation by local authorities considering a complaint.

Regulation 10 applies where a complaint wholly or in part relates to services in relation to which a person is registered under the Care Standards Act 2000. Regulation 11 applies where a complaint wholly or in part relates to action taken by a person who carries on an activity connected with the provision of adult social care, and the activity is a regulated activity under Part 1 of the Health and Social Care Act 2008. Regulation 11 is to come into force on 1st April 2010.

Regulation 12 specifies the time limits for making a complaint. Regulation 13 provides for how complaints are to be made and processed initially, including a discussion with the complainant as to how the complaint is to be handled and the likely period for investigating the complaint and responding to the complainant. Regulation 14 provides for the investigation of the complaint and the response to the claimant. Regulation 15 makes provision for electronic communications.

Each responsible body is required to ensure that its complaints arrangements are made available to the public (regulation 16), to record certain matters about complaints for monitoring purposes (regulation 17) and to prepare and make available an annual report (regulation 18).

Regulations 19 to 21 make transitional provision for complaints made before 1st April 2009 under the Local Authority Social Services Complaints (England) Regulations 2006, or the National Health Service (Complaints) Regulations 2004, which are revoked by regulation 22. Regulation 23 and the Schedule make consequential and transitional amendments to regulations relating to complaints about services provided by certain providers of health care.

An impact assessment has been prepared in relation to these Regulations and is available from the Department of Health, Quarry House, Quarry Hill, Leeds LS2 7UE.

Status:
This version of this Instrument contains provisions that are prospective.

Changes to legislation:
There are outstanding changes not yet made by the legislation.gov.uk editorial team to The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. Any changes that have already been made by the team appear in the content and are referenced with annotations.
View outstanding changes

Changes and effects yet to be applied to :

- Sch. para. 1 coming into force by S.I. 2009/309 reg. 1(2)
- Sch. para. 2 coming into force by S.I. 2009/309 reg. 1(2)
- Sch. para. 3 coming into force by S.I. 2009/309 reg. 1(2)
- Sch. para. 4 coming into force by S.I. 2009/309 reg. 1(2)
- Sch. para. 5 coming into force by S.I. 2009/309 reg. 1(2)
- Sch. para. 6 coming into force by S.I. 2009/309 reg. 1(2)
- Sch. para. 7 coming into force by S.I. 2009/309 reg. 1(2)
- Sch. para. 8 coming into force by S.I. 2009/309 reg. 1(2)
- Sch. para. 1 revoked by S.I. 2012/1909 Sch. 8 para. 9(2)(l)
- Sch. para. 2 revoked by S.I. 2013/349 Sch. 10 para. 7(b)
- Sch. para. 3 revoked by S.I. 2015/1862 Sch. 5 Table
- Sch. para. 4 revoked by S.I. 2015/1879 Sch. 4
- Regulations modified by S.I. 2022/734 reg. 31(3)
- Regulations words substituted by S.I. 2022/634 Sch. para. 1(1)(3)
- reg 1 am by S.I. 2009/1768 reg 2
- reg. 1 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 2 words substituted by S.I. 2012/1909 Sch. 8 para. 11
- reg. 2 words substituted by S.I. 2013/349 Sch. 10 para. 7(a)
- reg. 2(1)(2) coming into force by S.I. 2009/309 reg. 1(2)
- reg. 2(1) words inserted by S.I. 2013/235 Sch. 2 para. 123(2)(d)(ii)
- reg. 2(1) words inserted by S.I. 2019/248 reg. 9(2)
- reg. 2(1) words omitted by S.I. 2013/235 Sch. 2 para. 123(2)(d)(i)
- reg. 2(1) words omitted by S.I. 2013/235 Sch. 2 para. 123(2)(d)(iii)
- reg. 2(1) words substituted by S.I. 2013/235 Sch. 2 para. 123(2)(a)
- reg. 2(1) words substituted by S.I. 2013/235 Sch. 2 para. 123(2)(b)
- reg. 2(1) words substituted by S.I. 2013/235 Sch. 2 para. 123(2)(c)
- reg. 2(1) words substituted by S.I. 2013/235 Sch. 2 para. 123(2)(e)
- reg. 2(1) words substituted by S.I. 2015/1862 Sch. 4 para. 4
- reg. 2(1) words substituted by S.I. 2019/248 reg. 9(3)
- reg. 2(1) words substituted by S.I. 2019/248 reg. 9(4)
- reg. 2(3) coming into force by S.I. 2009/309 reg. 1(3)
- reg. 3 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 4 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 5 coming into force by S.I. 2009/309 reg. 1(2)
- reg 6 am by S.I. 2009/1768 reg 3
- reg. 6 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 7 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 7(1)(a) words substituted by S.I. 2013/235 Sch. 2 para. 123(4)(a)(i)
- reg. 7(1)(a) words substituted by S.I. 2013/235 Sch. 2 para. 123(4)(a)(ii)
- reg. 7(1)(b) words substituted by S.I. 2013/235 Sch. 2 para. 123(4)(b)
- reg. 7(1)(b) words substituted by S.I. 2022/634 reg. 37(2)(a)
- reg. 7(2) words inserted by S.I. 2019/248 reg. 11(3)
- reg. 7(3)-(5) words inserted by S.I. 2019/248 reg. 11(4)
- reg. 7(3) words substituted by S.I. 2013/235 Sch. 2 para. 123(4)(c)(i)
- reg. 7(3)(a) words substituted by S.I. 2013/235 Sch. 2 para. 123(4)(c)(ii)

- reg. 7(3)(a) words substituted by S.I. 2022/634 reg. 37(2)(c)(i)
- reg. 7(3)(b) words substituted by S.I. 2013/235 Sch. 2 para. 123(4)(c)(iii)
- reg. 7(3)(b) words substituted by S.I. 2022/634 reg. 37(2)(c)(ii)
- reg. 7(4) words substituted by S.I. 2013/235 Sch. 2 para. 123(4)(d)(i)
- reg. 7(4) words substituted by S.I. 2013/235 Sch. 2 para. 123(4)(d)(ii)
- reg. 7(4) words substituted by S.I. 2022/634 reg. 37(2)(d)
- reg. 7(5) words substituted by S.I. 2013/235 Sch. 2 para. 123(4)(e)(i)
- reg. 7(5)(a) words substituted by S.I. 2013/235 Sch. 2 para. 123(4)(e)(ii)
- reg. 7(5)(a) words substituted by S.I. 2022/634 reg. 37(2)(e)
- reg 8 am by S.I. 2009/1768 reg 4
- reg. 8 coming into force by S.I. 2009/309 reg. 1(2)
- reg 8 rev in pt by S.I. 2009/1768 reg 4
- reg. 9 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 10 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 11 coming into force by S.I. 2009/309 reg. 1(3)
- reg. 12 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 13 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 13(5)(a) words substituted by S.I. 2013/235 Sch. 2 para. 123(5)
- reg. 14 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 15 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 16 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 17 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 18 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 18(4) words inserted by S.I. 2019/248 reg. 12(2)(b)
- reg. 18(4) words substituted by S.I. 2013/235 Sch. 2 para. 123(6)(a)(ii)
- reg. 18(4) words substituted by S.I. 2019/248 reg. 12(2)(c)
- reg. 18(4)(a) words substituted by S.I. 2013/235 Sch. 2 para. 123(6)(a)(i)
- reg. 18(4)(b) words substituted by S.I. 2019/248 reg. 12(2)(a)
- reg. 18(5) words substituted by S.I. 2013/235 Sch. 2 para. 123(6)(b)
- reg. 18(5) words substituted by S.I. 2019/248 reg. 12(3)
- reg. 18(6) omitted by S.I. 2013/235 Sch. 2 para. 123(6)(c)
- reg. 18(7) words omitted by S.I. 2013/235 Sch. 2 para. 123(6)(d)
- reg. 19 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 20 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 21 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 22 coming into force by S.I. 2009/309 reg. 1(2)
- reg. 23 coming into force by S.I. 2009/309 reg. 1(2)

Changes and effects yet to be applied to the whole Instrument associated Parts and Chapters:

Whole provisions yet to be inserted into this Instrument (including any effects on those provisions):

- reg. 6(1)(ba) inserted by S.I. 2013/235 Sch. 2 para. 123(3)
- reg. 6(1)(ba) words substituted by S.I. 2022/634 reg. 187(2)
- reg. 6(1A)(b) substituted by S.I. 2019/248 reg. 10(3)
- reg. 6(1ZA)(1ZB) inserted by S.I. 2019/248 reg. 10(2)
- reg. 7(1A)(1B) inserted by S.I. 2019/248 reg. 11(2)
- reg. 7(1A)(b)(i) words substituted by S.I. 2022/634 reg. 37(2)(b)(i)
- reg. 7(1A)(b)(iii) words substituted by S.I. 2022/634 reg. 37(2)(b)(iii)
- reg. 7(1A)(b)(ii) words substituted by S.I. 2022/634 reg. 37(2)(b)(ii)
- reg. 7(6) inserted by S.I. 2019/248 reg. 11(5)

East London
NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE
18th July 2024

Title	Legal Claims Annual Report- 1 April 2023 to 31 March 2024
Author/Role	Christina Helden- Associate Director of Legal Affairs
Accountable Executive Director	Dr David Bridle- Chief Medical Officer

Purpose of the report

To provide an overview on claims activity under the Clinical Negligence (CNST), Liability to Third Party (LTPS) (this is made up of Employer Liability and Public Liability claims) schemes and financial implications.

The report covers the period between 1 April 2023 and 31 March 2024.

This report does not consider Employment Tribunals, Court of Protection, Judicial Reviews or 'Ex Gratia' matters.

Committees/meetings where this item has been considered

Date	Committee/Meeting
18 July 2024	Quality Assurance Committee

The total number of open claims across both the CNST and LTPS schemes (72) is identical to 2022/23 (72).

There were 13 new CNST claims and 25 new LTPS claims received between 1 April 2023 and 31 March 2024. This is consistent with the 12 new CNST claims and 28 new LTPS claims received in the preceding 12 months (2022/23).

The estimated total value of all claims closed between 1 April 2023 and 31 March 2024 is £1,843,633. This is significantly higher than the 2022/23 figure (£665,739) but does not directly translate into costs for ELFT due to membership of the CNST and LPTS schemes run by NHS Resolution.

Strategic priorities this paper supports

Improved population health outcomes	☒	Appropriate dissemination of learning from clinical negligence claims to Directorates enabling the identification of incident trends within populations.
Improved experience of care	☒	Appropriate management of clinical negligence claims leads to confidence that the Trust is open and transparent and willing to learn from incidents.
Improved staff experience	☒	Appropriate management of claims received from staff leads to confidence that the Trust is open and transparent and willing to learn from incidents.
Improved value	☒	Appropriate and timely management of claims minimises the financial impact on the Trust.

Implications

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	Appropriate handling to claims ensures that any financial redress is appropriately managed.
Service User/ Carer/Staff	Appropriate handling of claims ensures that anybody who is disadvantaged by the action so of the Trust is appropriately compensated.
Financial	Robust management of claims ensures that financial implications are effectively managed.
Quality	The Legal Affairs Team (the Team) annual claims plan will be realized via corporate QI project.

1. Background

1.1. This report will focus on the claims activity under the Clinical Negligence (CNST), Liability to Third Party (LTPS) schemes between 1 April 2023 and 31 March 2024.

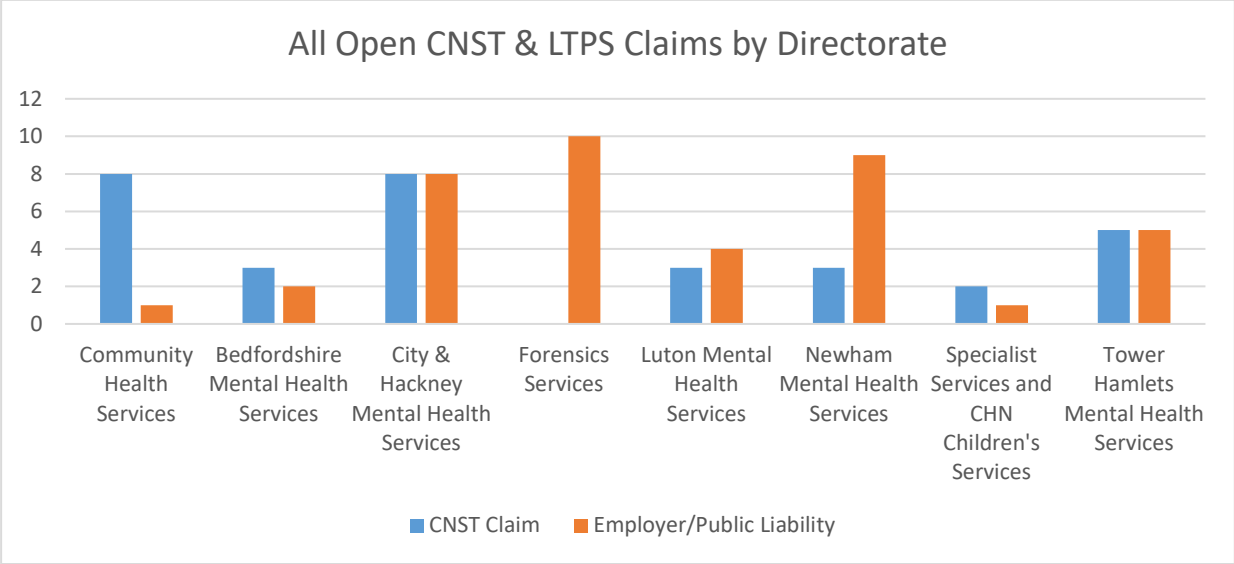
1.2. Please note the LTPS scheme covers both employer's liability and public liability claims.

1.3. The Trust's database of claims has changed since the preparation of the 2022/23 report. Due to suspected related issues with data translation/cleansing between the old and new systems, there may be minor errors(+/- 1-2 matters) in this data that will be corrected over the course of the year.

2. Claims overview

2.1. As at 31 March 2024 there were 72 open claims across both schemes. Of these, 32 are CNST and 40 are LTPS claims. In the previous financial year, there were also 72 open claims. 37 were CNST claims and 35 were LTPS claims.

2.2. The graph below shows the number of open CNST and LTPS claims, split by Directorate.



2.3. All claims are categorised on receipt based on the categorisation used for incident recording.

2.4. The estimated total value of all claims closed between 1 April 2023 and 31 March 2024 is 1,537, 613. This includes damages plus the legal fees for both claimants and the Trust's instructed lawyers. The figure got 2022/23 was £665,739.

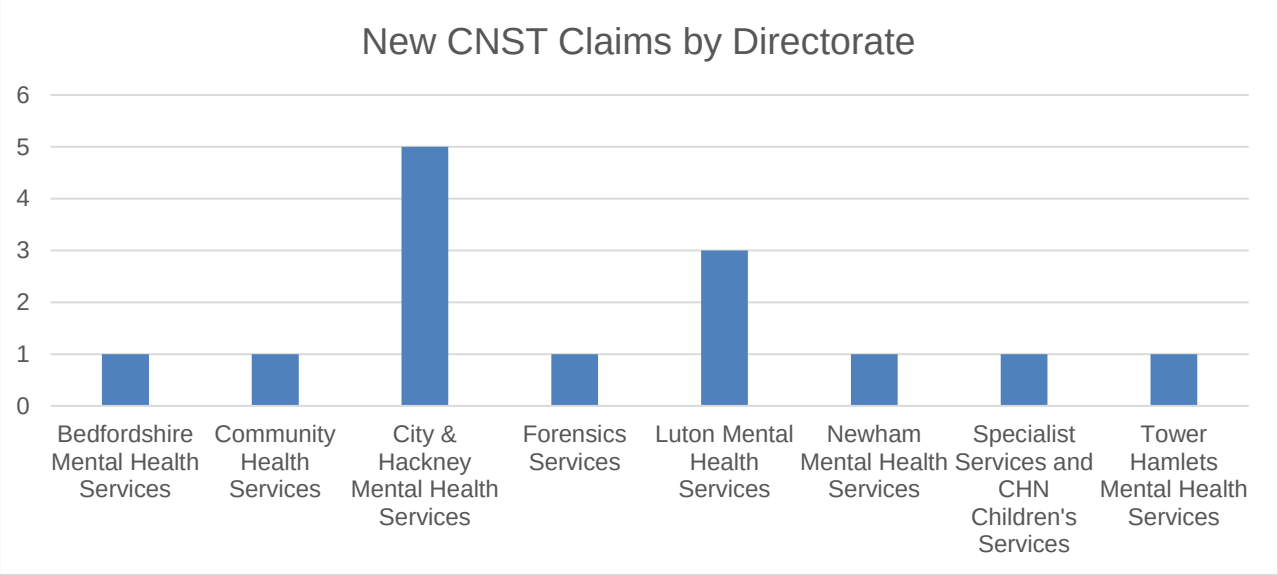
2.5. You will be aware that NHS Trusts make an annual payment to NHS Resolution to be covered by the respective CNST and LTPS schemes, which cover all CNST costs plus LTPS damages above a certain level. Levels of contribution to the CNST and LTPS schemes are determined by the levels of potential damages that could be incurred. East London NHS Foundation Trust's (the "Trust's") level of contribution to NHS Resolution for membership of the CNST and LTPS schemes has remained stable between 2022/2023 and 2023/24.

3. CNST Claims

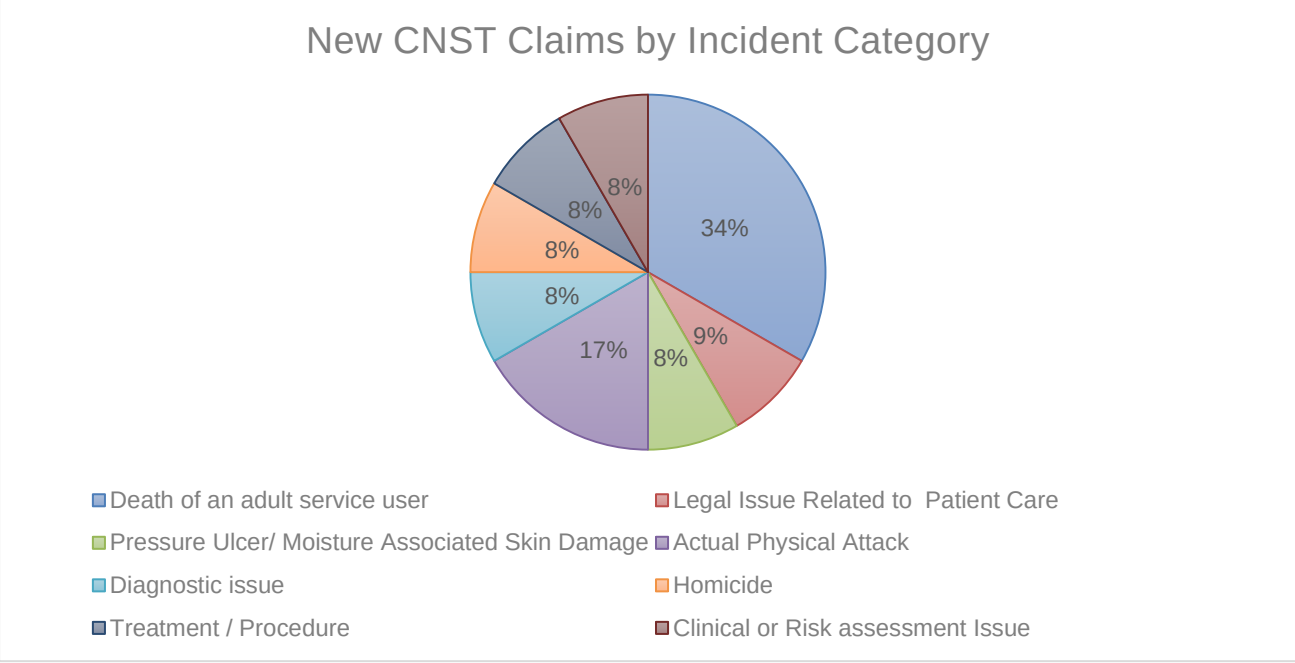
3.1. New CNST claims

3.2. Between 1 April 2023 and 31 March 2024, 14 new CNST claims were received.

3.3. The graph below shows the new claims received during this period broken down by Directorate.



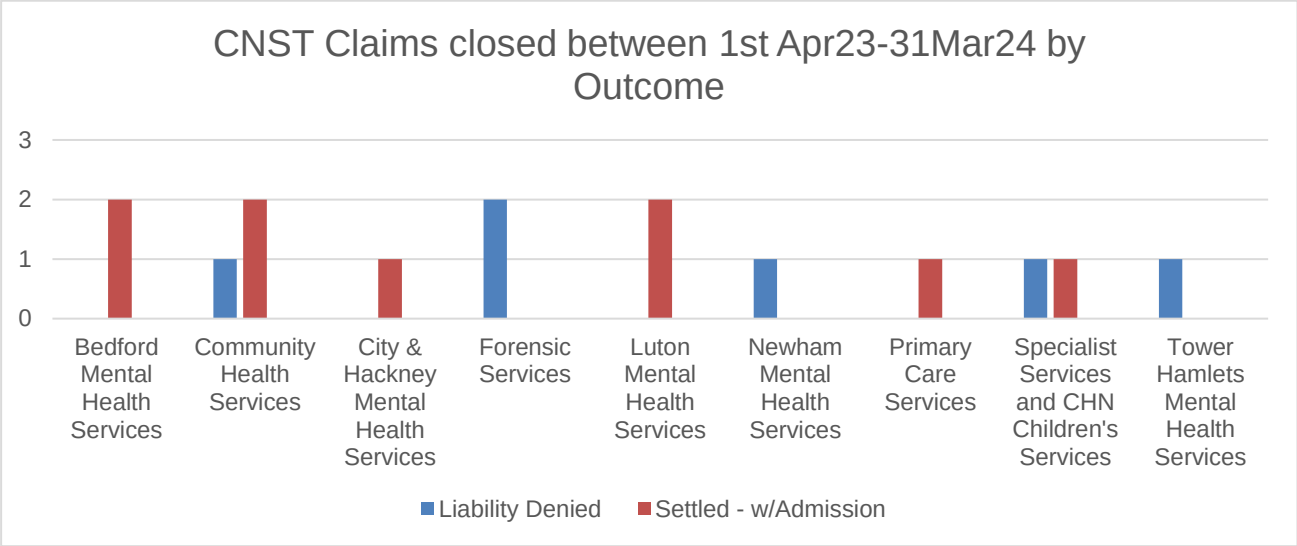
3.4. The pie chart below shows the new claims received during this period broken down by incident category (where an incident category has been recorded). Death of a service user accounts for the highest proportion of new CNST claims. This is consistent with previous years.



3.5. **Closed CNST Claims**

3.6. Between 1 April 2023 and 31 March 2024, 15 claims were closed under the CNST scheme.

3.7. The graph below shows the number of CNST claims closed during this period broken down by outcome and Directorate. For six claims, liability was denied. Nine claims settled with an admission of liability.



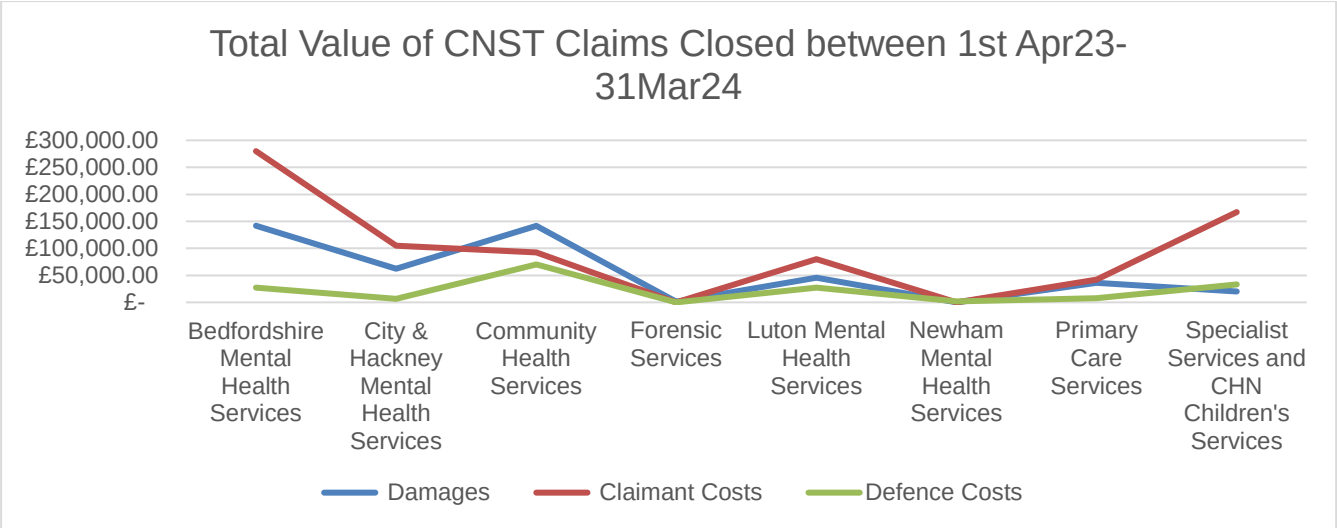
3.8. **Value of CNST claims closed between 1 April 2023 and 31 March 2024**

3.9. All CNST claims have a nil excess.

3.10. As stated above, the number and value of claims each year has an impact on the Trust's contribution to NHSR's CNST scheme the following year. The NHSR site states that *"individual member contribution levels are influenced by a range of factors, including the type of trust, the specialties it provides and the number of "whole time equivalent" clinical staff it employs. Claims history is also taken into account meaning that members with fewer, less costly claims pay less in contributions."*[1]

3.11. The graph below shows the value of CNST claims closed between 1 April 2023 and 31 March 2024 by Directorate, broken down by damages, claimant legal costs and ELFT defense costs:

[1] https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/



3.12. Damages - £448,890

3.13. Claimant legal costs - £766,500

3.14. Trust legal costs – £174,093

3.15. Total - £1,389,483

4. CNST Trends

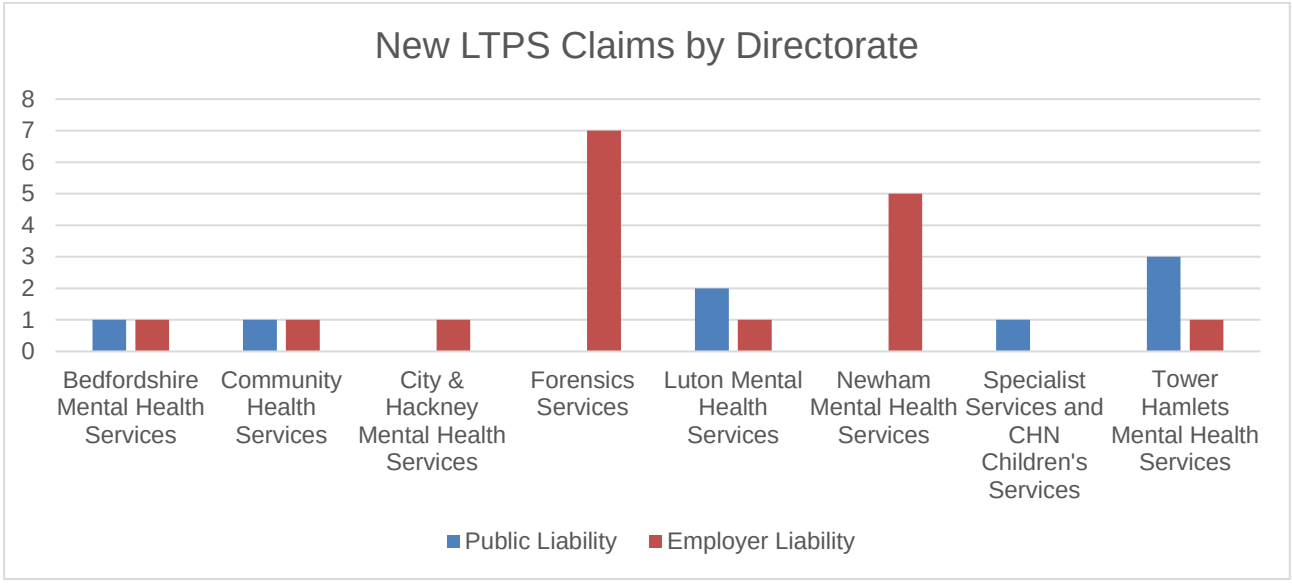
4.1. In last year's report, several claims (unusually) high value claims were highlighted. These were settled this year which explains the increase in CNST damages compared to last year. This is expected to return to the same levels of previous years.

4.2. Of the 32 open CNST claims, five involve forged observations. This matter has been raised throughout various inquests over the last 5 years. NHSR has raised concerns about this trend and the Legal Affairs Team (the 'Team) are being asked to report to NHSR on all cases where observations have been a concern, regardless of whether it is a CNST claim. Additionally, they have requested confirmation that the Trust has highlighted all observation related incidents to the CQC.

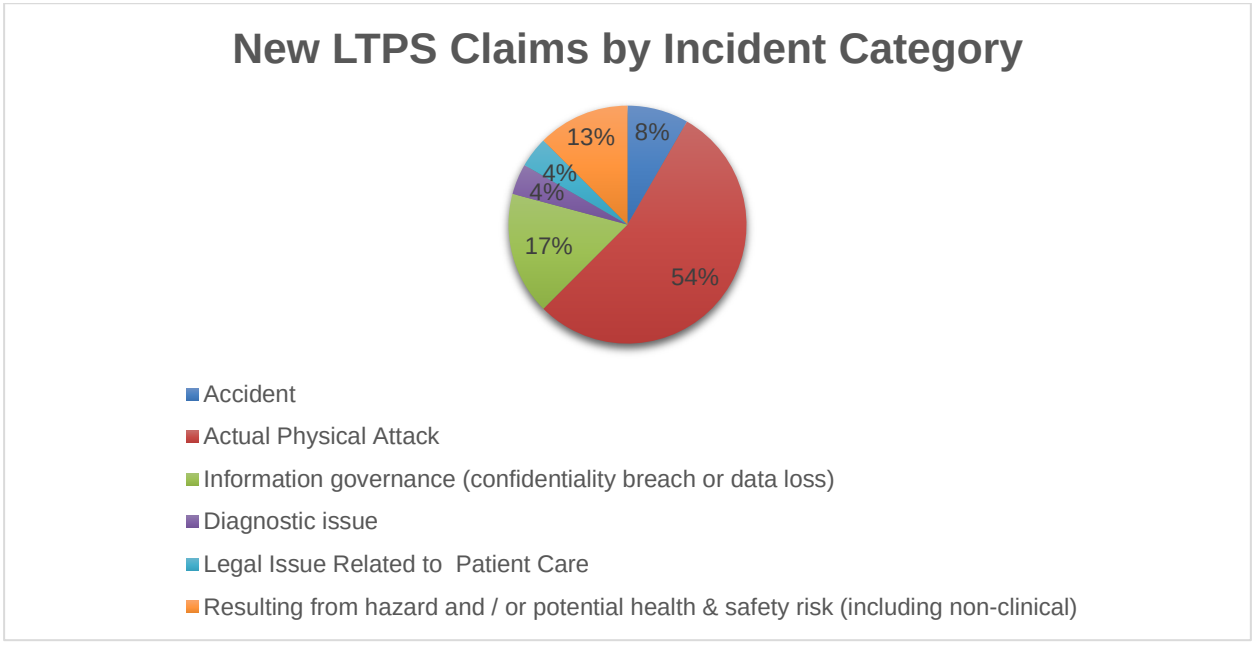
5. EMPLOYER LIABILITY AND LIABILITY TO THIRD PARTIES (LTPS)

5.1. New LTPS Claims

5.2. Between 1 April 2023 and 31 March 2024, 24 claims were received under the LTPS scheme. The graph below shows these broken down by Directorate.



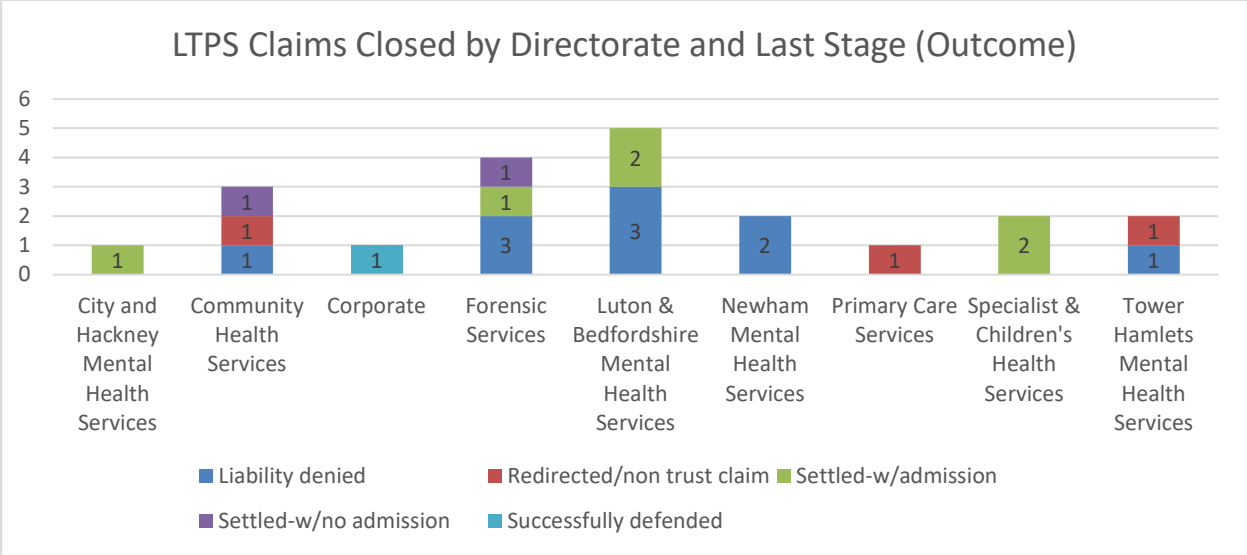
5.3. The graph below shows number of claims received during this period broken down by incident type. The highest number of claims received during this period were for violence and aggression. This is consistent with previous years.



5.4. Closed LTPS claims

5.5. Between 1 April 2023 and 31 March 2024, 22 claims were closed under the LTPS scheme.

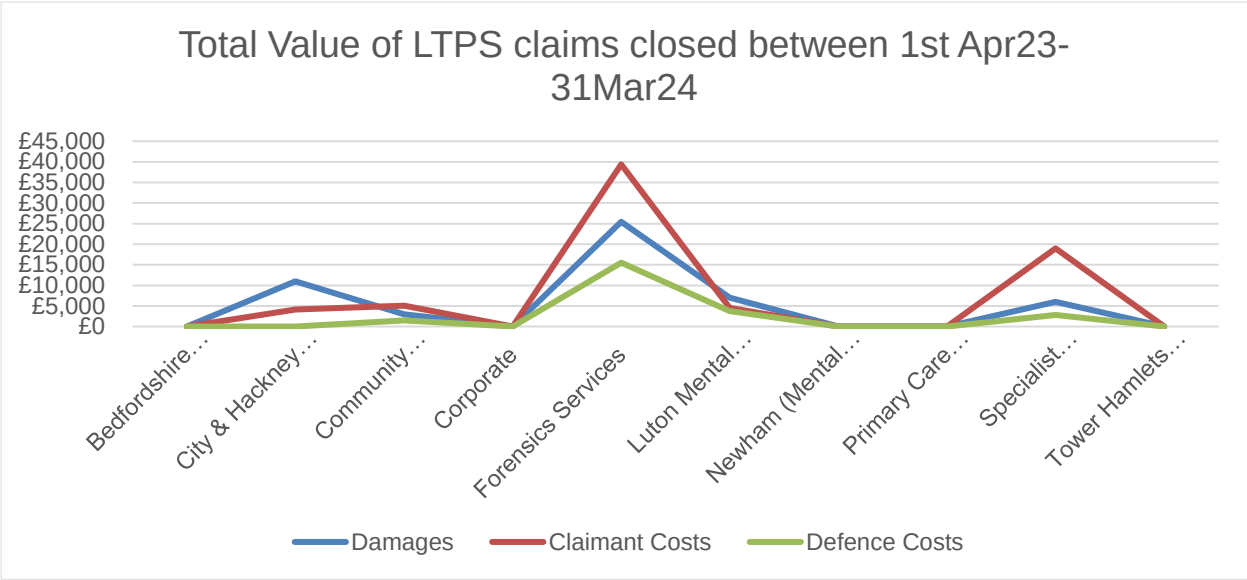
5.6. The graph below shows the number of claims closed during this period split by outcome and Directorate. Liability was denied in thirteen cases as no breach of duty could be established. Six claims were settled with admission and two settled with no admission.



5.7. Total value of LTPS claims closed between 1st April 2023 and 31st March 2024

5.8. *The Trust pays an excess on damages for LTPS claims. This is £10,000 for staff claims and £3,000 for other LTPS claims. It also pays for all claimant costs on cases for which it is found liable.*

5.9. The graph below shows the total value of the claims closed between 1st April 2023 and 31st March 2024.



5.9.1. Damages – £52,443

5.9.2. Claimant costs – £72,061

5.9.3. Trust legal costs – £ 23,626

5.9.4. Total – £148,130

5.10. **LTPS Trends**

5.11. In last year's report, we highlighted an increasing number of data breach claims. These types of claims presented for the first time in 2019/2020 with Covid. There were no data breach claims this year.

5.12. There appears to be an increase in LTPS claims surrounding allegations of lack of workplace assessments. Two of the claims relate to staff members falling off chairs. One pertains to a staff member who is alleging to have sustained an injury when he jumped off stacked chairs during a team building exercise. Two relate to injuries sustained following a manual handling exercise. There is no evidence of work place risk assessments by senior managers in each case.

6. Progress against claims workplan for last financial year

6.1. The Team has been contending with the backlog of covid jury inquests over the last three years. Therefore, our workplans from 2022-2024 have focused largely on managing these alongside the court of protection, judicial review and advisory workload. Beginning September 2024, when the majority of these inquests are completed, the Team will engage in a two-month monitoring process to see if new inquests stay stable or if the Coroner's Court increases the number of hearings to fill the space taken up by the jury inquests. The outcome will form the basis of the Team's larger workplan and goals going forward.

6.2. Despite the aforementioned increased workload, it became apparent that there may be room to improve the Team's claim's function. Therefore, all workplans and projects referred to in the remainder of this report will be solely in relation to the Team's claims work.

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6.3. A trial restructure took place beginning July 2023. The Legal Services Manager (Band 6) was seconded full-time to the role of Claims Manager (Band 7).

6.4. This proved successful, as the Claims Manager was able to focus fully on the claims workload without being distracted by the urgent queries that come with the workload described above.

6.5. They were able to highlight areas for improvement that will impact financial viability and ultimately patient safety. This relates mostly to LTPS claims as they are the only claims the Trust pays for (the excess and claimant costs) and has some control over (30 day deadline).

7. Claims workplan for the coming financial year

7.1. Due to the success of the secondment role, it will become permanent in the next month.

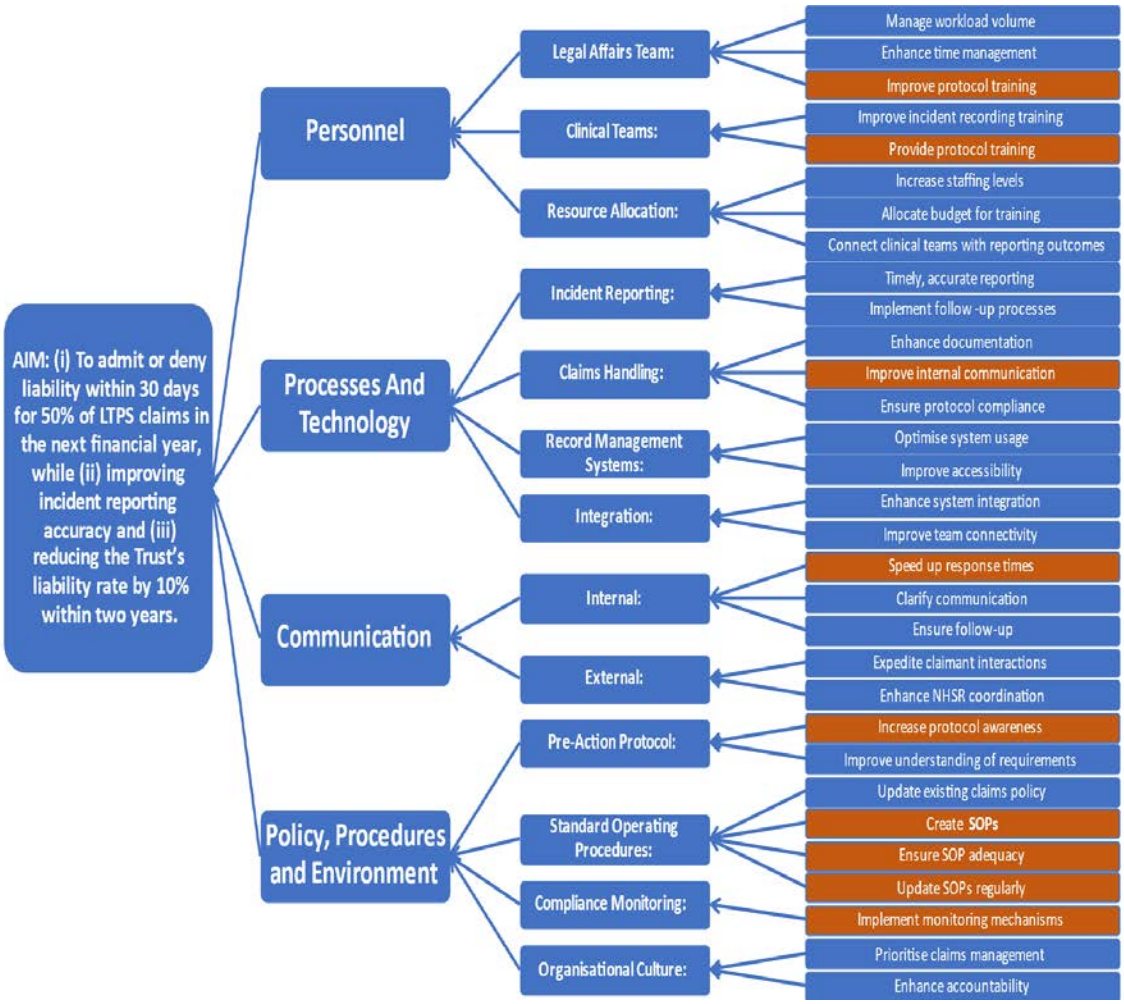
7.2. Alongside the Associate Director of Legal Affairs and the Claims Manager will head up a QI project that seeks to:

7.2.1. Decrease the number of LTPS claims by engaging the Directorates to ensure they are recording incidents with the detail required to respond to a claim. Without this information, the Trust is forced to admit liability due to a lack of evidence it can deploy in its defence. The knock-on effect is the payment of the excess and the claimant and defendant costs.

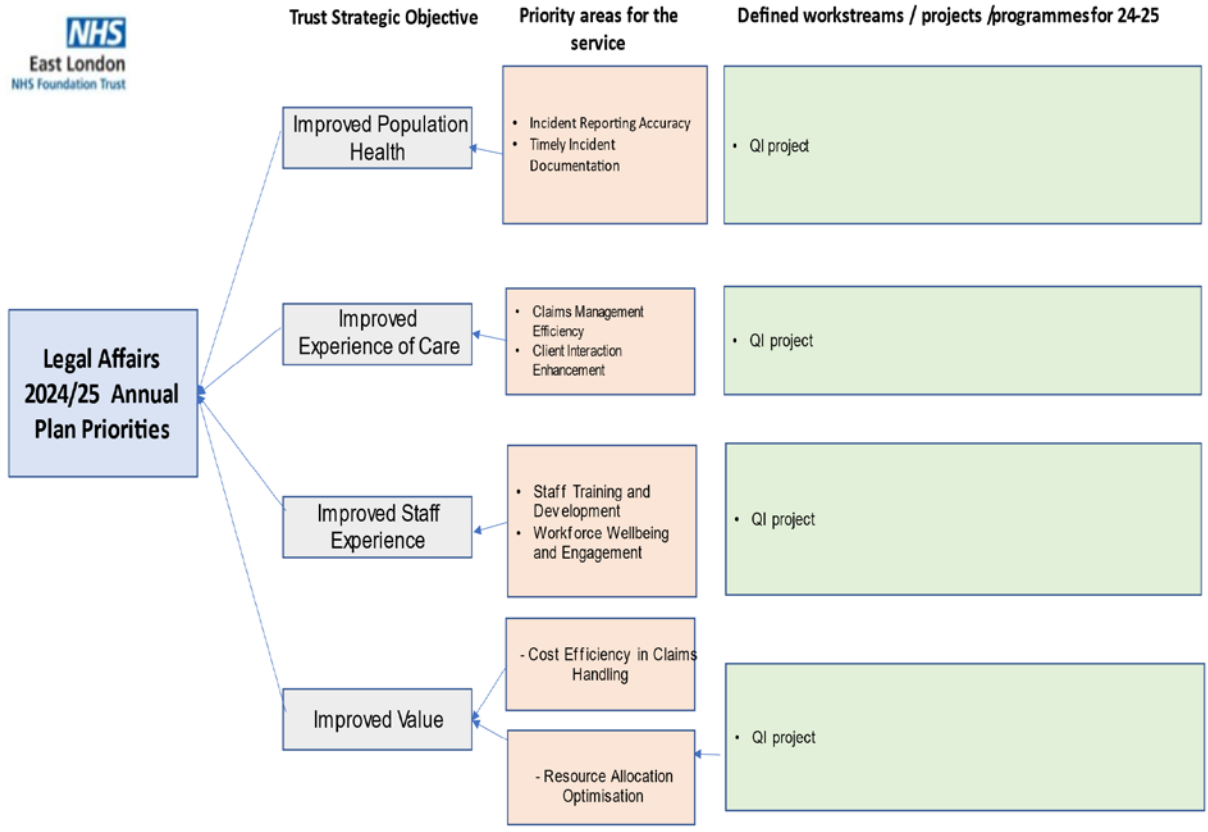
7.2.2. Increase the number of LTPS claims that are admitted or denied within 30 days. The claims pre-action protocol specifies that this limits the amount of claimant damages that can be claimed whether the Trust is found liable for an incident.

7.3. The immediate outcome of these actions should be to decrease costs to the Trust. Over the longer term we would anticipate it to have an impact on patient safety.

7.4. Please see the QI project driver diagram below.



7.5. This work feeds into the Team's annual claims plan per the diagram below.



7.6. To complete the QI project and meet the goals of the workplan, data will be collected on the number of LTPS claims for which: 1) the incident is not recorded; and/or 2) not enough detail is recorded to deny liability. Additionally, it will involve recording the reasons why the 30-day deadline is not being met.

7.7. The Team is in the process of setting up a schedule with our Corporate QI Advisor that is achievable. Our progress will be reported to the Associate Director of Legal Affairs line manager and to this committee.

7.8. The key stakeholders in delivering the plan will be the Claims Manager, the Associate Director of Legal Affairs and the Trust DMTs. The Team will seek to engage with the DMTs via quarterly face to face meetings.

7.9. The Team is lean and manages a busy and unpredictable workload. If the Coroners Courts backfill the space that will be left by the covid backlog cases keep pace or if planned maternity cover does not work optimally, the Team will not be able to undertake the project without additional support (additional staff).

8. Action Being Requested

8.1 The Board/Committee is asked to:

RECEIVE and **DISCUSS** the findings of the report

NHS
East London
NHS Foundation Trust

ANNUAL REPORT TO THE QUALITY COMMITTEE

18 July 2024

Title	Medical Education Report
Author	Prof. Frank Röhricht, Medical Director R&I and Medical Education Marius Johnston, Medical Education Manager
Accountable Executive Director	David Bridle, Chief Medical Officer

Purpose of the report

The purpose of this report is to highlight key updates of relevance to the board regarding medical education
This report is presented for information/assurance purposes.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Key messages

This report highlights our key achievements, challenges, quality interventions (internal and externally run) that have taken place in the last year. Substantial progress has been made with Faculty Development initiatives including appointing to Faculty Development Lead, IMG Lead and Faculty Development Coordinator roles, to enable Med Ed support, training and development of SAS doctors, International Medical Graduates (IMG) and wider medical cohorts. We continue to develop and implement our simulation agenda, with on-going work to develop a wider multidisciplinary simulation faculty. We also continue to support and develop our links for the hosting of international medical students from the University of Nicosia.

Whilst progress has been made, we are aware of certain challenges addressed by doctors in training and this report highlights how we are working with service leads to reduce these, and highlights key focus areas for the year ahead including analysis of and any change actions needed from General Medical Council (GMC) national trainee survey results, implementing our 'future plan' for improving the trainee experience of psychotherapy training in-Trust and also continuing to support and develop our current Physician Associates, as well as the new Medical Apprenticeship model.

Strategic priorities this paper supports

Improved population health outcomes	☒	Training of next generation of psychiatrist according to trust values to contribute to ELFT's overarching population health strategy
Improved experience of care	☒	By innovating and focusing training and teaching on positive therapeutic relationships and utilising service user lived experiences, we are creating an environment of learning that puts patient care at the heart of all learning.
Improved staff experience	☒	Exposing staff to multi-professional learning, developing our profile as a lead provider in teaching and training and developing a culture that shows positive feedback, that is shared and acted upon, internally and via external surveys such as the GMC survey.

Improved value	☐	

Implications

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	Report provided assurance to the committee on medical education activities.
Service User/ Carer/Staff	This Medical Education plan promotes an active involvement with service user representatives in the development of our programmes, and will aim to provide simulation training across all professional groups.
Financial	No financial implications are related to the report.
Quality	Quality is measured by compliance with departmental objectives as well as through regular and systematic evaluation of learning outcomes according to objectives; that includes feedback for teachers / lecturers regarding teaching style, engagement and inclusiveness.

1.0 Background/Introduction

1.1 ELFT is a major educational provider for the undergraduate and postgraduate medical education for psychiatry in the North and East London (NEL) and East of England (EoE) regions.

1.2 The Trust employs over 400 medical staff including consultants, specialty and associate specialist (SAS) doctors and doctors in postgraduate training. We also provide clinical placements and teaching to 500+ medical and Physician Associate students every year attached to Barts and The London School of Medicine and Dentistry (Queen Mary University of London - QMUL) and Cambridge University. We also have our medical student numbers increased with our international collaboration with University of Nicosia; we currently host 12 UNiC students per year but have plans to increase these numbers for the upcoming academic year 2024-25.

1.3 Doctors in postgraduate training at ELFT are attached to NHS England (NHSE) North Central and East London and NHS England-East of England (NHSE-EoE). The training programmes include core and specialty psychiatry training, GP specialty and Foundation training programmes.

1.4 ELFT employs GPs within the GP practices that it runs and in clinical or managerial and leadership roles within community services. Additionally, we work in partnership with the GPs in East London and Bedfordshire.

1.5 Our ambitious forward going plans emphasise the educational contribution to the overarching trust strategy: improve the quality of life of all we serve. Therefore, the service user perspective features in all multi-professional learning sets; we integrate a range of new technologies and innovative experiential learning methods to prepare the medical workforce for a radical shift of practice that relies in great parts on co-production, interpersonal skills and artificial intelligence. The main objective is to deliver personalised health care and 'precision medicine' across population health footprints rather than within narrow frameworks of specialist services.

1.6 Medical Education's USP:

2.0 Report Content

2.1 The purpose of this report is to highlight to the committee key updates within Medical Education for information

3.0 Achievements in the last year

Postgraduate

3.1 **Medical Education Faculty Away day:** In October 2023, the Medical Education Faculty regrouped to review priorities and set out what is to be delivered in the next 5 years, taking what we have learnt from the last five years and the new structures we developed during the pandemic, considering the evolving workforce needs of the future. Reflecting key components of quality in all clinical learning environments for all learner groups, and our commitment to developing a sustainable workforce, we decided to map our key priorities for 2023 – 2028 against the HEE Quality Framework 2021 as well as the NHS People Plan aligning to ELFT's primary driver of improved experience of staff.

3.2 **Faculty / IMG / SAS development:** Following successful appointment to Faculty Development Lead, IMG Lead and Faculty Development Coordinator roles substantial progress has been made with Faculty Development initiatives. In autumn 2023 our faculty Development Lead with Medical Education support conducted focus groups and surveys of trainees and trainers, looking at how we can further develop the skills of our trainers. We have reviewed the format and content of existing courses, as well as the feedback received and based on this we have made more of the courses face to face, and in particular ensured that the training curriculum is covered, as well as all other HEE required domains. We have also increased the availability for popular courses, for example running extra coaching and mentoring training, along with sessions for supervisors supporting trainees involved in serious incidents.

We have developed an innovative new simulation course focusing on supporting trainees who are international medical graduates (IMGs). This was co-produced with

IMG trainees and the Medical Education IMG and Faculty Development leads, and was successfully delivered in May 2024 with positive feedback. The IMG lead has also contributed to developing a standardised support package, not only around organisation induction but around logistical and practical support being offered to overseas recruits by ELFT.

For our SAS cohort of doctors a large number of developmental and leadership courses have been delivered throughout the year with funding received from NHSE, supported by our SAS Tutor and SAS Advocate roles and Medical Education. Our first ELFT SAS Wellbeing day was held during SAS week in October 2023 with higher management support and we also supported and ran a successful SAS Away day in March 2024 that was well attended, positive feedback received and which included a group activity for SAS doctors to think about shaping the future of SAS doctors in ELFT with lots of engagement and ideas discussed to work towards, as part of our commitment to the SAS Charter.

Undergraduate

3.3 **University of Nicosia international students**: We continue to successfully support an ongoing rotation of medical students from the University of Nicosia. Students were clinically supported by a consultant psychiatrist from the Community Integrated Mental Health Service team in the Newham locality. This has now expanded to Older Adult and Psychotherapy specialities too. Academic placements have gone well, with positive feedback consistently received (our placements have received the highest feedback scores across the placement scheme) and we are currently planning for the 24/25 cohort of UNiC students, with discussions ongoing regarding an increase in student numbers and the additional funding this will provide.

3.4 **QMUL (London) and University of Cambridge (Luton & Beds) medical students:** We continue to support a significant number (500+) Year 2 and Year 4 medical students across London and Luton & Beds:

i) Our first Quality Assurance site visit in Luton & Beds was held in November 2023, with excellent feedback received from the Cambridge University visiting team and no concerns raised. This will now be a recurring yearly visit, with the next one planned for November 2024.

ii) For our (London) Y4 psychiatry clinical skills workshops that provide OSCE-style teaching to promote self-confidence, communication skills, and clinical acumen, this year we have included Service Users from the ELFT Academy of Lived Experience. With support and guidance from our Medical Educations Fellows, Services Users have been able to give constructive feedback to students, and to develop scenarios to role-play in place of the usual agency actors. The feedback for these sessions is excellent and agency actors, clinical staff and students have valued the inclusion of a lived experience (LE) angle.

iii) Formal teaching sessions for Y4 students have also been transformed by our current Medical Education Fellows, with 2 sessions of team based learning in place of traditional lectures piloted. Both the formal feedback has been exceptional for these sessions and attendance has vastly improved. The development of these new sessions has again benefitted from the collaboration and involvement of LE colleagues at every step.

iv) Our yearly London Quality Assurance site visit by QMUL was held in April 2024 with overwhelmingly positive feedback received from the visiting team.

v) Our Undergraduate (UG) Medical Education Away Afternoon was held in June 2024 as an opportunity for our UG faculty members and Medical Education to meet, reflect on the previous academic year and discuss forward thinking plans and improvements. It was also attended by the Head of MBBS from QMUL, who

put forward our ‘complex case management and lessons learnt’ session to be included in their GMC good practice log as one of the best examples of reflective practice and educational governance seen at an NHS placement provider.

4.0 Challenges

4.1 Finance and cost pressures for appointing to RCPsych stipulated Addictions Tutor and Lead Psychotherapy Tutor roles is an ongoing challenge and a resolution needed considering this links into completion of addictions competencies for Core Trainees (for the Addictions Tutor role) and our ongoing work within Medical Education around improving psychotherapy training delivery and support considering trainee feedback from the 2022 GMC survey; for the Lead Psychotherapy Tutor role for ELFT, this post is currently appointed to, however, this is job planned in SPA time and not through paid additional programmed activity.

4.2 Expectations and demands of Consultant’s clinical time commitment is constantly increasing which is contributing towards tensions between service and training provisions. A number of Medical Education interventions have had to take place as a result of Clinical Supervision being compromised which will require ongoing monitoring and liaison with Clinical Directors. Due to high level of clinical workload pressures across the Trust there is also the continued difficulty of identifying nominated supervisors for Undergraduate and Postgraduate supervision.

4.3 NHSE withdrawal of central funding for our Physician Associate Ambassador role for the current financial year and moving forwards was unexpected and has created a challenge for this Medical Education work-stream. Physician Associates pooled funding couldn’t be identified from medical budgets to continue to support the appointment of a substantive PA Ambassador role within ELFT, which ultimately led to our PA Ambassador resigning. Our PA workforce has also reduced from a previous total of 8 PAs working in-Trust to 3 currently working in clinical services. The wider debate around the Physician Associate workforce at NHSE and RCPsych has also impacted our ability to support the PA workforce.

5.0 Formal Quality Interventions

5.1 Following NHS England (NHSE) interventions and meetings held with trainees in City & Hackney and the Coborn Unit following the 2022 General Medical Council (GMC) National Trainee Survey (NTS) results, Medical Education in liaison with NHSE, local service leads and trainees have been methodically working through outstanding NHSE actions towards resolutions. To enable this we completed a process mapping exercise and created a document to know exactly where we need to focus on to implement changes to improve the trainee experience.

5.2 Significant improvements have been made locally and innovations continue to be implemented and carried forward, such as a monthly trainee safety questionnaire, standing agenda items in local Junior/Senior meetings to discuss areas of concern led by trainees and the implementation of a standard operating procedure for trainees being chaperoned when attending wards out of hours whilst covering on-calls.

5.3 Whilst we are pleased to confirm all outstanding actions with NHSE have now been closed, we continue to work closely with service leads to regularly review the training experience and work with trainees to further improve the quality of the training experience they receive. To that end, outside of the standard forums (Junior Doctors Forum, local Junior/Senior meetings etc), we have also introduced a monthly meeting between Medical Education and trainees reps, to provide an open forum for trainees to feedback to us, along with the introduction of a dynamic ‘you said we did’ document,

where trainee feedback received from a number of forums and platforms is inputted and maintained with Med Ed actions, and regularly sent to trainees so they're aware what work is being carried out to support their training needs and experience.

6.0 Plan for Coming Year

6.1 **GMC trainee survey:** The GMC trainee survey plays a key role in our being able to gauge trainee satisfaction across the training schemes we support. The results are due to be released circa mid-end July 2024 and will be one of our main priorities for initial analysis and interpretation of results, feeding back trainee responses to clinical services and implementing any improvement actions that are highlighted, in liaison with NHSE and service leads. We have a meeting scheduled with NHSE in early August 2024 to discuss the results and to work in collaboration as needed. We will also utilise our trainee feedback forums and tools highlighted within this report (monthly trainee rep meeting and 'you said we did' document etc) across the year to ensure trainees continue to feel supported and any actions required are carried out with their input.

6.2 **Psychotherapy:** A priority for the year ahead will be implementing our psychotherapy 'future plan,' developed by Medical Education and our Trust Psychotherapy Lead in response to feedback received by trainees as part of the City & Hackney quality intervention, towards improving trainee experience of psychotherapy training competency delivery in ELFT. We will again be utilising our trainee feedback forums and tools highlighted within this report across the year to gauge improvement through direct feedback received, and to ensure trainees continue to feel supported in meeting their psychotherapy training competencies.

6.3 **Physician Associates / Medical Apprenticeships:** Despite the challenges highlighted above we continue to support our Physician Associates. We have also highlighted a small amount of funding to enable our former PA Ambassador to work with us for a small number of hours on an ad-hoc Bank basis, which is work in progress, to continue with our PA work-stream and to support PA development. Our plan is to also highlight some additional funding to enable the permanent appointment of a Band 4 in Luton & Beds, who was employed on a fixed-term basis from funding received from NHSE, and who is now fully embedded in supporting Medical Education activities in Luton & Beds. The Medical Doctor Degree Apprenticeship scheme, as part of the NHS Long Term Workforce Plan, is a relatively new scheme and a cross-London conversation is still to take place with NHSE and other NHS Trusts to discuss implementation, which we will actively be involved within.

6.4 **Simulation:** Whilst initial support for simulation development within MDTs is very positive, there is slow development of a simulation faculty amongst other professional staff groups. Our aim is to further develop ELFT's definition of Simulation and how we can incorporate it further in MDT settings. To that end we have joined NELFT to create a bespoke train the trainer package to do in-house Simulation Based training for staff who want to join the simulation faculty. Further progress on this last point will enable us to create a simulation programme not just for doctors but for all staff (MDT based). We were also successful in highlighting funding that enabled the appointment of an additional Medical Education Fellow, starting in August 2024, who will spend half or their time focused on simulation, with the intention they can assist with pushing our simulation agenda forward. Progress will be evidenced by expansion of our simulation faculty and wider engagement by MDTs and other staff groups.

6.5 **Faculty / IMG / SAS Development:** To provide additional support to IMGs, supplementary induction material is being developed and an IMG webpage is under

construction. This is in line with national recommendations for NHS organisations who employ IMGs ('Welcoming and Valuing IMGs: A guide to induction for IMGs recruited to the NHS') and both our SAS Tutor and SAS Advocate are involved in this conversation, to support newly employed IMGs. We also continue to develop training for supervisors on differential attainment training (the unexplained variation in attainment between groups who share a protected characteristic and those who do not share the same characteristic, for example, ethnicity, gender and disability), and safe orientation to the NHS and ELFT. Within our faculty development agenda we are planning to deliver new courses later this year on 'supporting trainees with violence' and also 'how to deliver simulation training,' the last of which will help support our wider simulation agenda. There are also ongoing conversations between Medical Education, SAS Tutor and Advocate, IMG and Faculty Development lead roles, to set out a continuation of our development programme for our SAS doctor cohort for the year ahead. Our SAS doctors are actively involved in this conversation based on regular feedback forums including the recurring SAS Steering group meeting.

7.0 Action Being Requested

7.1 The Board/Committee is asked to: **RECEIVE** and **NOTE** the report

NHS
East London
NHS Foundation Trust

ANNUAL REPORT TO THE QUALITY ASSURANCE COMMITTEE

18 July 2024

Title	Annual Report on Research & Innovation
Author	Karin Albani, Associate Director of Research Frank Röhricht, Medical Director R&I and Medical Education
Accountable Executive Director	David Bridle, Chief Medical Officer

Purpose of the report

To present to the Quality Assurance Committee (to receive and note) the Research & Innovation (R&I) activities taking place within the Trust over the last year and give the committee an update on the progress on our five-year plan to transform into a corporate function supporting our services to deliver the improvement agenda, and broadening the spectrum of what we mean by 'R' to include not just clinical research trials, but also service evaluations, case studies, and dovetailing research with QI (Quality Improvement).

Committees/meetings where this item has been considered

Date	Committee/Meeting
30 May '24	Research Committee

Key messages

Innovation and research is a key part of the work of the NHS, ensuring that patients in the UK continue to benefit from improved and modern services, and helping to deliver better outcomes to patients across the country. The primary objective of the R&I department, therefore, is to maximise opportunities for our citizens to participate in research, while minimising the demand on clinical services.

To that end, recruitment into research studies in 2023/24 increased for the fourth consecutive year to an almost record high, with a particular focus on reaching out to underserved communities, while also widening both our geographic reach and the breadth of clinical services we engage.

However, in spite of some success in launching peer networks of both staff Research Champions and local ELFT study leads (also referred to as Principal Investigators, or PIs), we continue to struggle to collaborate effectively with our clinical services. Indeed, throughout the NHS, R&I continues to be perceived as an optional add-on, needing resource from clinicians, but not embedded as core to our service delivery.

Strategic priorities this paper supports

Improved population health outcomes	☒	Evidence shows that the engagement of clinicians and healthcare organisations in research is associated with improvements in healthcare performance.[1] Patients cared for in UK trusts with strong research activity have improved health outcomes – lower mortality and less post-operative complications.[2] Moreover, the benefits apply not just for patients enrolled in the research, but other patients with the condition who didn't take part in studies.

[1] Silberman et al., 2012, *Recruiting researchers in psychiatry: the influence of residency vs. early motivation,* Academic Psychiatry, 36(2): pp. 85–90.

[2] Downing A, et al, (2017) *High hospital research participation and improved colorectal cancer survival outcomes: a population-based study*. Gut. 2017 Jan; 66(1):89-96.

Improved experience of care	☒	Patients express strongly positive experiences of participating in research, highlighting their empowerment and the strength of their relationship with clinical teams. The National Institute for Health Research (NIHR)[3] conducts an annual survey on the experience of those taking part in clinical research, which regularly finds that over 90% would consider taking part in research again.[4]
Improved staff experience	☒	Staff who conduct research also report positive outcomes for themselves, which should facilitate recruitment and retention of committed and qualified staff and strengthen a general atmosphere of enthusiasm, creativity and positive change. The Royal College of Physicians now stresses the importance of research as part of direct clinical care for doctors.[5]
Improved value	☒	Research is recognised in the NHS constitution[6] and is a key objective in NHS England's long-term plan.[7] The NIHR took this evidence to the Care Quality Commission, which include questions about research in the "well-led" domain of their assessments of trusts.[8]

Implications

Equality Analysis	No equality impact assessment has been carried out. Research carried out however should aim to improve access to treatment for all.
Risk and Assurance	Research should assist in the mitigation of Trust risks.
Service User/ Carer/Staff	The scope of research should extend as widely as possible, therefore all directorates and service groups are potentially impacted.
Financial	Trust investment required but full details are not laid out in this paper.
Quality	Impact on quality and effectiveness of service provision and care of patients.

1.0 Background

1.1 Innovation and research is a key part of the work of the NHS, ensuring that patients in the UK continue to benefit from improved and modern services, and helping to deliver better outcomes to patients across the country. The Government expects us to promote and support participation by NHS organisations, patients and carers in research.

1.2 Evidence shows that the engagement of clinicians and healthcare organisations in research is associated with improvements in healthcare performance. Furthermore, clinical trials activity is associated with improved Care Quality Commission (CQC) ratings.

[3] The Department of Health and Social Care's (DHSC) established the NIHR in 2006 to "create a health research system in which the NHS supports outstanding individuals, working in world-class facilities, conducting leading-edge research focused on the needs of patients and the public". Working in partnership with the NHS, universities, local government, other research funders, patients and the public, the NIHR funds, enables and delivers health and social care research focused on early translational research, clinical research and applied health and social care research.

[4] NIHR Participant in Research Experience Survey (PRES)

[5] *Delivering research for all: expectations and aspirations for the NHS in England*, Royal College of Physicians (April 2019)

[6] NHS England. The NHS Constitution for England. NHS, 2015.

[7] The NHS Long Term Plan, *Research and innovation to drive future outcomes improvement* (2019)

[8] Care Quality Commission (2018) *CQC Inspection framework: NHS trusts and foundation trusts: Trust Wide Well Led* (W8)

1.3 Service Users generally find satisfaction in participating in research studies. Playing an active role in their own healthcare is empowering, and research volunteers gain a sense of gratification from their contributions to society.

1.4 ELFT's mission is to improve the quality of life for all we serve. Our vision for the Research & Innovation (R&I) function in ELFT is to work together with, and in support of, our care services' objectives to continuously improve.

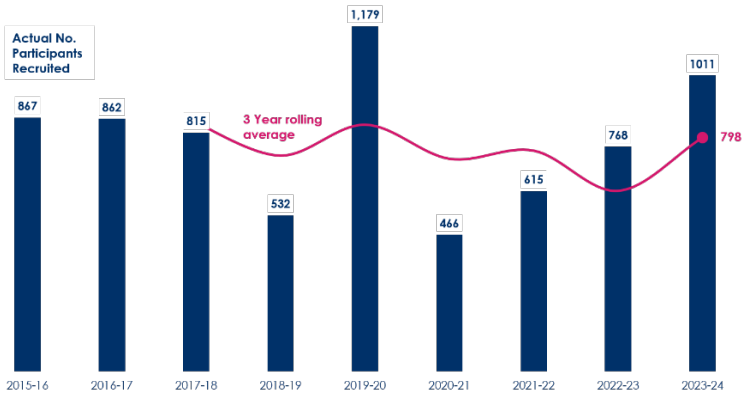
1.5 ELFT is now four years into a five-year plan (App A) to transform Research & Innovation (R&I) into a corporate function supporting our services to deliver the improvement agenda, and broaden the spectrum of what we mean by 'R' to include not just clinical research trials, but also service evaluations, case studies, and QI. This report provides an overview of the progress we have made over the past year.

2.0 Key achievements during last financial year

2.1 Priority: maximise opportunities for our citizens to participate in research, while minimising the demand on clinical services

2.1.1 Recruitment into research studies in 2023/24 increased 32% year on year (the fourth consecutive year we've seen an increase) to an almost record high with over 1,000 participants enrolled into 29 studies from the NIHR research Portfolio[9] although this increase was significantly reliant on recruitment into survey, rather than observational or interventional studies. This is almost two-thirds above the average recruited at other London based trusts providing mental health services.[10]

Figure 1: Total recruitment to NIHR Portfolio studies



2.1.2 We have made a conscious effort in ***increase recruitment of participants from underserved communities***. For instance, for the Genes & Health study, which aims to improve population health in Pakistani and Bangladeshi communities, we have set-up drop-in clinics and approached potential participants in community settings e.g. Roshni cooking group in Luton. We also worked with the Trust Communications team to create a bespoke mail-out for this study, which included translated study information in Urdu and Bengali. We also delivered two studies that involved the recruitment of people with learning disabilities, who are often excluded from taking part in clinical research. Currently, we are exploring the feasibility of running a focus group for the PEGASUS study, which aims to

[9] NIHR Clinical Research Network (CRN) support is available to all studies, regardless of location, study type, study size, therapy or research area, provided they meet the DHSC established eligibility criteria. Those that do are considered part of the *NIHR Portfolio.*

[10] We exclude SLAM from peer group comparisons since it is part of the designated NIHR Biomedical Research Centre for Mental Health which means they should (and do) outperform everyone else in the nation. But they also receive over £100m investment - exponentially more than any other mental health Trust.

improve physical health in people with severe mental illness, in a language other than English in Luton.

2.1.3 Successful delivery of ***commercial research*** has been identified as priority area for the Department of Health and Social Care, but quite difficult to implement in mental health and community settings. This year, we participated in two commercial research studies, with a third study currently in set-up.

2.1.4 This year, we have actively prioritised ***widening our research portfolio to reflect our both our community as well as our mental health care services***, incorporating a range of studies across different specialties and services, including tissue viability, smoking cessation, perinatal mental health, forensics, learning disabilities to name a few. Indeed, last year ELFT recruited studies in more speciality areas than any other community and/or mental health care provider. In spite of this, 79% of the trust's 2023/24 portfolio of recruiting studies are badged as mental health, an increase from 76% in 2022-23 and 60% in the 2021-22 financial year.

2.1.5 Following on from feedback and interest from services across the BLMK (Bedfordshire, Luton & Milton Keynes) region to take part in research, we have ***rebalanced our workforce across the geography we serve***, creating two full-time posts based in Luton. These two posts along with one study-funded Research Assistant have enabled us to increase the volume of research delivered in the region.

2.1.6 Feedback from Trust clinical services has indicated ***more direct engagement with clinical teams*** is required in order to ensure successful study delivery. To meet these needs, we implemented a shift from a study-led model to one focused on clinical areas, with each Clinical Studies Officer (CSO) taking responsibility for at least two clinical areas and acting as the lead research liaison for that service.

Whilst this approach has required more time dedicated to service engagement, we have received positive feedback from services, PIs and our CSOs, who see this as a good career development opportunity. This collaborative working style is likely to have a direct impact on recruitment numbers in the longer term, as evidenced by some of our studies where we have successfully implemented this approach over the past year e.g. the RAPID trial where we now consistently recruit around seven participants per month on average.

2.1.7 Following feedback from clinical services and benchmarking programmes at other Trusts in the region and nationally, we revised and relaunched the Trust Staff ***Research Champions*** programme. We were successful in recruiting two dozen Champions from a wide range of services and professional groups to this year's cohort.

However, we are still working on ways to ensure successful engagement at workshops. We are working on seeking feedback from the Champions at every step of the process and incorporating these into the programme. For instance, rather than all workshops being held face-to-face, we are now alternating between in-person and virtual workshops.

2.1.8 We started a new ***network for Principal Investigators*** and Local Leads of research studies across the Trust to get together and share their experiences and learning. The first event held in November 2023 included talks from external speakers highlighting training and support available for interested clinicians. As a result, we now have one of our hosted studies enrolled onto the NIHR Associate PI scheme.

2.1.9 Navigating the various study options and their respective governance routes can be a potential hurdle for teams wanting to undertake an improvement project. To

assist we recruited a multidisciplinary team, including lived experience experts to ***design a series of two short animations*** to help investigators choose which route to take and how to get the right permissions *(click on the screen shots below to view the animations)*

Figure 2: Which route to take on your R&I journey? – choosing a study type

Figure 3: Taking your R&I project forward – which permit do you need?

2.2 Priority: Growing our own portfolio of applied research

2.2.1 Following last year's announcement of a partnership with University of Cambridge, we have appointed Dr Shobhana (Shobi) Nagraj as the new Associate Professor of Community and Primary Care. Dr Nagraj is a clinical academic, with a background in implementation science and theory-informed design and evaluation of complex interventions. Her research focuses on developing innovative models of care for improving maternal child health across the life course. Shobi has worked extensively with grassroots organisations in low resource settings both globally and locally, to co-design interventions that meet the needs of communities, service-users and the healthcare workforce.

2.2.2 During her first year in post, Shobi will be working on creating a research hub in Bedfordshire & Luton to enable clinicians in the area to engage with research and to advance quality of care improvement initiatives, using novel research methodologies. She will also be creating a research network between ELFT communities and the university to address their needs, tackling global challenges in a local setting. Her focus will be on the first 1000 days or life and early years.

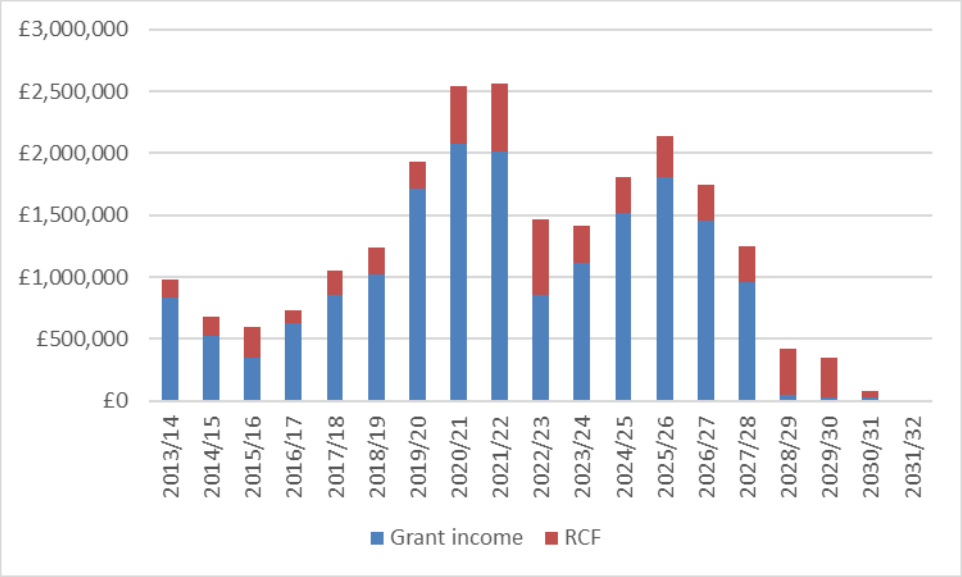
2.2.3 We have replaced a variety of letters of commitment with a new overarching agreement for working with City, University of London modelled after the Cambridge University partnership, and used these as the basis for renewing our agreement with Queen Mary, University of London (QMUL) so that all partnerships are formalised on a similar basis.

2.2.4 In 2023/24 the NIHR entrusted one new research grant to ELFT's management as host organisation. Dr Afia Ali from QMUL's Unit for Social and Community Psychiatry, was awarded £2.5m over the next five years for a programme seeking to improve quality of life and behaviour that challenges in people with mild to moderate intellectual disability through person-centred solution-focused communication (ICONIC).

2.2.5 Our revenue from research grants, including the associated Research Capability Funding generated, averages about £1.5m per annum.[11] However, we need to continuously replace the pipeline of research grants or this revenue stream can quickly peter out (see Figure 4 below).

[11] Average from 2013/14 through 2027/28

Figure 4: Annual revenue from research grants[12]



2.2.6 At QMUL's Youth Resilience Unit, Jennifer Lau has been awarded £3m to establish one of five new research hubs, which form the basis of the UKRI mental health research platform to tackle key challenges in severe mental illness. Prof Lau's hub aims to generate new knowledge on the role of social determinants (the conditions in which people are born, grow, work, live and age) in influencing the course and outcomes of serious mental illnesses (SMIs) and explore how we can leverage 'protective' social factors to build resilience and recovery in people with SMIs. ELFT is an intended delivery site for this research, bringing the latest opportunities to the young people in our region.

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

2.3.1 ***Specialist research finance expertise:*** The complexity of the research funding arrangements means that specialised expertise is required. Understanding the cost attribution and various funding streams relating to research is very different from mainstream NHS financial management where in the main there are fewer funding streams, mainly related to commissioned services (clinical commissioning groups or specialised services).

A significant challenge is that there are numerous funding bodies, with varying application processes and reporting requirements. There is no standard application form or process across the numerous bodies. Teams supporting researchers need to be able to interpret specific guidance on funding applications to not only understand, but also plan and schedule the various financial reporting requirements of the numerous funding bodies once funding is awarded. This regularly spans Trust financial years.

Additionally, the recognition of research income within NHS has grown up over time, with practice and some guidance not consistent with accounting rules and the DHSC group accounting manual. Application of accountancy guidance may generate conflict between various significant interest groups and may create practical difficulties. There is often a lack of understanding between contract income and income through grants and role of sponsor.

All of the above leads to the necessity of specialist research finance expertise in order to maximise value and minimise risk. We drafted a business case and were able to achieve consensus around the option that Trust finance would take on

[12] Actual figures for 2013/14 to 2023/24, and projected from 2024/25 onwards

additional responsibility to provide this support. Turnover within the department has delayed implementation until 2024/25.

2.3.2 We had a goal to undertake the ***first QI project in the R&I department***, specifically aimed at improving the way in which we engagement with clinical services to set-up and delivery studies. This aim was launched at the first Research Champions' workshop where we attempted to scope out the problem and develop our driver diagram. Unfortunately, we were unable to find a clinical service interested in working with us to pilot / develop the proposed QI project.

Instead, we have returned to the initial problem scoping data and pivoted to a new area to focus our efforts on which does not rely on engagement from clinical services. In 2024/25, the IMPART *(IMproving research PARTicipants' experience)* project will apply QI methodology to increasing responses from ELFT research study participants regarding their experience via the NIHR Participant in Research Experience Survey (PRES). Our aim is to use this feedback to identify further areas for iterative improvement, as well as develop an evidence base for constructive engagement with services, and ensure that service user feedback is taken into account when we set-up new studies. This project also has allowed us to build a good working relationship with the Trust QI team, which we hope to continue in the future.

2.3.3 Bring together under a joint ***'People in Research'*** banner, the lived experience research advisory panel developed at City, University of London (known as SUGAR) with the Trust's service user and carer led mental health research group (known as PPLR) whose purpose is to facilitate and conduct health research, with a particular focus on integrating service user and carer perspectives and experiences into the research process. However, with the main driver of this project on parental leave, we were unable to make progress beyond initiating the change management process of moving SUGAR from the university to the Trust, and it is unclear whether there is resource to support further development of the initiative.

2.3.4 While revenue from research grants will always have a net zero impact on the Trust's financial position (funders only pay for expenses actually incurred), we could be better at exploiting our research ideas for income generation, for example, to offer training in the DIALOG+ intervention. We need to join up better across R&I, Business Development and QI to identify opportunities at an early stage

3.0 Objectives for the coming financial year

3.1 In addition to the plans noted above, other initiatives on the horizon for 2024/25 include:

3.1.1 Working with the World Health Organisation (WHO) Collaborating Centre for Research and Training in Trieste, and the Italian National Research Council, ELFT is developing a proposal to ***pilot a "Trieste Model"*** of delivering mental healthcare services in East London.

Recognized by the WHO as demonstrating a global best practice in community-based mental health care, the Trieste Model has been described as a "whole system, recovery-oriented approach" the central premise of which is that mental health treatment should place the suffering person—not his or her disorders—at the centre of the health care system.

Should we be successful in our bid to pilot the model, ELFT also is collaborating with QMUL's WHO Collaborating Centre for Mental Health Service Development on a bid to conduct a high-quality impact assessment / outcome evaluation of the UK-wide pilots that would be of national significance.

3.1.2 We have worked with the NIHR CRN to obtain funding (c.1PA) in 2024/25 to pilot a local ELFT ***Equality, Diversity and Inclusion (EDI) Lead for Research*** and Dr Rahul Bhattacharya has taken up the role. In this pilot we hope to:

a) Provide advice in study design to promote inclusion and increase equity of access publish on the ELFT R&I microsite the various EDI resources

b) Promote recruitment into active studies by regularly reviewing studies in the set-up pipeline from the lens of accessibility to underserved communities, identifying barriers to participation and brainstorming suggestions to mitigate them.

c) Help disseminate evidence relevant to research which focused on underserved communities, if possible, by engaging a trainee to represent the relevant research activity / initiatives in the regular Trust Patient and Carer Race Equality Framework (PCREF) sessions

3.1.3 Also in conjunction with QMUL, ELFT is a designated mentor institution on the University of Lancashire's ***bid to develop a Mental Health Research Group (MHRG)***, assisting them to boost local research capacity and capabilities. The Lancashire and South Cumbria region has numerous disadvantaged places in comparison with wealthier parts of the country meaning some of the most severe heath inequalities. Within this context, young people are particularly affected, and the cumulative effects of disadvantage for young people are known to persist into poor health in adulthood. There are specific groups of young people who face even more damaging circumstances, and this is reflected in our bid. We aim to build our capacity to coproduce research addressing these health inequalities. Our applied research programmes will target the needs of specific disadvantaged groups of young people to identify, understand and reduce health inequalities. We emphasise place-based approaches.

3.1.4 ELFT's Forensic Service is leading on setting up a research unit in the service, as part of (and funded by) the North London NHS Forensic Collaborative, which will promote studies to improve the quality of forensic services, by providing dedicated capacity for clinicians to engage in research. The ***proposed Forensic Research Unit*** (FRU) will fund a number of dedicated research posts (which will include giving clinicians protected / funded time for research activity), as well as training for the post-holders in research skills such as thematic analysis, Delphi interviews, statistics packages, ethics, etcetera. It is envisaged that there will be involvement from qualified psychologists, trainee psychologists and masters' students as well as allied health professionals (AHPs).

The first, critical, post to create and fill is for the Clinical Research Lead after which an audit will be undertaken to find what studies are currently being undertaken and what stages they are at. This will allow the proposed FRU to help drive some of the existing work, ensure it is co-ordinated, and made more visible. It is hoped that this will enable findings of current work to be collected and shared more quickly, which will allow the service to respond accordingly. It is also hoped that the dedicated Unit will encourage contributions from those less familiar with research activity – further driving innovation. Following this audit, a Forensic Research & Innovation Strategy will be developed by the FRU. Taking the proposal forward, however, depends on the outcome of the financial review of our Forensic Services.

3.2 Data we will be collecting to understand our performance

3.2.1 Enrolment in NIHR Portfolio studies is recorded locally in a local NIHR CRN online database used for the management of all study records within the NIHR Portfolio and then aggregated nationally in the Central Portfolio Management System (CPMS). These figures are used by the NIHR to calculate NHS providers' proportional funding to deliver the service support and treatment activities associated with research studies.

Unfortunately, ELFT's own electronic patient record databases are not used to record participation in research studies (or services users' preferences to opt out of

such opportunities) which means we are unable to gain a full picture of research activity beyond the NIHR Portfolio.

3.2.2 We have adapted an evidence-based Research Culture Index Survey[13] that we intend to administer in throughout ELFT with the support of our Research Champions to gauge the research readiness and interest within various staff groups at the Trust. We can then measure changes against this baseline in future years.

3.2.3 As mentioned above (see 2.4.2), the IMPART project is intended to increase responses from ELFT research study participants regarding their experience via the NIHR Participant in Research Experience Survey (PRES).

3.3 Resourcing requirements or other risks

3.3.1 Throughout the NHS, R&I continues to be perceived as an optional add-on, needing resource from clinicians, but not embedded as core to our service delivery. As a result, there is very little supporting structure for R&I in the Trust and we rely on volunteers and good will, e.g. in-kind resources such as Research Champions (see 2.1.7). This further translates into gaps where regular dedicated resources are required, for example finance (see 2.4.1) and operational / administrative support.

Our initiative to create research capability and opportunities for non-medical professionals with 1-2 posts per professional group (AHP, Nurses, Social Workers, and Psychologists) is currently not progressing. We hope that the renewed membership with representation form all professional groups in the Research Committee can help to move this forward.

3.3.2 The national transformation from current NIHR Clinical Research Network to a new structure of NIHR Research Delivery Network is already behind schedule and may be further impacted by national election, which creates uncertainty around funding for service support and research treatment costs after 30 September. We are making provision within the existing budget (e.g., postponing backfilling vacancies) to mitigate the potential cost pressure until there is more clarity regarding future funding.

3.3.3 Against this backdrop of limited resources, we may be underestimating the support required to deliver research grants, particularly as they do not bring in overheads to cover indirect costs to the Trust (such as redundancy, finance, contracting). Looking at grants commenced in the last eight financial years, all – without exception – have overrun their expected completion dates, on average by over 60 percent. As we review our management of research finance (see 2.3.1) we hope to incorporate this experience into planning for future grants.

3.3.4 Finally, the fragmented nature of our innovation streams – QI, Assurance (for Audit), R&I (for service evaluations and research) – may contribute to lack of institutional awareness. Over the past year, we have had Trust departments questioning national advice (for example on the use of patient data and to facilitate research staff working across multiple organisation) and thus actually impeding the delivery of research. We are working with Information Governance and People & Culture teams respectively to address these issues.

4.0 Action Being Requested

4.1 The Committee is asked to RECEIVE and NOTE the report for information.

[13] Whitford et al (2006) Developing R&D capacity in a primary care trust: use of the R&D culture index. Primary Health Care Research and Development, 6 (1). pp. 17-23.