NHS East London NHS Foundation Trust

Quality Assurance Committee Meeting

Monday 7 July 2025 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 Abiola Ajayi-Obe	14:05
4	Safeguarding Annual Report	Assurance	Claire McKenna Eileen Bryant	14:20
5	Infection, Prevention and Control Annual Report	Assurance	Claire McKenna Rana Begum	14:35
6	Mental Health Law Annual Report	Assurance	David Bridle Dominique Merlande	14:50
7	Emergency, Preparedness, Resilience and Response Annual Report	Assurance	Edwin Ndlovu Richard Harwin	15:05
8	Health, Safety and Security Annual Report	Assurance	Edwin Ndlovu Richard Harwin	15:15
	10 Minutes Break			15:30
9	Freedom To Speak Up Annual Report	Assurance	Claire McKenna Anita Hynes	15:40
10	Complaints, PALS and Compliments Annual Report	Assurance	Claire McKenna Evah Marufu	15:55
11	Legal Claims Annual Report	Assurance	David Bridle Christina Helden	16:10
12	Medical Education Annual Report	Assurance	David Bridle Marius Johnson	16:25
13	Research and Innovation Report	Assurance	David Bridle Karin Albani	16:40
14	Any Other Business	Note	All	16:55
15	Issues to be brought to the Board's attention*	Note	Donna Kinnair	

16 Dates of Future Meetings*:

- Monday 1 September 2025 14:00-16:30
- Monday 10 November 2025 14:00-16:30
- Monday 5 January 2026 14:00-16:30
- Monday 2 March 2026 14:00-16:30

*All meetings will be held by video conference from 14:00 – 16:30 unless otherwise indicated

17 Close 17:00

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

NHS
East London
NHS Foundation Trust

ANNUAL PATIENT SAFETY REPORT TO THE QUALITY COMMITTEE

June 2025

Title	
Authors	Fabiola Ojo, Head of Incident Management Abiola Ajayi-Obe, Associate Directors of Governance & Risk Ashraf Zaman, Incident Coordinator
Accountable Executive Director	Dr David Bridle, Chief Medical Officer Claire McKenna, Chief Nurse

Purpose of the report

To set out progress against the work plan for the past financial year, and to set out proposed work plan for the coming financial year.

Summary of key Messages

Key Messages

- **Enhancing Patient Safety Through System Learning:** The Trust is transitioning from investigation-focused processes to insight-driven improvements that inform systemic change. This year, thematic reviews, SEIPS integration, and action quality analysis have strengthened our approach to risk identification and mitigation, ensuring learning translates into tangible improvements**.**

- **Embedding Safety Learning Across the Trust:** We are committed to ensuring that learning extends beyond patient safety investigations to drive Trust-wide improvement. Progress is underway, with ongoing leadership support essential for embedding this approach at scale**.**

- **Strategic Safety: Focusing on Impact - We are prioritising what matters—because strategic safety means knowing what not to do:** With increasing national data visibility (LFPSE) and system demands, we will be reviewing the totality of all the requirement for the team to support the PSIRF process with a view to prioritising those initiatives which will result in meaningful learning and adds value, while stepping back from activities with limited impact.

- **Embedding Equity and System Learning**: **Equity, system learning, and culture are becoming part of how we work—but sustained change needs backing:** Social factors are routinely informing reviews, family engagement is strengthening, and staff are adopting a systemic approach to safety reviews. These shifts are taking root, but sustained leadership investment in these initiative is essential for long-term impact.

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.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Implications

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	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.

Glossary

Abbreviation	In full

1.0 Background/Introduction

This annual report provides a strategic overview of patient safety activity and system learning across the Trust for the period April 2024 to March 2025. It builds on the biannual patient safety report submitted in January 2025 and extends the narrative by reflecting on how the Trust is evolving—from a delivery-focused model to one that is more learning-oriented, system-aware, and aligned with the core principles of the Patient Safety Incident Response Framework (PSIRF).

The report sets out progress across the eight core improvement workstreams identified in the 2024/25 driver diagram (see Figure 1.0), with a particular focus on how learning is being embedded, how systems thinking is shaping response, and how the Trust is using insight to support safer care, better engagement, and more effective use of data.

In addition to this strategic overview, Part B of the report summarises operational activity across the year, including volumes of learning responses and observations on what the data shows. While this information is shared regularly through monthly and quarterly governance reporting, its inclusion here provides a consolidated year-end view to support transparency and organisational learning. It is not a detailed performance analysis, but an opportunity to bring activity into focus and identify areas that may require further attention or development.

This annual summary is intended to sit alongside routine reporting, offering a broader lens on how patient safety contributes to the Trust's strategic objectives—supporting quality improvement, resource stewardship, and improved population outcomes.

The report is structured to provide:

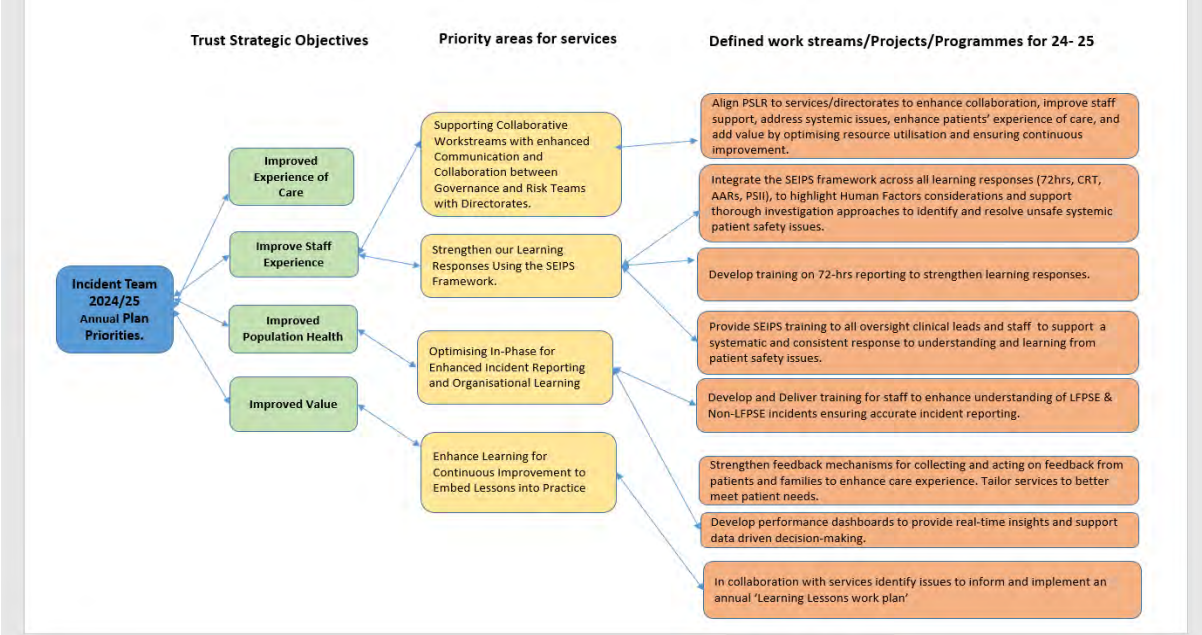
- A strategic overview of achievements and progress across safety priorities
- Insight into how learning is being embedded and acted on across the Trust
- Identification of emerging risks and operational pressures influencing delivery
- Forward priorities for 2025/26 and areas for further system strengthening

2.0 Progress Against the 2024/25 Work Plan

During 2024/25, the incident team made measurable progress across the eight strategic workstreams set out in the annual work plan (Figure 1.0 – Driver Diagram). These workstreams were aligned to the Trust's priorities and focused on embedding systems thinking, strengthening the quality of learning responses, improving governance oversight, and enhancing the use of data to support patient safety assurance and improvement.

While some areas have matured significantly, others remain in development or have been adapted based on operational learning and available capacity. Taken together, the progress made reflects a broader shift in our role—from a primarily investigative function to a strategic safety and learning partner within the Trust.

Figure 1.0 Annual Work Plan Incident Team 2024/2025



Key areas of progress and achievement include:

- Thematic learning has become more structured, with a multi-year review of PSIIs and SIs highlighting shared risks across the system. This has sharpened the focus for commissioning future improvement work. SEIPS integration is more visible across multiple review levels, with growing confidence in the use of systems thinking amongst investigating colleagues.

- 'Action Plan' quality has been reviewed in line with a thematic analysis of PFDs. This has clarified that many of our recorded actions remain weak in nature (e.g., reminders, audits). As a result, we have now initiated a QI project to support teams in developing stronger, more sustainable SMART actions.

- Patient safety dashboards have been developed and shared at key forums. These are early-stage tools, and work is ongoing to refine their content and ensure they support consistent, insight-driven governance discussions.

  Strengthening Patient and Family Engagement in Safety Investigations with particular reference to their experience of the investigative process. Insights into patient and family experiences of the investigative process have been shared at governance forums. Emphasis is now on ensuring this feedback drives positive action and system-level improvements.

- Mortality review processes have stabilised. The shift away from desktop reviews of all expected deaths has allowed resources to be used more strategically. This has also created

space to explore more meaningful insights, such as the potential inclusion of social determinants and equity indicators in future thematic analysis.

- Engagement with directorates continues. While initial intentions aimed for full integration, the approach has since been adapted in response to current capacity and operational realities. A more tailored model is now in place—balancing patient safety priorities with sustainability. Expert input is provided where it supports improvement and can be maintained without compromising the core investigative and learning function.

- 'The PSIRF journey so far' was reviewed one year post-implementation. Our processes—grading i.e. determining of learning responses, and learning responses oversight—have continued to evolve, with clearer alignment to Trust structures and a growing readiness to use incidents as a source of meaningful changes to practice and adoption of good practices across the organisation as appropriate.

This year has made it clearer what our value proposition is—not just delivering investigations, but helping shape how the Trust learns from them. The narrative is shifting from output to insight. Our goal remains to support safer care through intelligent investigation, practical learning, and a systems approach to improvement.

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

- **Prioritisation works when learning is thematic, not transactional** – The Trust's shift to priority-based safety work has helped move from isolated incidents management to identifying strategic themes.

- **Embedding Systems Thinking in Safety Strategy** - SEIPS is beginning to shape language and decision-making, but full integration requires sustained support to ensure maturity and impact**.**

- **Visualisation sharpens governance** – Dashboards are most powerful when they highlight outliers, surface patterns, and connect data to decisions. This is a work in progress.

- **Cross-team learning builds cultural consistency** – Learning seminars have shown that peer-to-peer learning is a powerful lever for mindset change.

- **Learning response tools must be flexible and proportionate** – One-size-fits-all approaches do not work. The success of the new models will depend on how well they meet teams where they are.

- **Action tracking must evolve beyond volume to impact** – The early groundwork with the PSIRF app and InPhase is promising, but it must result in oversight that ensures system-wide impact, not merely duplication.

- **Early incident reporting needs deeper insight. The enhancing of early incident reporting**- Improvements to 72-hour reporting demonstrate progress, but consistency and depth remain key areas for development to strengthen insight and impact.

- **Patient and family feedback is revealing, but under-utilised** – Insights from families involved in patient safety incidents have been both illuminating and humbling. We have learned that how we engage relatives—when, how often, and what we ask—can significantly shape the depth and quality of system learning issues identified. Some families were unsure how to contribute or what was expected of them, highlighting a need to rethink how we frame our engagement to invite genuine input and offer meaningful support. We recognise that this is a learning curve, and we will explore more meaningful, consistent ways to bring patient and carer's voice into the safety process.

4.0 What was not achieved, and what have we understood about the reasons for this?

Table 1.0- What Was Not Fully Achieved: Progress and Lessons

Objective	Status	Commentary	Priority for 2025/26
Collaborative support to directorates and governance teams	Amber	Not achieved at scale due to resource constraints. We are now exploring a more measured, prioritised support model.	Yes
Aligning patient safety leads to directorates	Amber	Integration inconsistent. Reviewing options for a lighter-touch approach (e.g. thematic champions / designated contacts).	Yes
Strengthening feedback mechanisms from patients/families	Green	Insights from families have been captured and shared at key forums. Learning is being used to improve how we engage and respond.	Yes
Translating patient voice into system-level learning	Amber	Early insight shared. Next step is formalising how this is linked to and informs system-wide improvements.	Yes
Training and awareness on LFPSE and use of InPhase	Green	Embedded in InPhase. Awareness improved through seminars. Monthly sessions will be launched to embed further.	Yes
Embedding SEIPS framework into all learning responses	Green	SEIPS is used across all review levels, and language is visibly shifting. Embedding remains an active journey.	Yes
Develop and deliver training on 72-hour reporting	Green	Training delivered and hosted on intranet. Recognised this will be an ongoing need, not a one-off.	Yes
Develop dashboards for real-time learning and governance insight	Green	Dashboards are in place and in use. Refinement is ongoing to maximise value.	Yes
Use thematic findings to inform learning lesson seminar programme	Amber	Thematic insights have been aligned to sessions. This is progressing but	Yes

		will require ongoing resource to sustain.	

5.0 Strategic Focus for 2025/26

The coming year will build on the foundation laid in 2024/25—moving from delivery to deeper learning and system improvement. Our work will continue to balance core investigation duties with a growing focus on enabling insight, assurance, and safer care.

Our key strategic priorities:

1. **Biannual Thematic Analysis of Completed Incidents**: We will continue reviewing completed PSIIs and CRTs every six months to surface themes, reduce duplication, and target system-level risks. These insights will support executive decision-making and inform organisational priorities.
   Why this matters*:* Thematic learning creates a stronger link between what happens at the front line and how the Trust sets safety priorities.

2. **Rollout of the New Learning Review Tool (An expanded version of SWARM)**: A SEIPS-informed learning response model, co-designed with frontline teams, will be implemented. This tool supports timely, proportionate reflection and gives teams ownership of the learning process.
   Why this matters*:* Not all incidents require full investigation—but all deserve thoughtful learning. Co-design ensures staff engagement and system fit.

3. **QI Project on Action Quality**: Following analysis showing a high volume of weak actions, a Trust-wide quality improvement project is now underway to strengthen how actions are designed. Teams will be supported to develop SMART, system-based actions with identified impact parameters.
   Why this matters*:* Moderate and Strong actions are evidence of meaningful learning. They reduce the recurrence of repeat or isomorphic incidents and assist in the building of safer systems.

4. **Embedding Equity Through Mortality Review**: We will build on a stabilised mortality review process by exploring how to incorporate social determinants and ethnicity into future thematic analysis.
   Why this matters*:* Understanding how wider factors shape patient outcomes and population health helps us make care safer and fairer.

5. **Refining Learning Infrastructure and Use of Data**: We will continue to improve our use of InPhase and the PSIRF app to capture and act on learning. We will align our dashboards and data processes to support real-time oversight and reduce duplication.
   Why this matters*:* Good data isn't just about reporting—it's about enabling decision-making and system learning.

6.0 Emerging Risks and Opportunities

6.1 Emerging Risk

National Publication of LFPSE Data

The Trust is now actively reporting into the **Learning from Patient Safety Events (LFPSE)** system alongside STEIS. NHS England has indicated plans to publish national-level LFPSE data, including incident numbers, severity, and potentially outcomes. This information may be visible in comparison to other providers, creating a de facto benchmark—even where local context differs.

Risk: If data is published without local validation or cleansing, there is a risk that the Trust's incident profile, particularly severity levels may appear disproportionately high or inaccurate.

Why this matters: Public visibility of patient safety data is increasing. Ensuring our data is reviewed and understood internally before publication will help reduce misinterpretation and support more meaningful system learning.

Action underway: The patient safety team is working with InPhase leads and directorates to prioritise regular review of incident severity and build a manageable monthly validation schedule. While resource is limited, efforts are focused on fatal incident data and those most likely to affect external perceptions.

6.2 Opportunities

- **Embedding Equity into Safety Intelligence**: By incorporating social determinants and ethnicity into mortality and thematic reviews, the Trust can better understand systemic drivers of risk.
  Opportunity: This supports fairer, data-driven safety planning aligned to population health goals.

- **Implementing a Tailored Learning Review Model**: Co-designing a SEIPS-based, context-aware alternative to traditional reviews allows for more proportionate, timely learning.

  Opportunity: Increases staff engagement and avoids investigation fatigue while strengthening organisational memory.
- **Aligning Safety with Quality Improvement**: Linking safety insights to existing QI capability enables more sustainable, outcome-focused responses.
  Opportunity: Supports a shift from reactive learning to active system improvement.

- **Learning Across the System**: Peer learning and benchmarking with similar organisations offer a chance to adopt smarter practices and accelerate maturity.
  Opportunity: Helps the Trust avoid duplication and adapt more confidently to national change**.**

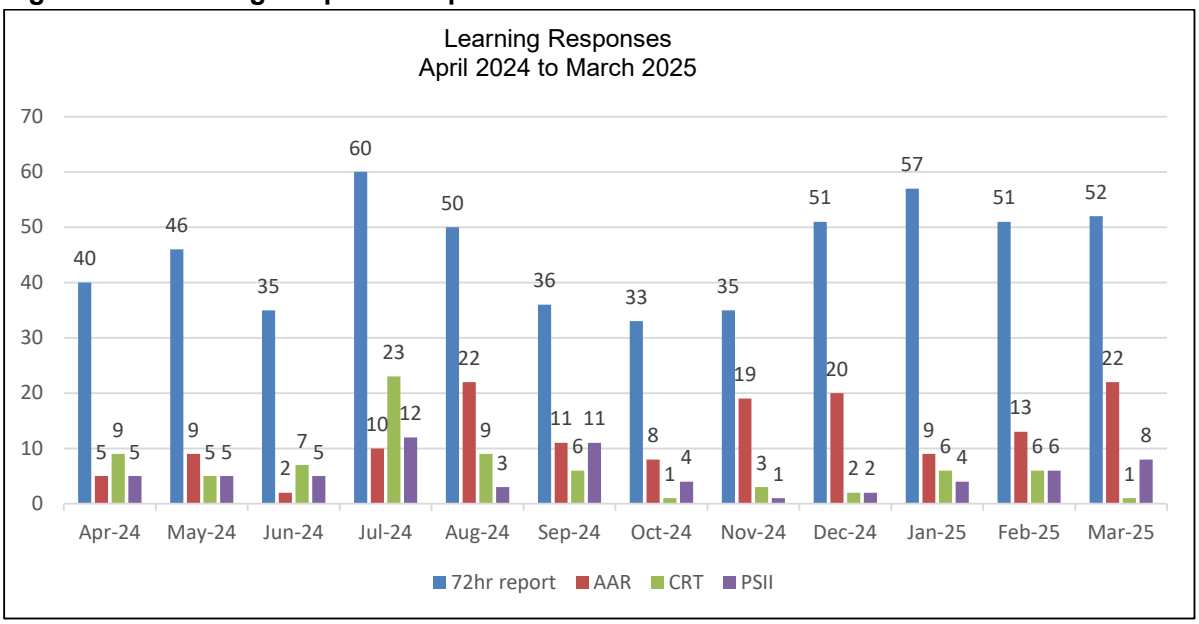
Part B:Operational Activity and Insight

1.0 Learning Responses

This section provides a year-end summary of core patient safety activity for the period April 2024 to March 2025. While this data is already reported through monthly and quarterly governance committees, the overview here brings together the full-year trend for context and transparency.

As shown in the chart and in figure 2.0 below, learning responses have remained consistent throughout the year, reflecting both the scale of operational demand and the Trust's commitment to maintaining timely investigation and safety oversight.

Figure 2.0: Learning Responses April 2024 – March 2025



Bar Chart

Learning Response Activity: Overview

The chart above show the full-year distribution of learning responses across the Trust. While the overall level of activity remains high, the approach to incident response has evolved—with greater use of early-stage tools and more proportionate learning responses in line with PSIRF.

- 546 72-hour reports were completed and quality assured by the incident team. These reports now play a more prominent role in the Trust's safety processes and are increasingly used in coronial proceedings.

- 66 Patient Safety Incident Investigations (PSIIs) were completed. While this is a reduction from previous years under the SI Framework (historically, between 119 –124 annually), it reflects a shift to a system wide review providing a more comprehensive picture of the process involved evaluating the incident.

- 78 Care Review Tools (CRTs) were completed. CRTs are used where appropriate to review incidents, support governance, and identify learning, without the need for full PSII. Some CRTs were escalated to PSII following review, depending on emerging insight.

- Together, these account for 144 structured learning reviews (CRTs and PSIIs), indicating that while the type of response has changed, the overall investigative and learning activity remains significant.

- 150 After Action Reviews (AARs) were requested over the year. While some are facilitated by the incident team and tracked, many are locally led, with variable visibility. There is no current mechanism to consistently monitor completion, which limits the Trust's ability to gain full assurance on the learning process. Strengthening this is a priority for development.

2.0 Learning Seminars and Strategic Learning Infrastructure

In addition to formal responses, the team facilitated eight Learning Seminars across the year. Topics included physical health, therapeutic observation, and key insights from independent reviews. These events supported cross-team dialogue and system learning, and will now be aligned with the seven thematic priorities identified through the Trust's three-year thematic review.

The intention going forward is to establish an annual Learning Seminar Plan linked directly to those themes, strengthening the Trust's approach to targeted and system-led learning.

3.0 Involving and Engaging Families in the Investigation Process

Over the past year, feedback gathered from families following patient safety incident investigations has offered valuable insight into their experience of the process, what supports them, what creates confusion, and where further improvement is needed. Recurring themes include the need for clearer communications, earlier involvement, and support that is both compassionate and timely.

In response to this, standard family correspondence sent by the Trust has been updated to provide clearer explanations of the investigation process and signpost to appropriate emotional and practical support services. Work is also underway to develop trauma-informed prompts to support investigators in engaging families with greater sensitivity.

Looking ahead, the development of a dedicated family-facing leaflet is planned, designed to clarify what families can expect and how they can be meaningfully involved at a pace that respects their needs. This work contributes to a wider cultural shift: from transactional engagement to building more open and genuine partnerships with families, where their voices help shape learning and service improvement.

4.0 Action Plan Management - Safety Learning Response Action Plan Completion rates.

Embedding Action Plan Processes

During the reporting period, action plan management has become fully integrated into services and directorates as part of routine operations.

InPhase Management

The Action Module on InPhase is the Trust-wide digital platform for capturing patient safety learning responses and managing safety action plans. It serves as the central repository for assurance evidence and compliance tracking.

Efforts are underway to ensure services routinely update the 'progress completion' field by percentage, as staff previously misinterpreted the 'completed' field as an automatic progress update. To address this, Governance Leads have been formally briefed, and an Action Plan Guidance Document, outlining the correct update process, has been agreed and distributed across services and directorates.

Governance Network Group – Assurance Oversight

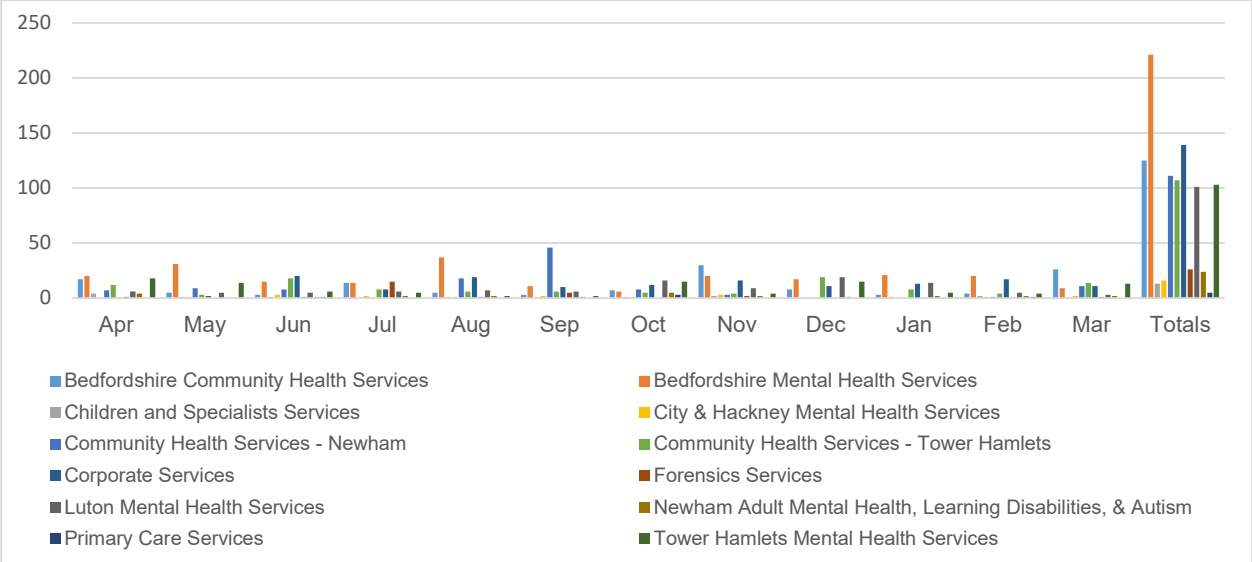
The Governance Network Group provides monthly oversight of action plan management, acting as an escalation point for services facing challenges in completion and evidence submission.

Annual Action Plan Review

- A comprehensive assessment of all Safety Learning Response Action Plan completion rates[1] has been conducted to evaluate progress and identify areas for focussed support.
- The number of Actions completed and evidenced in the Bar Chart below are in line with the number of learning responses generated for each service/directorate area.
- Overall, Bedfordshire Mental Health Services recorded the highest number of completed actions (221 total), indicating strong engagement with action plan implementation.
- Community Services in Bedfordshire (125) and Newham (111) also showed high completion rates, reinforcing their commitment to patient safety improvements.
- Children and Specialist Services, Primary Care Services, and Forensics Services had notably lower completion rates in line with much lower learning responses generated for these services.
- There is no evidence that 69% of Actions on InPhase have started. However, it is important to note that the Action Module is a live system with action progress rates changing daily as services engage with action completion tasks.
- Notably, the actions associated with Corporate Services (139) are mainly related to administrative related actions rather than specific learning responses.
- Altogether, there are no areas of concern with action plan completion rates.

[1] Please note that these completions relate to all Actions captured on the InPhase System inclusive of Actions relating to, Trust Audits, CQC and Complaints.

Figure 3.0- Learning Response Action Plan Completion Rates March 2024 to April 2025



5.0 Duty of Candour Compliance and Integration

The Trust has made significant progress in embedding Duty of Candour (DoC) as a core practice, supported by the Governance and Risk team. Following the successful completion of a Trust-wide Quality Improvement project and the implementation of key change initiatives, engagement with Duty of Candour is now fully integrated into routine operations across all services.

As shown in the table below, compliance has improved markedly, with overdue cases reducing from **over 1,000 in 2023 to fewer than 22 as of June 2025**. This reflects a sustained commitment to transparency, accountability, and continuous improvement in patient safety.

Table 2.0: **Where We Were to Where We Are Now:**

Directorate	Oct-23	Feb-24	Jun-25
	Total Outstanding	Total Outstanding	Total Outstanding
Bedfordshire MHS	30	29	0
Bedfordshire CHS	-	-	6
City and Hackney MHS	86	86	1
Newham CHS	80	80	6
Community Health Services	628	549	0
Forensic Services	30	28	1
Luton Mental Health Services	14	14	0
MHCOP	57	57	1
Newham (Mental Health)	44	43	0
Primary Care Services	3	2	0
Specialist Services and CHN Children's Services	74	72	2
Tower Hamlets (Mental Health)	54	54	2
Tower Hamlets CHS	30	27	2

Grand Total	**1130**	**1041**	**21.0**

5.1 Duty of Candour Identification and Assurance

To support staff in identifying Duty of Candour-eligible incidents more efficiently, guidance has been embedded within InPhase. Alongside this, the Governance and Risk team proactively identifies eligible incidents through the Daily Incident Review process utilising InPhase.

Compliance with Duty of Candour is monitored through InPhase reports, with any areas requiring escalation raised at the Governance Network for oversight and guidance given to support operational engagement at service level.

As at 25.6.2025 it has come to light that a number of incidents totalling 2091 where the harm level has been rated as moderate or above have not had DoC recorded or have been left as blank. For reporting purposes ‘blanks’ have not previously been reviewed as a category.

Since this has come to light a review of DoC incidents has been conducted. The following has been identified;

Approximately 1200 of these incidents relate to Pressure Ulcers which will be referred to services to pick up locally.

184 blanks were recorded as unexpected deaths. A deep dive into a sample of 40 of the unexpected death incidents identified the following.

- No response recorded for 30 incidents.
- DoC section blank for 28 incidents
- DoC partial recording for 2 incidents however the incident did not record key question Is this incident subject to Duty of Candour?
- InPhase pulled through 10 incidents incorrectly.
- 1 unexpected death incident recorded as moderate.
- At least 2 incidents recorded as fatal patient safety incidents but EOL.
- 21 incidents finally approved with blank DoC section.
- The majority of incidents left blank are for London Mental Health Services

The gaps identified will be addressed via local service engagement and at Patient Safety Forum.

6.0 Learning from Deaths

Since April 2024, the Medical Examiner has taken responsibility for reviewing all deaths, both expected and unexpected. This has led to a shift in the Trust’s review process:

- Previously, the Trust reviewed 50% of expected deaths, but this has now been streamlined.
- ELFT currently reviews 5% of community health deaths where individuals pass away in their own homes.
- There is no expectation for the Trust to review expected deaths occurring in acute hospitals, hospices, or care/nursing homes.
- Expected deaths in mental health wards or following transfer from a mental health ward to a hospital are redirected to the incident review process, which continues under PSIRF.

Reviews of Expected Deaths

Expected deaths requiring further review are identified through the daily notification process in DATIX/InPhase and categorised as follows:

Table3.0 Expected deaths requiring further review

48 hour report requested- These deaths were picked up at the daily notification review DATIX/InPhase stage	SJR and raised to SI -Picked up from SJR Reviewer	Gone to coroner's Inquest- Requested by Coroner and Legal affairs team
29	2	4

Reviews of Unexpected Deaths

All unexpected deaths are reported as Patient Safety Incidents via LFPSE in InPhase. These incidents undergo:

- Daily review by a Patient Safety Reviewer (PSR)
- Discussion in a Daily Grading Panel
- Decision-making process, where incidents may be:
- Closed with no further action
- Escalated for further investigation using 72-hour reports or Care Review Tools (CRT)

Learning from Mortality Reviews

Between April 2024 and June 2025, 512 deaths (15.45%) were reviewed for learning purposes:

- 199 reviews (6.01%) used the Care Review Tool (CRT) for anticipated deaths.
- 226 reviews (6.82%) involved 72-hour reports for unexpected deaths.
- 72 investigations (2.17%) employed Patient Safety Incident Investigations (PSII) and CRTs.

Additionally, 15 Learning Disabilities Mortality Reviews (LeDeR) were conducted, reinforcing the Trust's commitment to improving care for vulnerable populations.

Analysis of Learning & Impact

The mortality review process demonstrates the Trust's strong system for learning and improving care. While the high proportion of expected deaths reflects effective end-of-life care management, continued focus on unexpected deaths is essential to identify opportunities for enhancing patient outcomes.

Mortality Reviews & Inquests

The Trust actively tracks mortality data alongside inquest outcomes to identify trends and areas for improvement.

Deaths among people with Learning Disabilities or Autism:

- Between April 2024 and March 2025, 15 deaths were recorded among individuals with learning disabilities or autism.
- All cases were promptly reported to the LeDeR programme, ensuring transparency and continuous learning.

I**nquest Outcomes:**

- 98 inquests into ELFT patient deaths were formally concluded at the Coroner's Court.
- Suicide was identified as the leading cause of death in 26 cases, making it the most prevalent across the Trust.
- This trend underscores the need to strengthen suicide prevention strategies, ensuring early intervention, targeted mental health support, and expanded resources to safeguard vulnerable individuals and reduce preventable loss of life.

6.1 Assurance & Oversight of Mortality Reviews

All expected and unexpected deaths are reported on the InPhase system and undergo daily case note reviews conducted by a Daily Grader. To enhance oversight, a panel of safety reviewers conduct an additional case note review for all unexpected deaths, ensuring a thorough evaluation process.

The Learning from Deaths Committee continues to track the implementation and effectiveness of PFDs actions to ensure sustained improvements in patient safety and compliance with PFD recommendations
Overall, the bi-monthly Learning from Deaths Panel provides assurance by:

- Reviewing all Trust deaths and assessing the implementation of actions.
- Consider impact statements following Prevention of Future Death Reports, presented by Service Leads.
- Identifying themes and insights from Mortality Reviews to refine and improve service delivery.

Any escalated concerns are reported to the Quality Committee via the Integrated Patient Safety Report, ensuring governance oversight and continuous improvement in patient safety.

7.0 Action **Being Requested** the Board/Committee is asked to: Note the contents of this report.

NHS
East London
NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE

7 July 2025

Title	Associate Director of Safeguarding
Author	Dinh Padicala
Accountable Executive Director **Delegated Executive Lead**	Claire McKenna Eileen Bryant

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 adults and children 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, priorities and challenges for safeguarding during 2024-2025.

Committees/meetings where this item has been considered

Date	Committee/Meeting
09/05/2025	Trust 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.

This year has brought both challenge and reflection, prompting us to draw critical learning from national safeguarding failures, including the ongoing inquiries into Southport and Nottingham attacks. These events serve as powerful reminders of the serious consequences that can arise when concerns are overlooked, and systems fail to respond effectively.

At ELFT, we are proud to uphold a strong safeguarding culture, underpinned by high levels of training and supervision compliance, and driven by a shared commitment to professional accountability, compassionate care, and continuous improvement. These principles are central to our safeguarding approach and shape the way we respond across services.

We recognise that ongoing financial pressures across the Trust present real challenges to safeguarding delivery. Workforce shortages, funding constraints, and rising demand place pressure on our teams and systems. We remain firmly committed to a whole family approach, recognising that

safeguarding cannot be separated from holistic, person-centred care. Whether working in mental health, community services, or corporate teams, our staff collaborate across disciplines to ensure that children, adults, and families receive the right support at the right time.

This year marked key leadership milestones with the appointment of Lorraine Sunduza OBE as the Chief Executive Officer of ELFT and Claire McKenna as Chief Nurse and Executive Director of Safeguarding. Lorraine and Claire previously led the Corporate Safeguarding Team with clarity, compassion, and a deep-rooted dedication to protecting those most at risk. Their transition into this strategic role reflects both the outstanding leadership and the Trust's commitment to safeguarding at the highest level. The safeguarding team has embraced new structures and worked through staffing pressures including vacancies and secondments with remarkable resilience and professionalism.

Among the team's notable achievements is the launch of a new Quality Improvement project on Routine Enquiry into Domestic Abuse. This initiative aims to strengthen early identification of domestic abuse, enhance support pathways for service users, and ensure staff are equipped to respond sensitively and confidently to disclosures.

I extend our sincere thanks to the Corporate Safeguarding Team, our frontline staff, partner agencies, and Local Authority colleagues. Your vigilance, collaboration, and compassion form the bedrock of our safeguarding system. Together, we have responded to emerging risks, adapted to complex challenges, and continued to build a culture that places safety, dignity, and wellbeing at its core.

As we look ahead, we reaffirm our commitment to fostering a culture where safeguarding is everyone's responsibility — where all voices are heard, concerns are acted upon, and people feel safe and supported. With continued partnership and an unwavering focus on our values — We Care, We Respect, and We Are Inclusive — we will remain a Trust where safeguarding is not only embedded in practice, but led from the heart.

Strategic priorities this paper supports

Improved population health outcomes	☒	By using safeguarding to identify and address abuse, neglect, and exploitation early, preventing long –term harm. Embed safeguarding within wider health and social care systems to reduce health inequalities and protect the most vulnerable.
Improved experience of care	☒	By ensuring safeguarding process are person –centred, trauma –informed, and respectful of individuals' rights and dignity. Strengthen multi-agency collaboration to provide timely, coordinated support that builds trust and empowers those at risk.
Improved staff experience	☒	By providing clear safeguarding procedures, supportive supervision, and regular training to build confidence and reduce anxiety in managing concerns. Foster a culture of psychological safety where staff feel valued, heard, and supported when raising or responding to safeguarding issues.

Improved value	☒	By embedding safeguarding into all levels of care, leading to earlier intervention, reduce harm, and more efficient use of resources. This enhances outcomes for service users, supports staff confidence and retention, and strengthens the organisation's reputation and accountability.

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 audits.

NHS
East London
NHS Foundation Trust

Safeguarding Achievements – Key Highlights

What We Delivered	Impact
Launched QI Project on Routine Enquiry into Domestic Abuse	Strengthened our ability to identify and support victims—creating a safer, more responsive culture.
Represented ELFT at all safeguarding partnerships	Ensured a strong voice for ELFT in system-wide safeguarding strategy.
Provided integrated supervision and safeguarding advice	Frontline staff feel more supported, confident, and capable in managing complex safeguarding needs.
Achieved high training compliance across all levels	Boosted staff confidence and consistency in safeguarding practice.
Improved safeguarding supervision compliance	Supervision is now embedded in daily practice, reinforcing accountability and learning.
Worked through challenges with resilience	Despite secondments and vacancies, our team maintained timely responses and excellent service.
Hosted hybrid Prevent Safeguarding conference	Over 200 participants attended, enhancing collective understanding and coordination across agencies.

1.0 Introduction and background

This annual report provides a comprehensive overview of safeguarding activity across East London NHS Foundation Trust (ELFT), for the financial year 2024-25. It demonstrates the Trust's adherence to statutory duties under key legislation, including:

- Children Act 2004
- Mental Capacity Act 2005
- Care Act 2014
- Modern Slavery Act 2015
- Equality Act 2010
- Domestic Abuse Act 2021

The report aligns with the Safeguarding Accountability and Assurance Framework (2022), providing assurance to the Trust Board and external partners that effective safeguarding systems are in place to protect children, young people, and adults at risk.

The report outlines ELFT's safeguarding performance, key achievements, and forward priorities. Safeguarding practice is underpinned by the Trust's values—We Care, We Respect, We Are Inclusive—and reflects a commitment to proportionate, partnership-based responses to risk.

ELFT operates across East London, Luton and Bedfordshire, serving a highly diverse population with a workforce of 7,786 permanent staff. Safeguarding arrangements are delivered in close collaboration with multi-agency partners and are fully compliant with CQC Regulation 13: Safeguarding service users from abuse and improper treatment

2.0 Governance and Accountability arrangements for Safeguarding

ELFT maintains a robust safeguarding governance framework, ensuring effective leadership, accountability, and multi-agency collaboration across all services and boroughs. Safeguarding is a core responsibility embedded at all organisational levels, reflecting the Trust's values.

Strategic Leadership and Internal Governance:

- The Chief Nurse serves as the Executive Director for Safeguarding, providing Board-level oversight and leadership.
- The Director of Nursing is the delegated executive lead responsible for delivering the Trust's safeguarding strategy.
- The Associate Director of Safeguarding holds strategic and operational responsibility, ensuring the Trust meets its statutory safeguarding duties for children, young people, and adults at risk.
- Lead Professionals for Safeguarding Adults and Children provide operational leadership, oversee the corporate safeguarding team, and coordinate complex case management, training, and supervision.
- Named Safeguarding Professionals offer expert advice, training, and assurance, embedding safeguarding into everyday clinical practice.
- The Corporate Safeguarding Team operates under a 'Think Family' approach, supported by a unified Safeguarding Committee with integrated work plans.

Partnership Working and External Governance:

ELFT is committed to multi-agency collaboration, maintaining representation on five Safeguarding Adult Boards (SABs) and six Safeguarding Children Partnerships (SCPs) across its operational footprint.

The Trust contributes strategically and operationally through participation in various safeguarding partnership boards, subgroups, and local assurance meetings. This includes engagement in local audits, multi-agency training, and strategic reviews such as Safeguarding Adult Reviews (SARs), Child Safeguarding Practice Reviews (CSPRs), Domestic Abuse Related Death Reviews (DARDR), Channel Panels, and PREVENT/CONTEST Boards.

Direct contributions to local safeguarding reports and the implementation of actions are monitored by the Trust Safeguarding Committee. These arrangements ensure a cohesive safeguarding leadership, assurance, and accountability framework from frontline services to the Board, supporting the delivery of safe, inclusive, and responsive care.

3.0 Reporting of Safeguarding activity

The Trust Safeguarding Committee meets quarterly to provide challenge and assurance regarding safeguarding arrangements and monitors compliance. Quarterly reports are submitted, providing assurance against responsibilities outlined in CQC Regulation 13, Contractual Safeguarding requirements, the Children Act (1989/2004), and the Care Act 2014.

4.0 Risk Register

During 2024/25, the Trust Safeguarding Committee maintained close oversight of safeguarding risks through quarterly reviews and active mitigation. The summary below outlines key risks, mitigation actions, and status.

Risk Area	Risk Description	Mitigation	Current Status
Safeguarding Referrals	Variability in staff recording practices led to underreporting in some boroughs.	Policy changes requiring all children's safeguarding referrals via incident system.	Risk remains under monitoring
Prevent Training Compliance	National changes to Prevent Level 3 requirements caused a temporary dip in compliance.	Focused recovery plans implemented to restore compliance.	Risk removed from register
Non-Compliance with Mandatory Training	Low uptake of Level 2 and 3 safeguarding training for adults and children increased risk of unrecognised abuse or neglect.	Action plan introduced and monitored. Compliance improved.	Risk removed from register

Lack of Professional Curiosity	Failure to routinely exercise professional curiosity may result in missed safeguarding concerns.	Safeguarding supervision was strengthened across the Trust.	Risk removed from register
Impact of Team Restructure	Restructure led to increased staff responsibility, risking delays in support to services.	Digital changes and new leadership absorbed added responsibilities.	Risk removed from register
Workforce Shortages	Vacancies among Named Professionals paused non-urgent activities, affecting delivery capacity.	New staff members recruited to restore team capacity.	Risk remains under monitoring

5.0 Section 42 Responsibilities (Care Act, 2014)

The Trust continues to see growth in the number of section 42 enquiries being undertaken in all of its areas. In 2024-25 the Trust completed 863 enquiries compared to 643 the previous year. This was a 34.2% increase in enquiries compared to 2023-24 and a 102% increase from 2022–23.

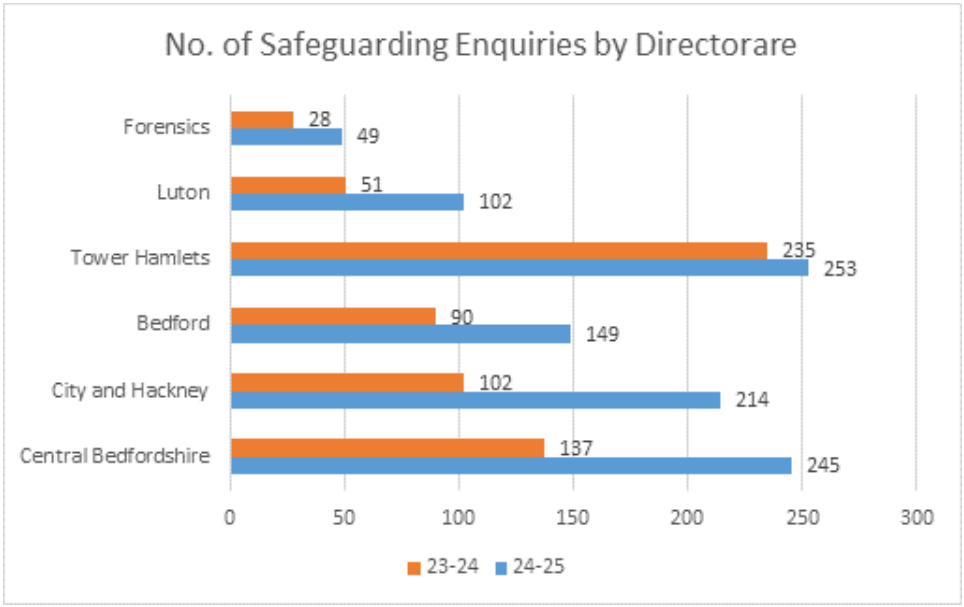
The Trust has seen a much higher increase in section 42 enquiries compared to 2% record in 2023-24 nationally (national data from 2024-25 is not yet available). There are a number of reasons for the increased number of enquiries being undertaken by ELFT, namely:

- Changes adopted by some local authorities in how they record enquiries and adoption three level section 42 enquiry framework.

- Higher conversion rate of concern to enquiry following improvement work undertaken with mental health directorates to improve both the quality of referral and s.42 threshold decision making.

- Improved identification of safeguarding concerns following improvement work undertaken by the safeguarding team through training, safeguarding supervision and monitoring of InPhase alerts. This also tallies with the substantial increase seen in InPhase incidents with safeguarding adult implications.

- Within London directorates, increased focus on timeliness of completion of s.42 decision, resulting in higher conversion rate to full enquiries.

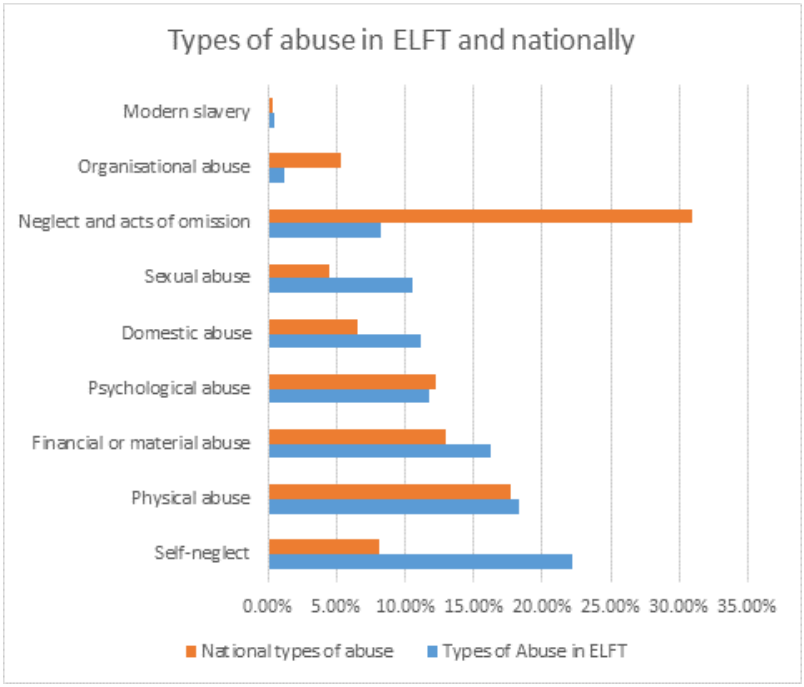


The most common location of risk for our patients is their own homes at 68%, but it should be noted a small but significant proportion is ELFT premises at 5% and highlights the necessity for close scrutiny and oversight of enquiries where adult are at risk or have experienced harm while in the Trust's care. Similarly, in 7% of enquiries source of risk was an ELFT member of staff (mostly allegations of neglect or acts of omission).

The most common source of risk were adults at risk themselves and this reflects the high number of enquiries where self-neglect is a concern. Members of the adult at risk's family, 12%, or their partner, 17%, account for the source of risk in 29% of ELFT enquiries. This is reflective of the higher proportion of enquires conducted by ELFT where there are concerns of domestic abuse.

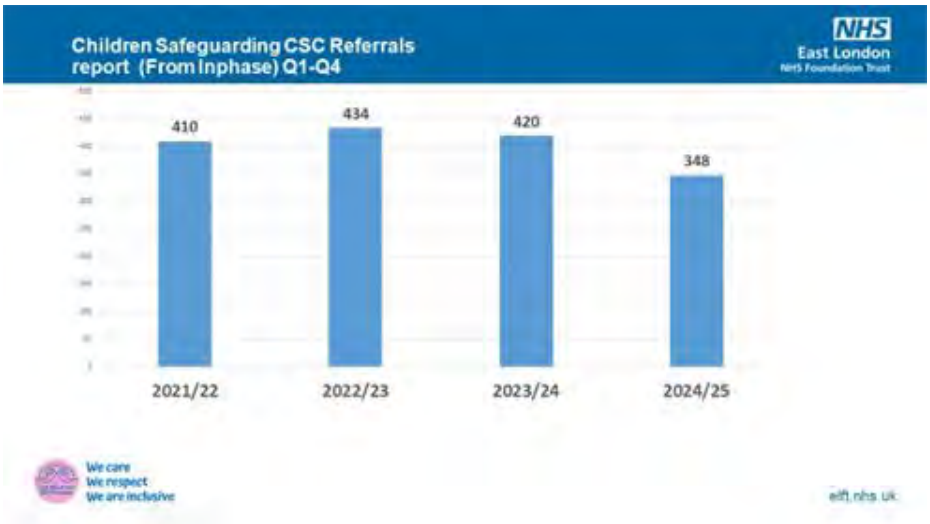
The type of abuse of neglect in enquiries undertaken by ELFT, differs significantly from the national picture and reflects that 83% of ELFT safeguarding enquiries are undertaken with working age adults whereas the national average is the reverse with over 85% of enquiries conducted with adults over 65 years of age.

In ELFT, the most frequent type of abuse in enquiries is self-neglect at 22% compared to 8% nationally while neglect and acts of omission and organisational abuse are significantly less frequent then the national average. As a mental health Trust primarily working with working age adults the types of abuse and risks these adults encounter is different from adults in older age. Our patients are younger likely more physically well than older adults are and less likely to be receiving domiciliary, residential or nursing care. However, they have different sets of vulnerabilities and this is accounted in the higher proportion of enquiries where self-neglect, domestic abuse and sexual abuse are identified compared to the national averages. These differences in the risks faced by our patients informs our work plans, training and safeguarding supervision.



Service Directors hold bi-monthly Section 75 meetings with Local Authorities, providing updates on delegated safeguarding and social care activities, attended by the Trust safeguarding team.

5.1 Children's Social Care Referrals (CSC) based on InPhase reporting



ELFT data indicates a 17% reduction in referrals to Children's Social Care (CSC) in 2024-25 (348 referrals) compared to the previous financial year (420 referrals in 2023-24). This decline is partly attributed to challenges in accurately recording and capturing referral data within ELFT's electronic systems, particularly when submissions are made directly

via Local Authority portals and not consistently recorded on RiO. The use of multiple electronic patient record systems further complicates data collection.

To address these issues and enhance accountability, the Trust has implemented an improved reporting process for CSC referrals. From 1 April 2025, all staff are mandated to complete an InPhase incident report form concurrently with any child protection referral to CSC. This measure will enable timely and accurate data capture, effective oversight by the safeguarding team and prompt, effective intervention.

6.0 Looked After Children (Children in Care)

The Children in Care (CIC) health team is responsible for assessing and meeting the health needs of all looked after children and young people from Newham, whether residing within the borough or placed out of area. The team also assesses the health needs of children from other authorities placed in Newham upon request. A child ceases to be "Looked After" upon adoption, returning home, or reaching 18 years of age. Social care also maintains responsibility for Care Leavers up to 25 years, irrespective of educational status. The Newham CIC team continues to support 18–25 year-olds through the Leaving Care Nurse.

Children in Care often enter the care system with poorer health outcomes due to factors such as poverty, inadequate parenting, abuse, and neglect. These young people frequently originate from chaotic home environments or via the criminal justice system.

As of March 2025, Newham looked after 706 children, representing a 38% increase from March 2024. For children living outside Newham, the CIC team sees those within a 20-mile boundary, beyond which care is requested from the host Local Authority and health provider. In specific cases, the Newham CIC team conducts home visits. In 2024-2025, 236 children newly entered care in Newham, consistent with the previous year's figures.

Health Assessments and Reviews:

- **Initial Health Assessments (IHAs):** 63.5% of IHAs were completed within the 20-working-day timeframe in 2024-2025, a 13.1% increase from the previous year. The national average target for IHA completion is 85%. Breaches of the statutory timeframe and 'did not attends' are reported weekly to NEL ICB. Main reasons for breaches include late receipt of paperwork, clinic slot unavailability, and young person refusal.
- **Under 5yr Review Health Assessments (RHAs):** 75.1% of under 5s RHAs were completed within the set timeframe in 2024-2025, an 8% increase from the previous year. The national average target for under 5yr RHAs is 90%.
- **5yr - 18yr Review Health Assessments:** 73% of over 5s RHAs were completed within the set timeframe, a 5.8% increase from the previous year. The national average is 90%. Reasons for non-completion include appointments cancelled by carers, young person refusal, and lack of consent from social worker. All cases of incomplete reviews are escalated to the child/young person's social worker.
- ELFT CIC ensures all children and young people leaving care at 18 years have a completed Care Leaver's health summary. In 2024-2025, 74% of care leavers had a completed health summary.

Unaccompanied Asylum-Seeking Young People (UASC):

33 UASC were seen in the integrated health care pathway in 2024-2025, a slight decrease from 34 in the previous year.

Children from Other Local Authorities:

By March 2025, the Newham Children in Care Health Team saw 116 children from other local authorities for IHAs and RHAs. This represents a decrease of 110 appointments from the previous year, primarily due to capacity constraints within the Newham CIC team.

Adoption Medicals:

Our medical advisor for adoption and fostering conducted medical assessments for 34 children in 2024-2025 prior to proposed adoptions, a 50% increase from the previous year.

CIC Governance and Reporting Arrangements:

The CIC health team actively participates in various governance and reporting forums:

- Attends Newham Joint Health Sub Group.
- Named Nurse attends the Newham Corporate Parenting Board, Corporate Parenting Board Operational Group, joint CIC and LBN meeting, and quarterly Foster Panel.
- Named Nurse attends the Clinical Governance meeting for Specialist Children's and Young Peoples Services (SCYPS).
- Named Nurse submits monthly KPI data to NEL ICB.
- The clinical team undertakes quarterly essential audits in record keeping and infection control.
- The Named Nurse conducts an annual RHA audit with the Designated Nurse for CIC on behalf of NEL ICB.
- The Named and Designate Doctors conduct an annual IHA audit on behalf of NEL ICB.

7.0 Safeguarding Audits

In 2024-25, the safeguarding team conducted several multi-agency and Trust-wide audits. Findings, learnings, and recommendations were reported to individual staff members, managers, and the Trust Safeguarding Committee. These audits were initiated in response to learning from local and/or national case reviews or internal reviews. Audit outcomes are presented to the Safeguarding Committee for assurance and to ensure relevant learning is disseminated across directorates to improve or change practice.

The table below shows the audits undertaken in 2024/25 by the safeguarding team:

No	Audit Type	Audit Findings	Actions Taken	Progress
1	**Think Family Approach**	• Good examples of family-inclusive practice identified. • Gaps remain in recording the	• Safeguarding supervision now includes prompts to review family demographics and ensure accurate referral data.	Ongoing. Policy review completed; re-audit planned. Staff

		child's lived experience, particularly where domestic abuse is a concern. • Inconsistent recording of family members, especially non-resident or 'invisible' males.	• Practitioners reminded to use the Safeguarding Alert system and tools such as "Day in the Life", Domestic Abuse Stalking, Harassment and Honour Based Violence Assessment (DASH), and the Pan-Beds Neglect Toolkit. • The safeguarding children policy has been updated. • A follow-up audit is scheduled for 2025–26 to include a larger sample across both adult and child records.	engagement continues through supervision and newsletter updates.
2	**Voice of the Child in Adult Services**	• Limited evidence of the child's voice or safeguarding concerns being recorded in adult inpatient records. • Discharge planning did not always reflect safeguarding action or parental responsibility arrangements.	• Audit tool updated to include child-focused prompts. • Inpatient teams engaged via away days and supervision to promote correct safeguarding referrals. • Operational leads reminded to update family demographics. • Signposting to neglect tools, threshold documents, and escalation policy reinforced.	Partially implemented. Training and operational reminders in progress. Full impact expected following actions planned for 2025–26.
3	**Domestic Abuse (DA) Practice and Reporting**	• DA concerns not consistently logged on InPhase. • Discrepancies between DA data recorded in incidents and formal safeguarding reporting.	• InPhase entries reviewed and reclassified to improve DA categorisation. • Targeted training sessions underway to address recording inconsistencies. • Domestic Abuse newsletter and safeguarding intranet launched to improve staff awareness. • Structured risk assessments promoted to	Actions ongoing. Training and communication activities in place; formal review of impact scheduled for 2025–26.

			support earlier identification of concerns.	
4	**Child Neglect**	• Neglect concerns were under-recorded or misclassified. • Application of the Think Family approach inconsistent across services.	• Safeguarding reporting forms updated to reduce misclassification. • Neglect screening tools standardised and shared via supervision. • Annual audits planned with findings disseminated to teams. • Staff encouraged to document lived experience and inter-agency activity.	Improved clarity in documentation and reporting. Further system updates scheduled for Q2–Q3 2025–26.
5	**Self-Neglect – City & Hackney**	• Self-neglect safeguarding referrals have reduced, but the rationale is unclear. • Further quality assurance of enquiry practice was required.	• Bespoke training developed and delivered on self-neglect, including use of the clutter scale. • Training compliance checks for Safeguarding Adult Managers (SAMs) and enquiry officers introduced. • Modular training package added to ELFT Learning Academy (ELA) platform. • Audit findings shared during safeguarding supervision.	Majority of actions complete. Training and compliance monitoring continue to support sustained improvement.
6	**Forensic Services – Safeguarding Deep Dive**	• Safeguarding practice had improved since the previous audit, though sustainability of improvements needed validation. • Some inconsistency remained in enquiry recording and training compliance.	• Deep dive completed to assess impact of previous recommendations. • Monthly safeguarding audits introduced at Directorate Management Team (DMT) level. • SAM and enquiry officer training compliance tracked monthly. • Bespoke training delivered, including guidance on RIO form completion and PIPOT. • Audit findings embedded into supervision and	Sustained improvement evident. Ongoing collaboration with forensic leadership. Monitoring and reporting now embedded into governance structures.

			monitored via forensic social work leadership.	

Key Themes Identified Across Audits

- Training & Supervision: Targeted efforts across all directorates to increase safeguarding competence and compliance.
- Data Quality: Enhanced InPhase reporting and audit tools introduced to improve accuracy and clarity.
- Child-Centred Practice: Renewed emphasis on capturing the voice and lived experience of children.
- Policy Alignment: Updated safeguarding policies to reflect Think Family and Domestic Abuse guidance.
- Continuous Learning: Use of repeat audits, supervision, and newsletters to drive quality improvement

8.0 Safeguarding Training Compliance

The Trust operates under a Safeguarding Training Strategy and Training Needs Analysis, 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. Second edition: July 2024

Safeguarding Training Compliance and Delivery

- The Trust has demonstrated strong improvement in safeguarding training compliance across both children and adult safeguarding in 2024/25:

- Level 3 Safeguarding Children training compliance rose to 89%, up from 83% in 2023/24 – a 6.7% increase year-on-year.
- Level 3 Adult Safeguarding training compliance saw a substantial rise from 62.3% to 89%, reflecting a 26.7% improvement over the reporting period.

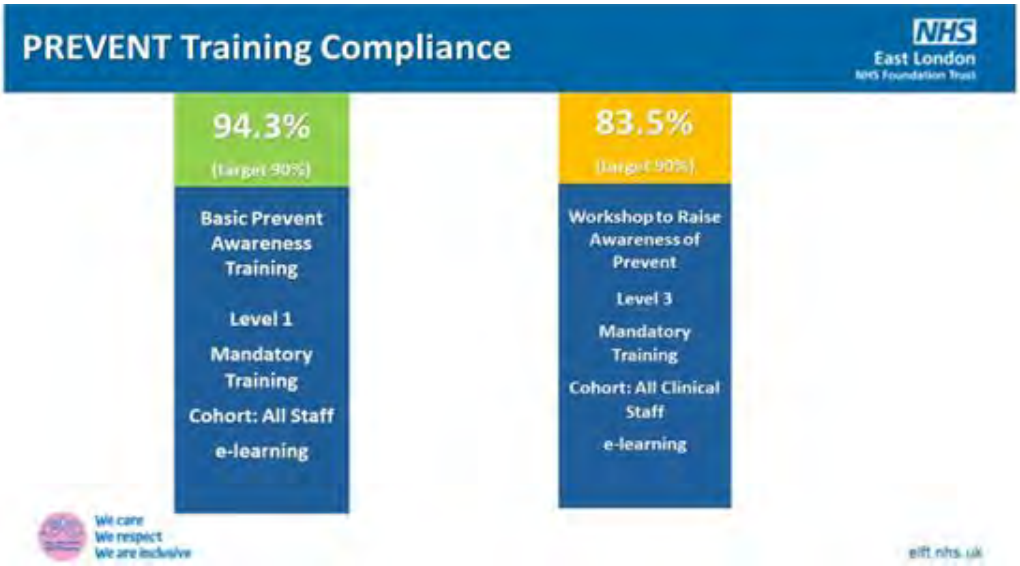
The Safeguarding Team delivered 45 Level 3 training sessions for both adult and children's safeguarding, training 2,763 staff members in 2024/25. While this is a 21% decrease in attendance compared to 3,485 staff in 2023/24, overall compliance improved due to more targeted training delivery aligned to strategic priorities.

Combined safeguarding training compliance for adults and children exceeded 88%, evidencing a well-coordinated and effective training approach that supports the Trust's statutory obligations and quality standards.

Training Feedback

- 96% of staff rated their confidence and knowledge as 4 or 5 out of 5 after attending Level 3 training.

Prevent Training (Basic Awareness Prevent – BAP)



BAP Level 1 compliance remained consistently above the 90% target throughout 2024/25.

BAP Level 3 experienced a temporary decline due to a national change requiring refresher training every three years. This adjustment led to a drop in compliance from 94% to 54% between Q4 2023/24 and Q1 2024/25. Recovery efforts have been effective, with compliance now at 83% and on track to reach the 90% target in Q1 2025/26.

9.0 Safeguarding Supervision

Safeguarding supervision for both adults and children continues to be delivered in line with Trust policies, reinforcing our commitment to high-quality safeguarding practice. Supervision remains a key mechanism for assurance, reflective practice, and professional development. It provides a structured forum for learning, supports practitioners in managing emotional demands, and enables critical analysis of complex safeguarding concerns.

In 2024–25, there was a marked increase in both planned and ad hoc supervision activity across the Trust. Several services achieved 100% compliance, reflecting sustained engagement with the safeguarding supervision framework. Supervision is now well-integrated across service lines, delivered through face-to-face sessions, group work, 1:1 meetings, and telephone consultations.

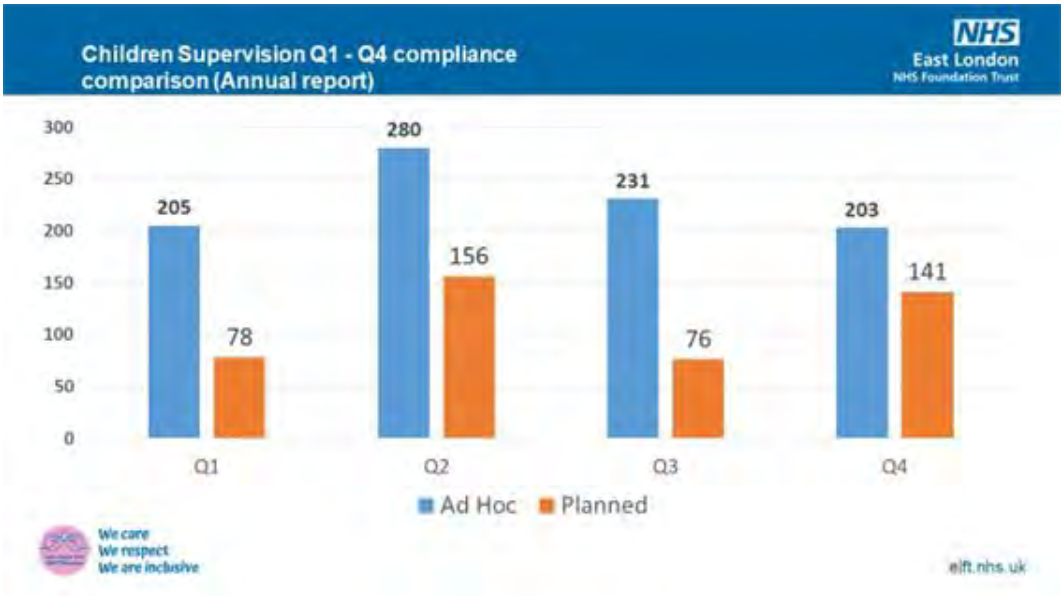
The safeguarding supervision platform has evolved into a multi-functional tool for:

- Delivering bespoke training by Named Professionals
- Disseminating learning from local and national reviews
- Sharing findings from audit activity and thematic analysis

Named Professionals played a key role in multidisciplinary forums such as High-Risk Panels, Complex Case Panels, MARAC, and Channel Panel, offering expert safeguarding advice and co-developing safety plans for complex cases.

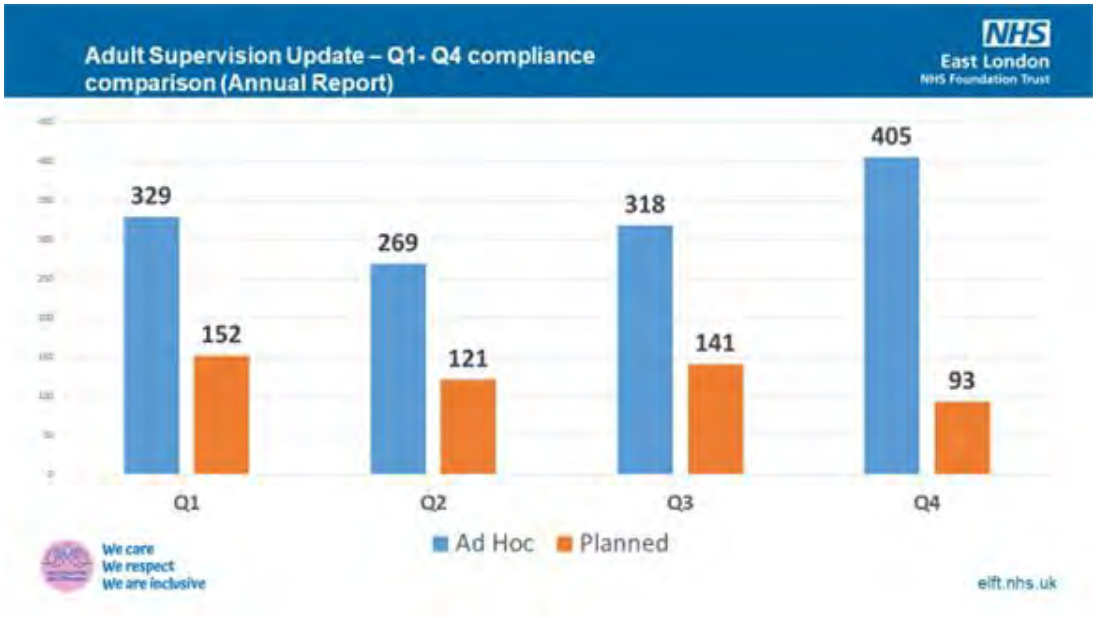
The safeguarding team was contacted 2240 times for ad hoc supervision, and provided 958 planned supervision sessions, demonstrating a high level of demand. A data improvement project is underway to better capture the volume and complexity of supervision contacts, as current metrics underreport activity (one advice form per case, despite multiple interactions).

Children's Safeguarding Supervision



- Ad hoc contacts: 919 in 2024–25 (up from 873 in 2023–24) — 5.3% increase
- Planned supervision sessions: 451 teams supported (up from 395) — 14% increase
- Top themes: parenting capacity & mental illness, domestic abuse — consistent with previous year

Adult Safeguarding Supervision



- Ad hoc contacts: 1321 in 2024–25 (up from 789) — 40% increase
- Planned supervision sessions: 507 delivered (up from 461) — 10% increase
- Some sessions were postponed due to staffing constraints
- Top themes: domestic abuse, self-neglect, and neglect/acts of omission — consistent across years

Supervision remains central to embedding a “Think Family” approach. Integrated safeguarding conversations ensure staff consider the broader familial impact of presenting issues, especially where parental needs affect child or adult safety. The development of new data tools will enhance insight into emerging supervision themes, driving proactive safeguarding across all services.

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	Children mental health, sexual abuse risk
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.	

10.0 Safeguarding Reviews

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.

Safeguarding Adults Review (SARs)

Safeguarding Adult Reviews 2024–25

Identifier	Review Type	Link
Joe - Bedfordshire	SAR	Published September 2024 - Click here
Steve - City and Hackney	SAR	Published November 2024 - Click here
JL- City and Hackney	SAR	Published September 2024 - Click here
Thematic Self-Neglect- Luton	SAR	Published: Final LSAB Thematic SAR Self-Neglect alongside an Executive Summary Thematic SAR Self Neglect.
Family T	Integrated Safeguarding Review	Published: Click here
Lilian - Newham	SAR	Published April 2024 – Click here
Tower Hamlets		No published SARs this financial year.

Safeguarding Children Practice Reviews (CSPRs) - 2024–25

Identifier	Type of Review	Link
Isabella - Central Bedfordshire, Suffolk and Norfolk	Published CSPR	Click Here
Child A - City and Hackney	Published CSPR	Click Here
Extra Familiar Harm and intra familiar abuse thematic review- Newham	Published CSPR	Concerns of serious youth violence - Click here
Child H - Newham	Published CSPR	Concerns of neglect, Concerns of neglect, parental and carer responsibility Click Here

Domestic Abuse Related Death Reviews (DARDRs) - 2024-25

Identifier	Type of Review	Link
Jane - Central Bedfordshire	DARDR	Click Here

The safeguarding committee receives updates and learning from these reviews and monitors any actions put in place to address any systems gaps or issues identified from the reviews.

11.0 PREVENT Duty

The Trust responded to 30 Prevent related concerns in 2024-25. These range from general enquiries to request by Channel Panel from assessments of people's mental health.

In 2024-25 the Trust made 7 Prevent referrals which is a slight increase compared to three Prevent referrals in 2023-24 which is consistent with the national picture.

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.

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

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

On 26th March 2025, the Trust hosted the Safeguarding Prevent Conference in partnership with Tower Hamlets Prevent team to raise awareness of Prevent. The training was open to other partners across the East London and Luton landscape, and was attended by 202 people.

12.0 Domestic Abuse

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.

The Trust has seen a sharp increase in the number of Domestic Abuse Related Death Reviews (DARDR's) and the Safeguarding team have been involved in about 22 ongoing DARDR's across the Trust.

The Corporate 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.

The Corporate Safeguarding team is doing a Routine Enquiry QI project. This project seeks to strengthen the trust's approach to routine enquiry for domestic abuse by embedding a robust, proactive, and patient-centred framework. The objectives are to improve identification of domestic abuse experienced by our patients and optimise response to provide a more compassionate, effective and trauma-informed approach for patients experiencing domestic abuse. The project is in its early stages and is receiving positive feedback where staff have introduced routine enquiry process.

The Trust "Domestic Abuse Steering" group meets bi-monthly to plan and identify areas of work that needs strengthening within the organisation to appropriately respond to concerns of domestic abuse. The meeting is chaired by the Associate Director of Safeguarding and is attended by the Corporate Safeguarding team, the Named doctors and the Public Health team. The group has a DA action plan to support the work, and reports into the Trust Safeguarding Committee.

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

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

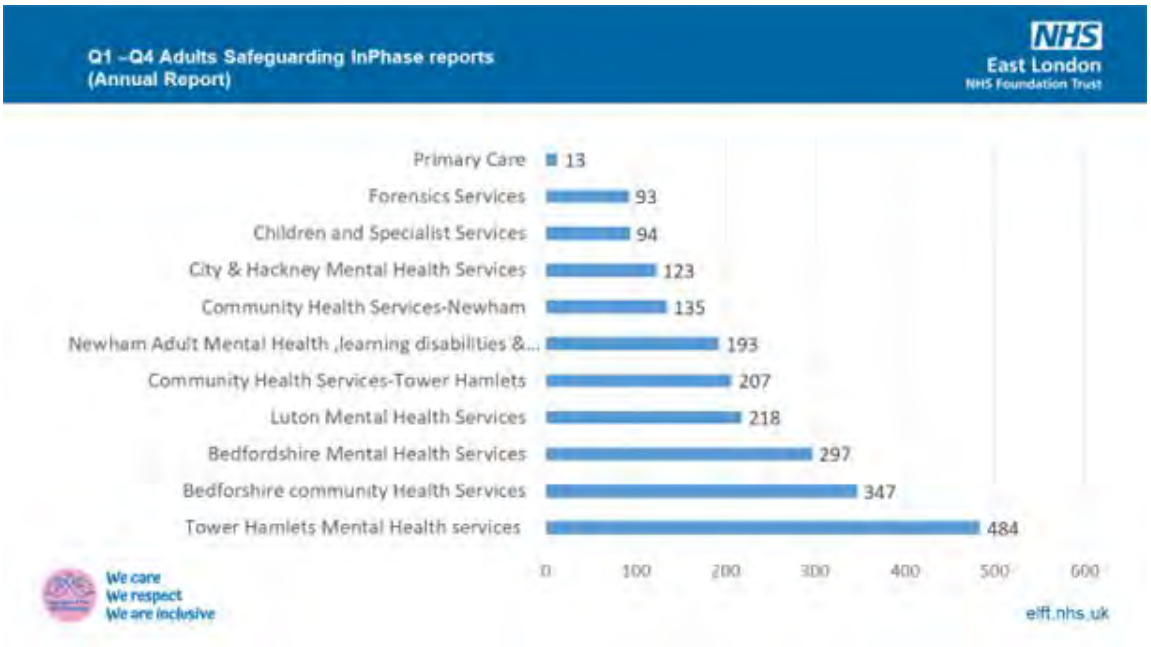
13.0 InPhase reported incidents (2024-25)

All patient safety incidents reported via InPhase are reviewed by the Corporate Safeguarding team to identify indicators of abuse, neglect, or poor care. This process supports frontline decision-making and strengthens safeguarding vigilance across the Trust.

In 2024–25, the Trust saw a substantial rise in reported safeguarding incidents, underlining improved awareness and reporting but also highlighting key thematic challenges.

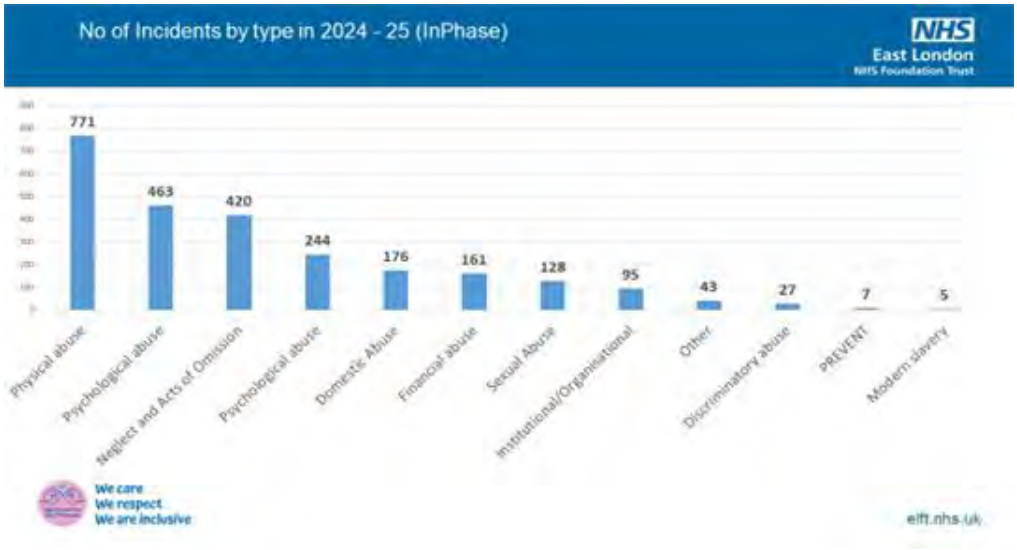
NHS
East London
NHS Foundation Trust

Adult Safeguarding: Volume and Patterns



- A total of 2,204 Adult safeguarding incidents were reported in 2024–25, up from 1,115 in 2023–24—an increase of 97%.
- The majority were reported by Mental Health services (1,408 incidents), followed by Community Health services (689 incidents).
- Highest reporting came from:
- Tower Hamlets Mental Health: 484 incidents
- Bedfordshire Mental Health: 297 incidents
- Luton Mental Health: 218 incidents
- Bedfordshire CHS: 347 incidents

Types of Abuse



- Physical Abuse was the most reported category, primarily due to patient-on-patient violence in inpatient units, reflecting the Trust's significant inpatient mental health footprint.
- Neglect and Acts of Omission and Self-Neglect followed closely. Community Health Services raised most Neglect-related concerns, while Community Mental Health Teams reported the most Self-Neglect cases.
- Benchmarking suggests similar trends in other NHS mental health trusts, where physical abuse is frequently the most reported type due to inpatient settings.

Domestic Abuse Reporting

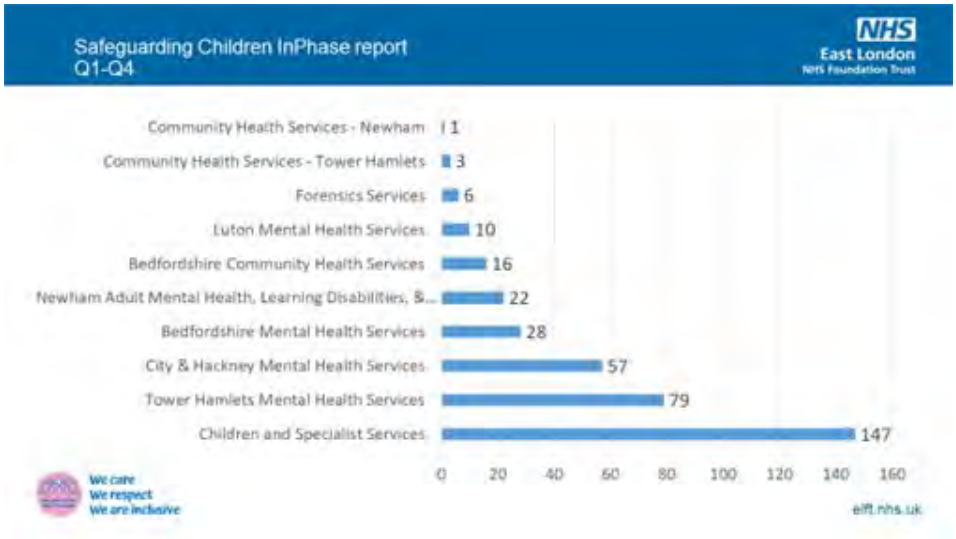
- 176 Domestic Abuse incidents were reported in 2024–25, excluding those categorised under physical, emotional, sexual, or financial abuse.
- This number is likely under representative, as incidents involving physical injury are often misclassified solely under physical abuse.
- The Corporate Safeguarding Team is proactively reviewing incident classifications to improve the visibility of Domestic Abuse within the dataset.

Other Notable Issues

- Financial Abuse showed an increase in Q3 and Q4.
- Organisational Abuse remains stable but low.
- Discriminatory Abuse is still underreported, suggesting further training is needed to support recognition and reporting.

NHS East London NHS Foundation Trust

14.0 Children's Safeguarding: Volume and Themes



- 369 Safeguarding Children's incidents were recorded in 2024–25, compared to 420 the previous year.
- Specialist Children's Services reported the most incidents (147), followed by:
- Tower Hamlets: 79
- City and Hackney: 57
- Neglect remains the leading category, followed by Emotional and Physical abuse.

14.1 Referral Activity

Although only 369 incidents were recorded in InPhase, 984 referrals were submitted by ELFT staff to local authorities based on partial data from Hackney, Newham, and Bedford.

This discrepancy highlights a known challenge—duplicate recording across multiple systems (InPhase, Rio, Emis, System One Care Path and LA portals) is often bypassed by frontline staff due to time constraints.

14.2 Systemic Improvements

To address underreporting and data fragmentation:

- A new policy now mandates an InPhase entry for all CSC referrals.
- The Safeguarding Team has operational policies and providing staff guidance to standardise children's safeguarding incident reporting and improve visibility.
- The rise in reported safeguarding incidents via InPhase demonstrates a growing organisational awareness and staff engagement in safeguarding responsibilities. While this is encouraging, improvements in recording accuracy, category recognition, and system integration are crucial to understand the themes, trends and risks in the organisation.

15.0 Modern Slavery Declaration

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.

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

16.0 Allegations against staff

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.

Within the reporting period, a total of twenty-two 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. Thirteen case met the Local Authority Designated Officer (LADO) threshold, however were closed after the review meeting with no further action.

17.0 Workforce

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 98.77%. This was due to a number of staffs members being off sick, on maternity leave and career break.

The Trust made a total of 8 DBS referrals in 2024-25 after the completion of the staff disciplinary process.

18.0 Safeguarding Challenges

- Rising Complexity of Need across Age Groups. There has been a notable increase in cases involving individuals, both children and adults presenting with intersecting risks. In children, this includes a convergence of mental health concerns, school exclusion, exploitation, and neglect. For adults, self-neglect, hoarding, with co-existing mental health conditions have been increasingly reported. These complex presentations often require prolonged safeguarding input, multi –agency coordination, and multiple interventional responses from the safeguarding team that go beyond initial intervention.
- Mental Health Pressures and Perplexing Presentations- Children and young people are experiencing a sustained rise in emotional distress, self-harm, and suicidal ideation, particularly impacting schools and CAMHS services. Similarly, adults are presenting with complex and often undiagnosed mental health conditions that underpin safeguarding risks such as self-neglect and resistance to care. The Trust continues to prioritise early

identification and trauma-informed responses, supported by safeguarding supervision and on-going support from the safeguarding team.

- Domestic Abuse and Coercive Control - Domestic abuse remains a persistent safeguarding concern across all demographics, including older adults, carers, and neuro-divergent populations. Despite progress, the routine enquiry QI is not yet embedded across all services, and remains a key area for improvement in 2025–26. The Trust's ongoing QI project aims to normalise and strengthen routine enquiry into domestic abuse, ensuring staff are confident in identification of, and response to Domestic Abuse.
- Exploitation and Online Harm - Nationally Child sexual and criminal exploitation, including county lines activity and intra-familial abuse, continues to affect all age groups, often compounded by online grooming and digital risk. For adults, increasing cases of modern slavery, trafficking, and exploitation are linked with homelessness, poverty, and substance misuse. Intelligence sharing across agencies remains a challenge, necessitating improvements in joint working and timely information exchange.
- Impact of the Cost-of-Living Crisis -The continued impact of economic hardship is evident in safeguarding referrals across all age groups. Families and individuals are facing heightened stress, hidden neglect, food insecurity, and housing instability. Higher thresholds for statutory intervention are reported across local systems, placing additional demand on safeguarding teams to offer sustained and holistic support.
- Systemic Pressures and Workforce Resilience -The safeguarding team experienced significant staffing shortages for much of the financial year. Despite this, the team demonstrated resilience and professionalism by absorbing additional responsibilities to maintain service delivery. Named Professionals fulfil highly specialist and demanding roles that require advanced expertise, emotional resilience, and regular opportunities for reflection and development. In recognition of this, the Trust provides monthly restorative supervision to support their wellbeing, enhance practice, and promote staff retention.
- Improve data visibility and reduce duplication- Currently, duplicate safeguarding reporting across some areas of the Trust undermines the ability to gain a coherent, accurate view of safeguarding activity and risk. The absence of consistent local data or centralised entries in the Trust's recording system limits the organisation's visibility and inhibits effective risk governance.

19.0 Key Priorities for 2025-26

Priorities	Actions
Domestic Abuse	• Implementing Routine Enquiry in services embedding a trauma informed approach to responding to domestic abuse. • Introducing Domestic Abuse Ambassadors across the Trust to raise awareness of Domestic Abuse and the use of Routine Enquiry
Trainings	• Self-Neglect and hoarding - In Progress • Legal Framework - In Progress • Responding to Allegations - In Progress • LADO/Pipot - In Progress • Neglect - In Progress • Domestic Abuse - Intergenerational and Intersectional training- In Progress • Integrated Level 3 refresher training • Safeguarding and Anti-racist practice
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. • Introducing “Let’s Change Practice” Newsletter when SAR’s, DARDR’s, CSPR’s, Section 42 enquiries and complex safeguarding cases.
Improved Data Visibility	• To reduce duplication in safeguarding reporting to enhance oversight of risk and progress across all services.
Safeguarding Quality Assurance	• To develop a new quality management framework that integrates quality planning, quality control, quality assurance, and quality improvement across all safeguarding processes within ELFT

20.0 Conclusion:

- During 2024-25, the safeguarding team had some staffing challenges which impacted on progressing with some of the safeguarding priorities and the safeguarding work plan.

- Despite the challenges, some of the objectives were achieved. Areas such as training, reporting, and auditing has improved and embedded in staffs practice as evidenced in this report.

- The current work plan will be reviewed and updated for the next 3 years. It will incorporate some of the ongoing work started in 2024/25 and will be reviewed by the Corporate Safeguarding team based on the priorities of the Boards and Partnerships. Progress will be monitored by the Safeguarding Committee

- Finally, this report seeks to acknowledge and provide focus to the numerous excellent safeguarding achievements which have occurred during 2024/25 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.

21.0 The Board/Committee is asked to:

- **RECEIVE** and **NOTE** the report
- **NOTE** the assurance provided and **CONSIDER** if further sources of assurance are required

ELFT Strategic Objective	No. Safeguarding Objective	Action Required	Lead	Evidence Measures	Time scale and Progress Update	RAG
Improved Population Health Outcomes	1. Promote Preventative and Early Intervention Safeguarding Across ELFT The Corporate Safeguarding Team will lead on embedding a preventative safeguarding culture across the Trust by strengthening early intervention, equipping staff with the knowledge, skills and confidence to recognise and	a) Deliver level 3 Safeguarding training b) Deliver targeted training on early safeguarding indicators, including Routine Enquiry into Domestic Abuse (REDA) c) Provide quarterly safeguarding supervision across services with a focus on prevention d) Monitor and report local safeguarding trends through InPhase e) Ensure updated policies and protocols reflect preventative safeguarding best practice	• The Named Professionals and Lead Professionals are responsible for the operational delivery of the actions in the work plan. • The Associate Director is primarily accountable for delivering the safeguarding strategy and coordinating the implementation of the work plan. • The Trust Safeguarding Committee provides the strategic governance and assurance	• Percentage of staff trained (target ≥90%) • Pre/post training evaluation • Attendance records • Supervision logs • Staff feedback surveys • Audit of supervision compliance (≥85%) • Quarterly reports- Examples of actions taken from trend analysis	Quarterly performance report to safeguarding committee evidencing the following areas of work : • Training Compliance • Planned Supervision compliance • Ad hoc advice compliance • Audit Reports • Inphase analysis reports • Action Plan progress of	Qtr 1 Qtr 2 Qtr3

	respond to safeguarding concerns affecting service users of all ages.	f) Undertake monthly audits to identify learnings and good practice g) Cascade learnings from safeguarding reviews via Safeguarding Newsletters and "Let's Change Practice" messages		• Log of policy reviews- Version-controlled documents- Staff awareness checks • Safeguarding Annual Report	safeguarding reviews. • Training feedback Safeguarding Adults and Children's dashboards	Qtr 4
ELFT Strategic Objective	**No. Safeguarding Objective**	**Action Required**	**Lead**	**Evidence Measures**	**Time scale and Progress Update**	**RAG**
Improved staff experience	2. Enhance Learning from Safeguarding Reviews and Enquiries The Corporate Safeguarding	a) Ensure Named Professionals contribute to all SAR/DHR/CSPR/PFD/LeDeR reviews b) Share learning through newsletters, workshops, training and supervision	• The Named Professionals and Lead Professionals are responsible for the operational delivery of the	• Record of IMRs/chronologies submitted- QA logs by Lead Professional/Associate Director	• Corporate Safeguarding team to attend all boards/partnerships and subgroups • Corporate Safeguarding team to engage in the	Qtr 1

	Team will ensure that learning from statutory and non-statutory safeguarding reviews—including SARs, CSPRs, DHRs, PFDs, and LeDeR reviews—is actively shared across the organisation and used to influence practice, policies, and system-wide improvement.	c) Monitor application of learning through practice audits d) Ensure lessons learnt are cascaded at borough DMT and Quality Forums	actions in the work plan. • The Associate Director is primarily accountable for delivering the safeguarding strategy and coordinating the implementation of the work plan. • The Trust Safeguarding Committee provides the strategic governance and assurance	• Copies of safeguarding newsletters • Staff training logs- Feedback from training sessions • Audit reports demonstrating practice change • Case studies shared at Safeguarding Committee • Meeting minutes and slide decks- Action logs with local team commitments	safeguarding review process. • Corporate safeguarding team to cascade learnings from reviews via newsletter, supervision, training and attendance at strategic trust meetings. • Corporate Safeguarding Team to monitor how much impact learning lessons are having on changing practice and embedding learning. • Attendance of service user at Trust Safeguarding Committee and interview panel.	Qtr 2 Qtr 3 Qtr 4

ELFT Strategic Objective	No. Safeguarding Objective	Action Required	Lead	Evidence Measures	Time scale and Progress Update	RAG
Improved Experience of care	3.Ensure Making Safeguarding Personal and Voice of the Child are Central to Practice The Corporate Safeguarding Team will ensure that all safeguarding interventions are person-led, outcome-focused, and aligned with the principles	a) Audit safeguarding documentation for evidence of MSP/Voice of the Child b) Co-produce safeguarding feedback form in partnership with people with lived experience c) Deliver staff training focused on applying MSP principles in complex cases d) Audit case files to ensure the Voice of the Child is central to all decision making	• The Named Professionals and Lead Professionals are responsible for the operational delivery of the actions in the work plan. • The Associate Director is primarily accountable for delivering the safeguarding strategy and coordinating the	- • Service user attendance at safeguarding committee and interview panel • Training evaluations • Case studies presented at Trust Safeguarding Committee	Quarterly performance report to safeguarding committee evidencing the following areas of work: • Training Compliance • Planned Supervision compliance • Ad hoc advice compliance • Audit Reports	Qtr 1 Qtr 2 Qtr 3

	of Making Safeguarding Personal (MSP), with clear consideration of the views, wishes and lived experience of service users, including children.	e) Embed TIC principles into all safeguarding training, supervision and advice f) Provide quarterly reflective safeguarding supervision sessions with TIC emphasis to cascade the practice g) Collect safeguarding feedback from service users when enquiries are completed h) Deliver integrated safeguarding training	implementation of the work plan. • The Trust Safeguarding Committee provides the strategic governance and assurance	• Audit reports demonstrating practice change • Service user experience to be incorporated in safeguarding training	• Inphase analysis reports • Action Plan progress of safeguarding reviews. • Training feedback Safeguarding Adults and Children's dashboards	Qtr 4
ELFT Strategic Objective	**No. Safeguarding Objective**	**Action Required**	**Lead**	**Evidence Measures**	**Time scale and Progress Update**	**RAG**

Improved Population Health Outcomes	4. Domestic Abuse and Routine Enquiry Corporate Safeguarding team to implement routine enquiry into domestic abuse across ELFT services using the QI methodology, underpinned by a trauma-informed approach, and supported by	a) NP's to roll out REDA training across priority services b) Embed REDA prompts into assessment documentation and electronic patient records (e.g. RiO) c) Identify and train Domestic Abuse Ambassadors in each borough/service d) Deliver quarterly REDA reflective forums for Ambassadors	• The Named Professionals and Lead Professionals are responsible for the operational delivery of the actions in the work plan. • The Associate Director is primarily accountable for delivering the safeguarding strategy and coordinating the	• Percentage staff trained • Pre/post knowledge evaluation • Updated templates approved • Audit of completed REDA documentation • Ambassador list and role descriptions- Training logs and ongoing	Quarterly performance report to safeguarding committee evidencing the following areas of work : • Training Compliance • Progress of the Routine Enquiry QI project • Planned Supervision compliance • Ad hoc advice compliance	Qtr 1 Qtr 2 Qtr 3

	the introduction of Domestic Abuse Ambassadors to promote awareness, consistency, and staff confidence in responding to disclosures.	e) Monitor the implementation and outcomes of REDA through supervision, audits and safeguarding reporting	implementation of the work plan. • The Trust Safeguarding Committee provides the strategic governance and assurance	support arrangements • Forum attendance records- Summary reports on challenges and impact • Staff feedback and REDA case study examples	• Audit Reports • Inphase analysis reports • Training feedback • Feedback from the Domestic Abuse Steering group	Qtr 4
ELFT Strategic Objective	**No. Safeguarding Objective**	**Action Required**	**Lead**	**Evidence Measures**	**Time scale and Progress Update**	**RAG**
Improved Value	5. Quality Assurance Corporate Safeguarding team to	a) Co-produce a safeguarding quality management framework aligned with CQC	• The Named Professionals and Lead Professionals are responsible for the	• To develop and published framework document	Quarterly performance report to safeguarding committee evidencing the	Qtr 1

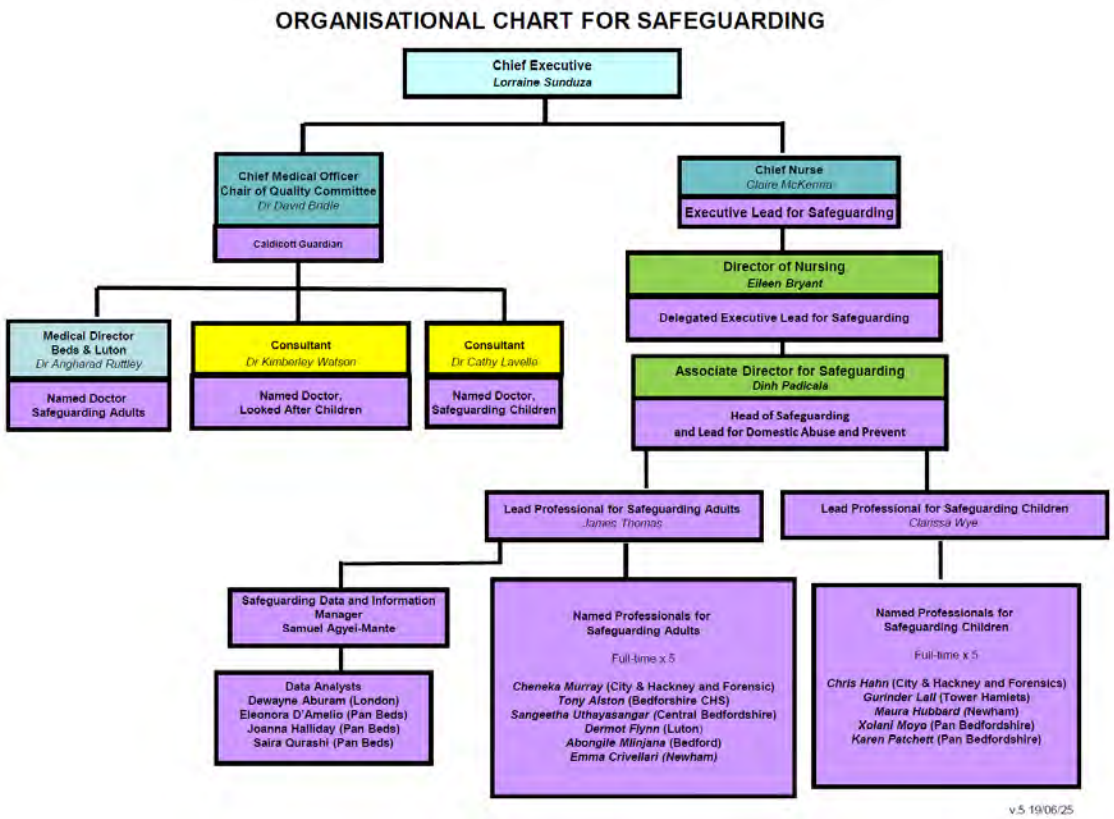
	design and implement a safeguarding quality management framework to strengthen accountability and assurance by embedding quality indicators that aligns with safeguarding activity with broader governance and quality priorities.	regulation 13 and ELFT standards b) Define measurable safeguarding quality indicators in line with statutory reporting c) Integrate quality control mechanisms into supervision, audits and training d) Implement quarterly quality assurance safeguarding audit cycle	operational delivery of the actions in the work plan. • The Associate Director is primarily accountable for delivering the safeguarding strategy and coordinating the implementation of the work plan. • The Trust Safeguarding Committee provides the strategic governance and assurance	• Agreed set of indicators across children and adults safeguarding- • Percentage of improvement in compliance or outcomes over time • Evidence of actions tracked to service improvement	following areas of work : • Changes introduced to improve the quality of safeguarding reporting Utilising PowerBi reporting for safeguarding Reducing recording duplication Real time progress of the safeguarding activity across the Trust	Qtr 2 Qtr 3 Qtr 4
ELFT Strategic Objective	**No. Safeguarding Objective**	**Action Required**	**Lead**	**Evidence Measures**	**Time scale and Progress Update**	

Improved Value	6. Improve data visibility and reduce duplication Currently, duplicate safeguarding reporting across some areas of the Trust undermines the ability to gain a coherent, accurate view of safeguarding activity and risk. The absence of consistent local data or centralised entries in the Trust's recording system limits the organisation's visibility and inhibits	a) Map current safeguarding reporting pathways b) Standardise safeguarding data entry protocols c) Integrate unrecorded local safeguarding activity into corporate reporting d) Define minimum safeguarding data requirements for local teams e) Audit data quality and duplication	• The Named Professionals and Lead Professionals are responsible for the operational delivery of the actions in the work plan. • The Associate Director is primarily accountable for delivering the safeguarding strategy and coordinating the implementation of the work plan. • The Trust Safeguarding Committee provides the strategic governance and assurance	• To identify where duplication occurs and where local data is missing. • To ensure all safeguarding activity is consistently captured in the Trust system • To develop plans for integration or local data retention. • Establish minimum data requirements for local teams to hold and report • Audit to see improvement in data completeness.	• Monitor and audit data entries quarterly to track reduction in duplication and improvement in data completeness. • Report quarterly to the Safeguarding Committee on progress towards reducing duplication and improving data visibility.	Qtr 1 Qtr 2 Qtr 3 Qtr 4

	effective risk governance.					

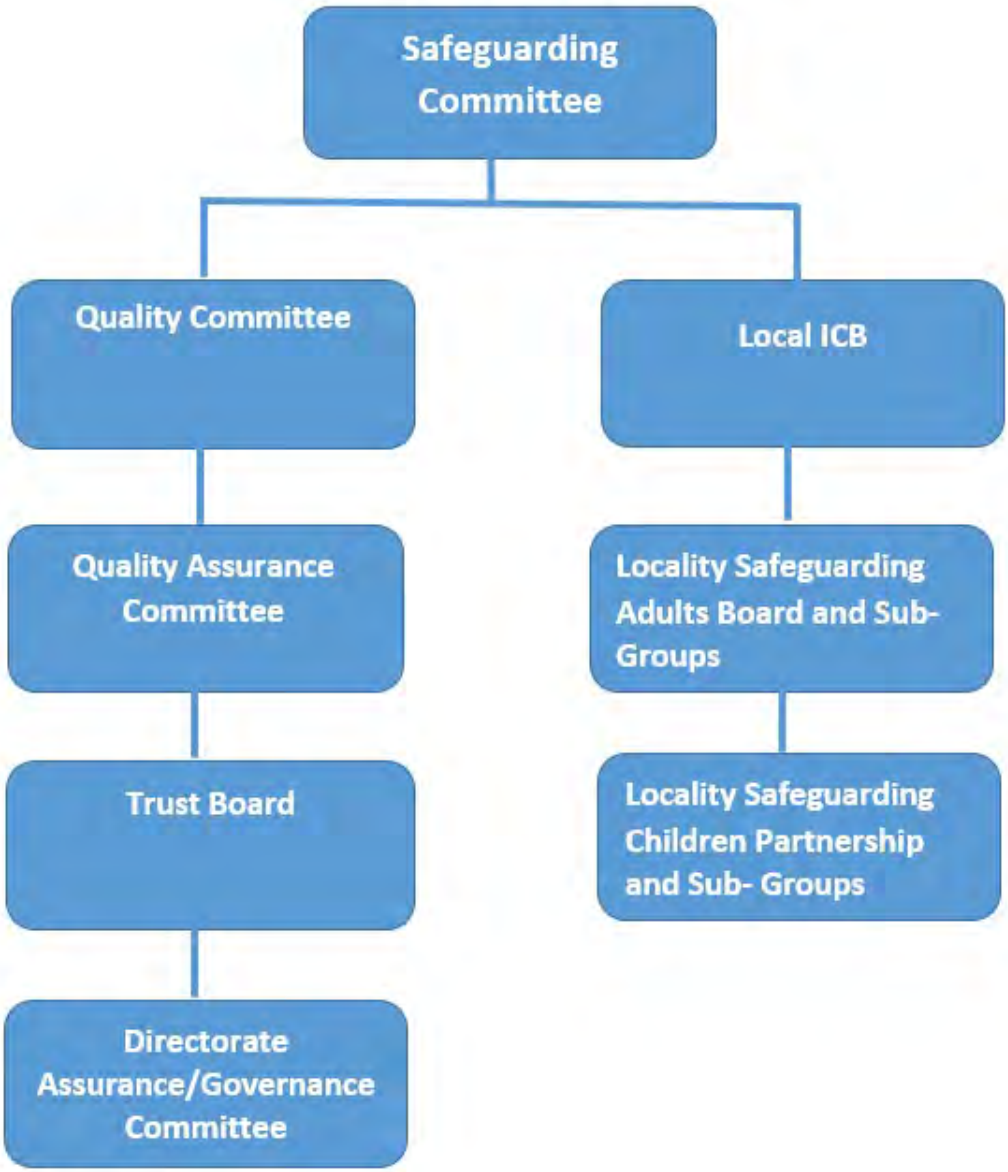
NHS
East London
NHS Foundation Trust

Appendix- 2 Organisational Chart



NHS
East London
NHS Foundation Trust

Governance and Reporting



INFECTION PREVENTION & CONTROL ANNUAL REPORT TO THE QUALITY ASSURANCE COMMITTEE
7 July 2025

Title	Infection Prevention and Control (IPC) Annual Report.
Author	Rana Begum – Trust-wide Lead Infection Prevention & Control
	• The author would like to thank the following individuals and department in developing the annual report: • Claire McKenna- Chief Nurse/ Director of Infection Prevention & Control • Ruth Bradley- Director of Nursing –Community Services London • Dr Giovanni Satta – Consultant Microbiologist / Infection Control Doctor • Bernadette Kinsella –Deputy Director of IPC/Physical Health Lead Nurse • Harriet Ddungu – Trust-wide Deputy Lead IPC/ Fit Testing Lead • Nichole Reid – Senior IPC Nurse • Serakoule Traore – Senior IPC Nurse • Inez Monteith – Senior IPC Nurse • Melanie Charles – IPC Nurse • Monsur Gabr –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
Accountable Executive Director	Clare McKenna – Chief Nurse / Director of Infection Prevention and Control

Purpose of the report

This report serves to:

- Provide the Trust Board with an update on the Infection Prevention and Control (IPC) standards upheld over the past year, ensuring the continued delivery of care in clean, safe, and hygienic environments for patients, staff, and visitors.

- Fulfil the requirements of The Health and Social Care Act 2008: *Code of Practice on the prevention and control of infections* thereby demonstrating effective governance, public accountability, and alignment of IPC practices at ELFT with quality care standards.

Committees/meetings where this item has been considered

Date	Committee/Meeting
July 2025	Infection Prevention & Control Committee

Key messages

Key Achievements for 2024-2025:

In 2024–25, the IPC team sustained high staff engagement through national campaigns, rebranded communications, and a new quarterly newsletter. Key projects included the 'Gloves Off' initiative, Gram-negative bacteria bloodstream infections reduction. All workplan objectives were achieved, including implementation of a new IPC investigation tool aligned with Patient Safety Incident Response Framework and support for the Trust's InPhase transition for risk register. Staff development and wellbeing remained priorities, with IPC nurses progressing through specialist training and leadership programmes, and a dedicated wellbeing officer for the IPC service providing peer support & restorative practice.

Healthcare on-set Infection Surveillance

In 2024–25, there were no reported cases of MRSA bacteraemia, *C. difficile*, or *Carbapenemase*-Producing Organism infections. One Gram-negative bacterium bloodstream infection (mixed infection with *Klebsiella pneumoniae* and *Pseudomonas aeruginosa*) was recorded (see section 3.6 for details). The team responded to 3,176 general IPC inquiries and 305 COVID-19-related queries.

Coronavirus

In 2024–25, the IPC team maintained daily surveillance, outbreak management, and education to ensure continued alignment with national guidance under the "Living with COVID-19" approach. Local procedures were regularly updated, and surveillance data submitted to NHS England. Communications and policies, including the IPC Manual and Respiratory Policy, were revised in line with emerging evidence and remain accessible to staff. COVID-19 cases dropped significantly to 47 cases, compared to 105 cases the previous year, reflecting increased herd immunity and the national move toward a 'Living with COVID-19' strategy with reduced testing and infection prevention measures.

Outbreaks Management

During 2024-2025, there were 12 Outbreaks due to infections reported. Eight outbreaks were due to *Covid-19* and four Suspected *Norovirus* outbreaks. All were reported and escalated through established outbreak management processes, with lessons reviewed and shared via the IPC Committee. All outbreaks were promptly identified and effectively contained. All service-user and staff members made a full recovery, with no adverse outcomes or incidents of harm documented during outbreaks.

Mpox

In August 2024, following WHO's declaration of *Mpox* Clade 1b as a public health emergency, ELFT issued a CAS alert, updated its SOP, and shared guidance across high-risk areas. The national risk remained low, with only five cases reported in the UK (none within ELFT).

Fit-Testing Service

In 2024–25, the Trust strengthened its Fit testing service for FFP3 mask use during aerosol-generating procedures amid rising demand from emerging infections such as *Mpox, Influenza*, and *Measles*. The Fit Testing service was integrated into IPC management structure, and a train-the-trainer model was introduced to support local delivery by ward staff.

Seasonal Influenza Vaccination Campaign

The 2024–25 Seasonal Influenza Vaccination campaign saw record staff engagement, with 94.87% (accepting or formally declining vaccination). Mobile clinics and targeted support improved uptake in hard-to-reach areas. A wellbeing-led approach linked Flu promotion to broader staff health initiatives. Although reported frontline staff uptake fell slightly to 27.49% (average, see Section 16 Figure 11 for full percentages), service-user vaccination increased by 37%, with 365 patients receiving both Influenza and COVID-19 vaccines.

Staff Health /Sharps Injuries

In 2024–25, 50 sharps injuries were reported, an increase from 33 the previous year. The IPC team provided follow-up, training, and education to reduce risk and support learning. Staff were also supported during the transition to a new safer sharps device (BD Eclipse) following the withdrawal of Vanish Point needles from NHS supply chain.

Antimicrobial Stewardship Programme
In 2024–25, the ELFT Antimicrobial Stewardship Programme continued to promote safe and effective prescribing to limit resistance and preserve antimicrobial effectiveness. Quarterly audits across all sites reviewed clinical notes and prescribing practices for guideline compliance, with findings analysed via a Power BI dashboard integrated with patient records. The AMR policy was updated to reflect new regional guidance, and quarterly meetings supported ongoing review of audit results and prescribing trends.

Environmental Cleaning
In 2024–25, the Trust maintained a cleaning score of 97%, exceeding the national average of 95%. The IPC team supported PLACE inspections and audits in collaboration with Estates, sustaining high cleanliness standards while addressing ongoing challenges.

Pest control
Pest control remains a priority for ELFT, particularly at City & Hackney where ongoing issues prompted escalation to Homerton Hospital senior leadership due to underperformance of the existing service agreement. Construction at Homerton Hospital site has contributed to increased activity, and ELFT is working with Ecolab on an improvement plan. At Mile End Hospital, joint actions with Bart's Health have led to progress. The Estates and IPC teams continue to promote good housekeeping and food hygiene, supported by updated factsheets and a revised Trust pest control policy with a strategic response plan.

Ventilation Safety
In 2024–25, the Ventilation Safety Group continued to oversee compliance with HTM 03-01 and manage ventilation risks across the Trust. The IPC team carried out assessments in key clinical areas, and all scheduled servicing and repairs were completed, improving system reliability. A structured maintenance programme is now in place, with 12 ventilation assessments underway. The Air Disinfection Study at Fountains Court, in partnership with Cambridge University Hospitals, also continued, with findings on co-designed air purifiers for mental health wards shared at 12 national and regional conferences.

Water Safety
In 2024–25, 11 positive legionella outlets were identified and promptly addressed, with follow-up testing confirming no further presence. The IPC and Estates teams completed water hygiene training, and the Trust's Water Safety Plan was reviewed and updated to strengthen compliance and awareness.

Waste & Sustainability
In 2024–25, the Trust remained fully compliant with HTM 07-01, with all Pre-Acceptance Waste Audits meeting standards and no high-risk findings. The Waste Management Policy remains current and effective. IPC and Waste teams supported key sustainability initiatives, including reusable cutlery and food waste caddies in Forensic Services, a reusable sharps bin pilot in Newham, and approval of anti-ligature collapsible bins for service user bedrooms.

Gloves Off Qualitative Improvement Project
The 'Gloves Off' project launched at Tower Hamlets and the John Howard Centre aimed to reduce unnecessary glove use and improve hand hygiene supporting the Trust Financial viability and Net Zero carbon footprint ambitions. The initiative achieved a 34.2% reduction of glove usage at Tower

Hamlets, saving £895.18, and a 35.8% reduction in Forensics, with projected annual savings of £2,259 during the first phase of the project.

IPC Risk Register

In 2024–2025, Infection Prevention and Control (IPC) risks were regularly reviewed through IPCC meetings. The primary risk identified was reduced IPC nurse staffing however, a safe effective & quality IPC service was delivered regardless of staffing capacity issues the department faced. To mitigate risk a workforce benchmarking exercise was undertaken to align staffing levels with comparable services. Despite these workforce challenges, the service has not breached compliance standards and continues to deliver against the annual work plan by prioritising key areas such as clinical advice, outbreak management, and targeted support to high-risk sites. Decontamination of reusable medical devices by Enabled Living Healthcare also remains a risk, with actions underway to address it.

IPC Annual WorkPlan 2025-2026:
The 2025–26 IPC workplan focuses on supporting clinical teams to deliver safe, clean care and maintain low rates of healthcare-associated infections. Infection prevention remains a Trust priority, with the team committed to providing evidence-based guidance, strengthening assurance, and promoting collaboration across services. The plan ensures continued compliance with national standards, including the Health and Social Care Act (2015), and aligns with the Trust's strategic objectives. See Appendix 1 for the workplan 2025-2026 driver diagram.

Strategic priorities this paper supports

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

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 2024-2025

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 Director of Infection Prevention and Control (DIPC) reports that East London NHS Foundation Trust remains fully compliant with The Health & Social Care Act (2015) (Regulation 12) and CQC Outcome 8. This report reviews IPC performance from April 2024 to March 2025, confirms full assurance against the NHSE IPC Board Assurance Framework (April 2025), and evidence of sustained low rates of healthcare-associated infection.

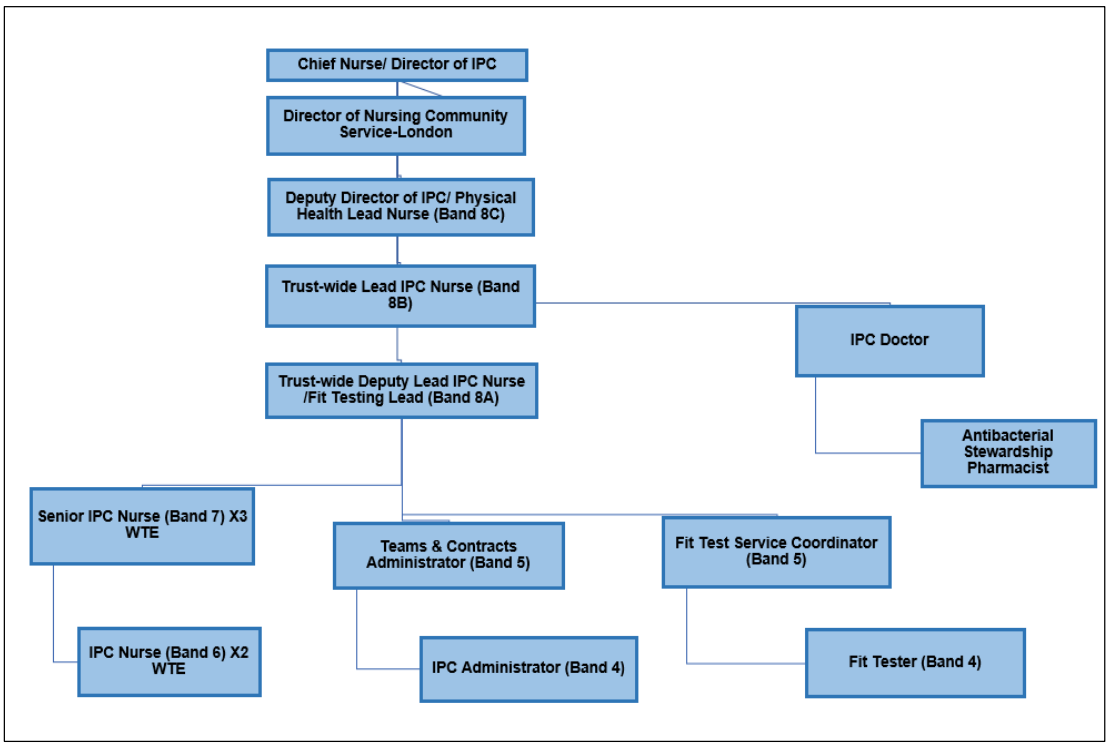
Robust audit, surveillance and reporting systems underpin these results and support the Trust's Annual IPC workplan for 2025-26 shown in Appendix 1, which sets out the next phase of priorities to further reduce infection risk and ensure consistently safe, clean care environments.

2. Management and Governance Arrangements for Infection Prevention and Control

The Trust Board maintains oversight of Infection Prevention and Control (IPC) through the IPC Committee (IPCC), which reports via the Quality Committee in line with statutory requirements. The Chief Nurse serves as the Director of Infection Prevention and Control (DIPC), providing strategic leadership and reporting directly to the Board. Operational delivery is led by the Deputy DIPC, who oversees day-to-day implementation and supports integration of IPC standards across services.

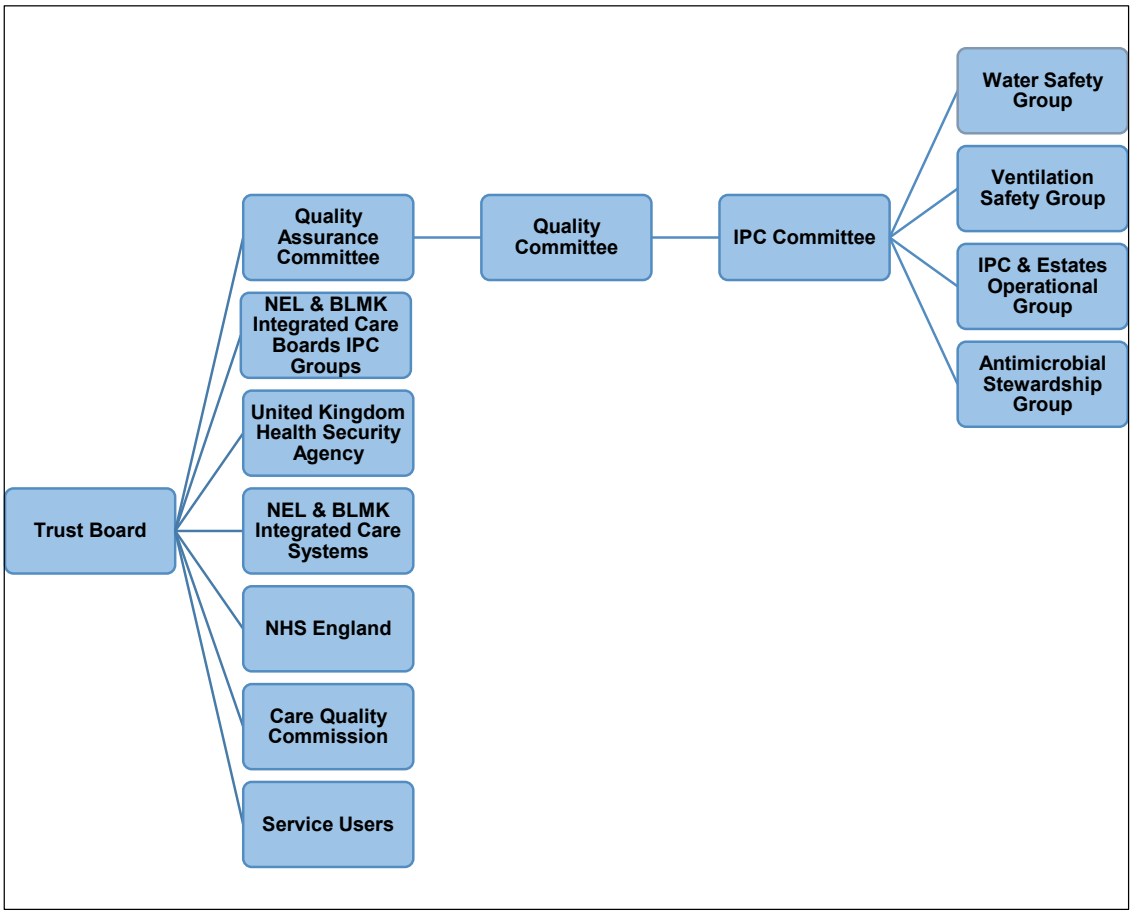
The IPC team is fully staffed. The Trust has access to Consultant Microbiologists/Infection Control Doctor from University College London Hospital (UCLH) with specialist advice and microbiology support. The Trust benefits from an in-house antimicrobial pharmacist.

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



2.1 Governance Framework for Infection Prevention & Control Committee

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



2.2 Infection Prevention and Control Committee (IPCC)

The Infection Prevention & Control Committee (IPCC), chaired by the DIPC, is the Trust's main forum for overseeing the IPC agenda. Meeting quarterly, it brings together key stakeholders to review HCAI data, outbreaks, audit findings, and overall IPC performance to support continuous improvement and benchmarking. The IPCC reports to the Quality Committee, chaired by the Chief Nurse, which provides strategic oversight of IPC within the broader clinical governance framework.

2.3 Infection Prevention and Control Board Assurance Framework (BAF)

The NHS England IPC Board Assurance Framework (BAF), introduced in June 2020 supports Trusts in monitoring compliance with national IPC guidance, including Covid-19 and seasonal respiratory viruses. The current BAF includes 95 key lines of enquiry (KLOEs) across ten domains.

The BAF is reviewed was updated in April and October 2024 and maintained by the Deputy Director of IPC, with quarterly oversight from the IPCC and assurance provided to the Quality

Committee. The IPC team confirms that sufficient assurance is achieved, with gaps actively managed and monitored. Mitigating actions are in place, with progress incorporated into the IPC Workplan for 2025–26.

2.4 Infection Prevention and Control Service

The Infection Prevention and Control (IPC) Service supports a safe care environment by minimising infection risks for patients, staff, and visitors. Core functions include expert advice, healthcare on-set Infections infection surveillance, policy development, staff education & training, audit, antimicrobial stewardship, and incident monitoring. The service ensures compliance with legislation and advises the Trust Board on IPC matters. Microbiology support is provided by Bart's Health NHS Trust for East London and Bedfordshire Hospitals NHS Foundation Trust for Luton & Bedfordshire.

3. Surveillance and Data Reporting

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

3.1 Surveillance of Healthcare on-set Infections (HCOI's)

The National Mandatory Data Capture System (DCS), led by the UK Health Security Agency (UKHSA), monitors Healthcare on-set Infections (HCOIs) nationally. For MRSA bacteraemia *Clostridioides* difficile (C. diff) and Gram-negative bloodstream infections (GNBSIs) trigger Patient Safety Incident Response Framework (PSIRF) investigations. These investigations support learning, improve clinical practice, and promote best practice across the Trust.

3.2 Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA screening is routinely carried out in ELFT's community physical health units for patients identified as high risk, in line with national guidance. Screening is not required in mental health services per Department of Health guidelines. No MRSA bacteraemia cases were reported in 2024–25.

3.3 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. No MSSA bacteraemia cases were reported in 2024–25.

3.4 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. No *C.diff* cases were reported in 2024–25.

3.5 Carbapenem-resistant Organisms (CRO)

Carbapenemase-Producing Organisms (CROs) are bacteria resistant to carbapenem antibiotics, typically used when other treatments fail. While often harmless in the gut, they can cause serious infections if they enter the bloodstream or urinary tract. No cases of CROs were reported across the Trust in 2024–25.

3.6 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.

***Figure 4**. below shows zero GNRBSI cases were reported across the Trust during 2024-2025:*

GNRBSIs	Q1	Q2	Q3	Q4
Trust-wide	0	0	1	0

During 2024-2025, a Gram-negative bloodstream infection was reported. This case involved a patient with a catheter-associated urinary tract infection (UTI) and peripherally inserted central catheter (PICC) line use across multiple care settings. The blood culture sample grew a mixture of *Klebsiella pneumoniae,* Coagulase-negative *Staphylococcus* and *Pseudomonas aeruginosa*. An After-Action Review was conducted jointly by staff on Fothergill ward at East Ham Care Centre and the IPC team. While the infection source remained inconclusive, key learning points included catheter care and skin integrity. The patient recovered, and action plans are in place to strengthen policies, audits, and staff/patient education around device intravenous line care.

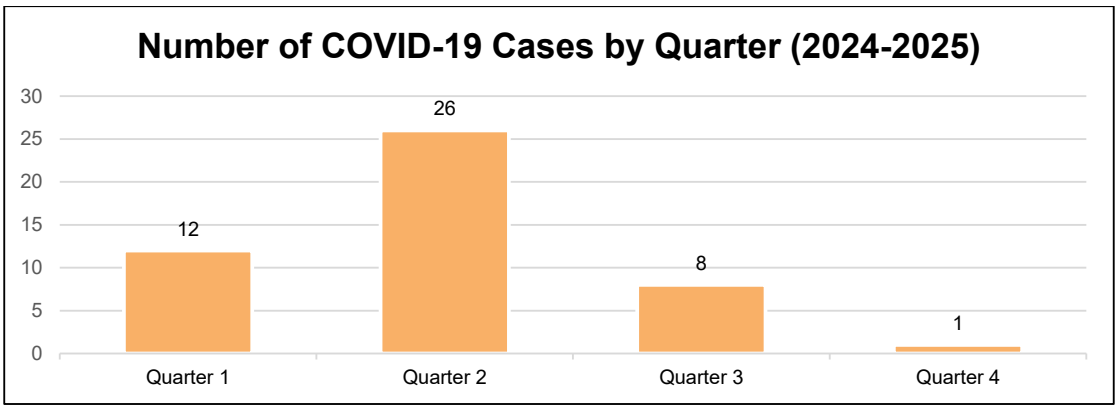
4. Coronavirus Disease 2019 (COVID-19)

Covid-19 emerged in December 2019 and was declared a pandemic by WHO in March 2020; the emergency status ended on 5 May 2023. The IPC team continue to maintain daily surveillance, safety huddles, managed outbreaks, updated guidance, and delivered staff-and-patient education. These activities ensured rapid alignment with changing national directives and kept both patients and staff safe. Under the current “Living with Covid-19” approach, the IPC service continues to review national updates and adjust local procedures accordingly.

4.1 COVID-19 Infections

During 2024–25, 47 *COVID-19* cases were reported, a significant decrease from 105 cases the previous year. This reduction reflects increased herd immunity and the national shift to a 'Living with COVID-19' approach, with less widespread testing and isolation.

***Figure 5**. below displays the total number of COVID-19 cases during 2024-2025 per quarter:*



5. IPC Service Enquires Surveillance

The IPC team offers specialist advice and guidance on infections. During 2024-2025 the IPC service responded to 3176 general enquires & 305 COVID-19 related enquires.

Figure 6. *below presents an annual breakdown of these infections:*

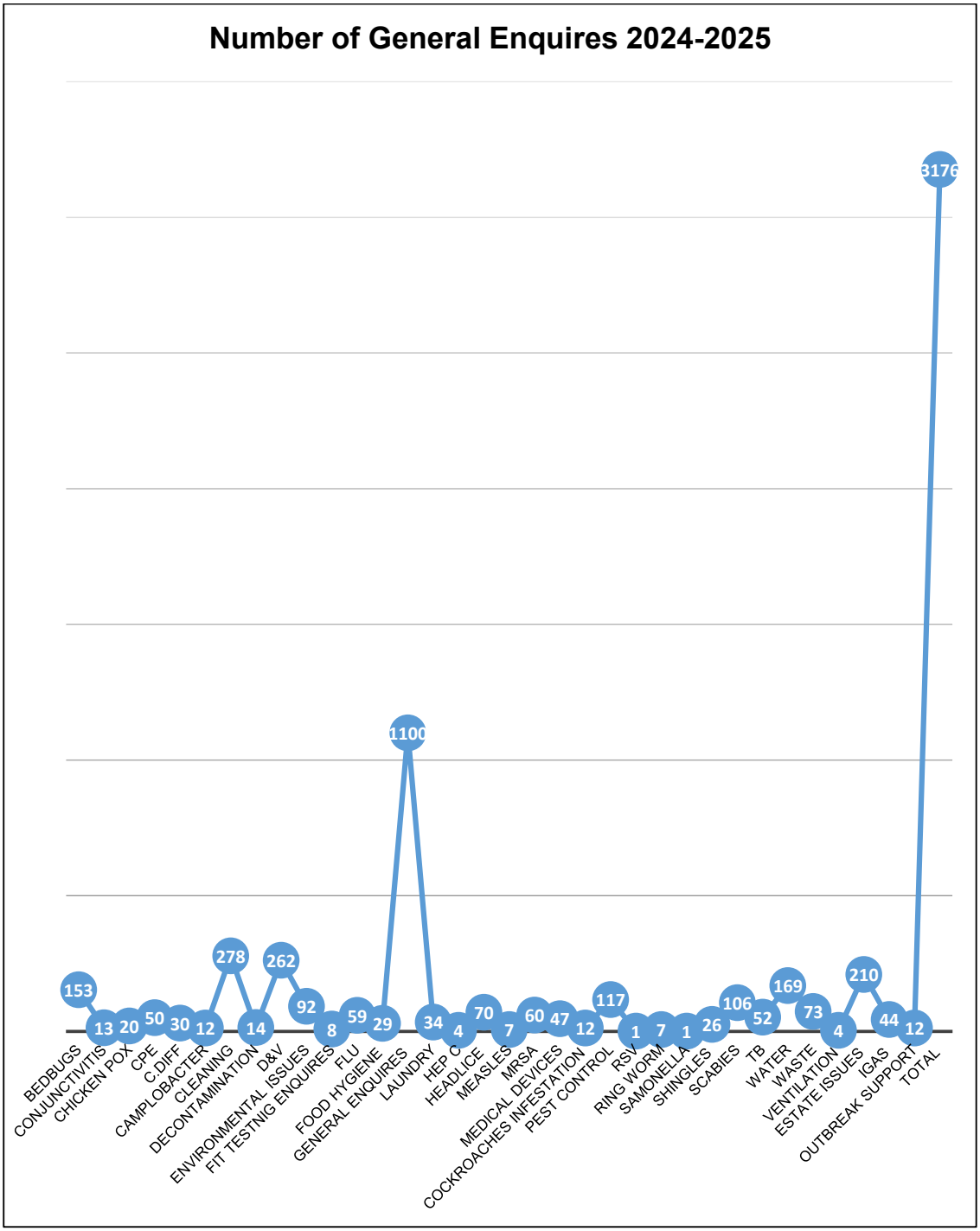
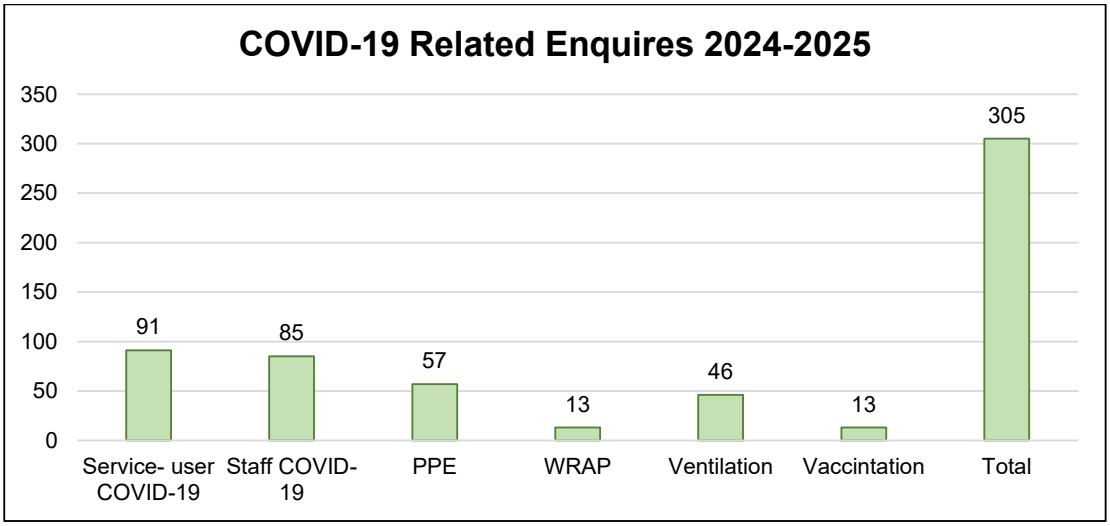


Figure 7. *below presents an annual breakdown of COVID-19 related enquires:*

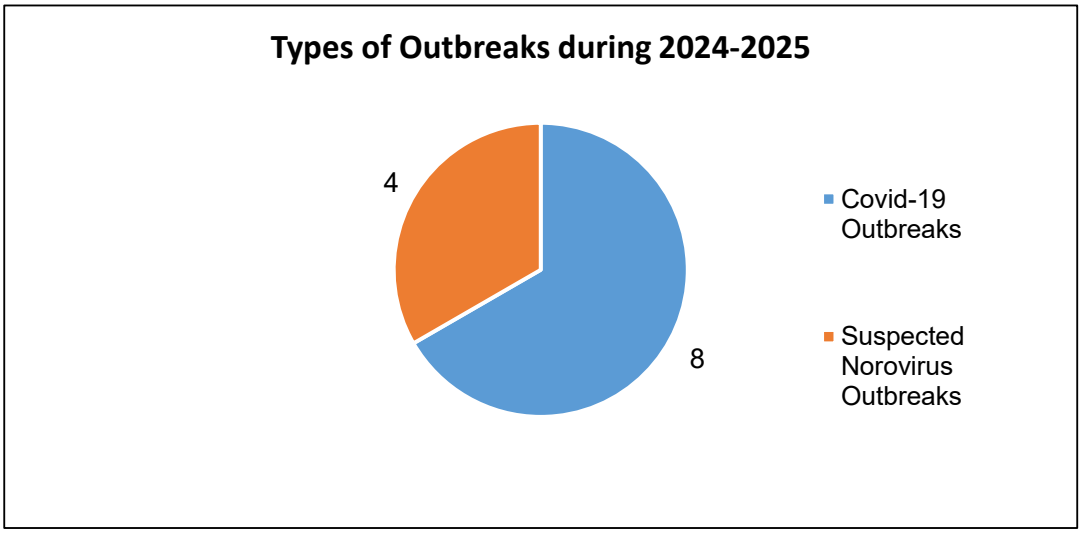


6. Outbreak Management

Under the Health & Social Care Act (2008) the Trust remains alert to emerging infections and acts swiftly on new cases. Outbreaks are managed in line with IPC policy and UKHSA guidance, with PSIRF investigations for HCIOs outbreaks, and staff/ contacts overseen by Occupational Health support during the Outbreak management protocol.

In 2024–25, 12 outbreaks were recorded: eight *Covid-19* and four Suspected *Norovirus* outbreaks. All were reported and escalated through established outbreak management processes, with lessons reviewed and shared via the IPCC.

Figure 8. *below illustrates a breakdown of COVID-19 Outbreaks across the Trust in 2024-2025 per quarter:*



7. Mpox

In August 2024, the World Health Organization declared *Mpox* Clade 1b a public health emergency. In response, ELFT issued a Trust-wide CAS alert, updated the *Mpox* SOP, and shared a communications bulletin to ensure preparedness, particularly in high-risk areas such as primary care and GP service. The risk remained low, with only five cases identified in the UK during the year (none within ELFT).

8. Serious Incidents.

In 2024-2025 there was no serious incident reported in relation to IPC.

9. Fit-Testing Service

In line with national guidance, the Trust continues to provide fit testing for staff using FFP3 masks during aerosol-generating procedures to protect against airborne infections such as COVID-19. Due to the emergence of infectious diseases of *Mpox, Influenza*, & *Measles* this resulted in increased demand of fit testing requirements. In 2024–25, a new Fit Testing Lead was appointed and the service was formally integrated into the IPC team's line management structure. The delivery model transitioned to a "train-the-trainer" approach, enabling ward-based staff to carry out testing locally. Compliance was highest in Q1 when three full-time fit testers were in place. As the two-year fit testing cycle comes to an end, a larger number of staff will require re-testing to maintain compliance. Planning is underway to ensure timely re-testing and sustain the required compliance levels across the organisation.

Figure 9. *below shows fit-testing compliance during 2024-2025:*

Testing Criteria – inpatient Trust wide	**Q1**	**Q2**	**Q3**	**Q4**
Total No. of staff passed an FFP3 fit-test	74%	74%	70%	68%
Staff requiring re-testing	10%	12%	14%	14%

**Data provided by Fit testing team*

10. *Annual Work Plan 2024-2025*

The 2024–2025 work plan was developed in line with the infection control code of practice, informed by stakeholder feedback and IPC nurse visits. Key themes shaping the action plan are summarized in last year's diagram (Appendix 2).

11. IPC Audit Programme

There is an annual planned programme of IPC clinical audits across the Trust.

11.1 Annual Environmental Audits

The Trust conducts annual clinical environmental audits, led primarily by Infection Prevention and Control Nurses (IPCNs). Staff are encouraged to audit low-risk areas with IPCN support. Action plans with timeframes are developed and monitored by IPCNs, ward managers, and

Matrons. Areas scoring below 85% are re-audited, with in-patient areas prioritized to maintain standards.

Audit findings are shared with site supervisors, IPC link practitioners, and managers, and escalated to Directorate teams and the IPCC. Infection control self-assessment audits are completed by local services via the InPhase platform, focusing on hand hygiene, decontamination, PPE, and waste management. These audits follow a quality improvement approach, underpinned by regular monitoring. Ongoing collaboration with Estates, clinical teams, and contractors helped sustain safe, clean environments across the Trust in 2024-2025.

11.2 Hand Hygiene Validation Audits and PPE Doffing and Donning Audits

Quarterly hand hygiene audits are carried out by each service as a key indicator of IPC compliance. Throughout the year, several initiatives supported hand hygiene promotion, including:

- Staff, public, and service user education sessions
- Participation in World Hand Hygiene Day in May
- Clinical Messages of the week highlighting hand hygiene importance alongside other IPC measures.
- Quarterly electronic Hand Hygiene validation audits in high-risk areas (e.g. older adult wards), led by IPC nurses and matrons, based on WHO's 5 Moments of Hand Hygiene.

12. IPC Training & Education

12.1 IPC Statutory & Mandatory Training Compliance

IPC training remains mandatory for all staff, with clinical staff completing annual Level 2 e-learning and non-clinical staff Level 1 every three years. Training is delivered through e-learning, induction, directorate away days, and targeted face-to-face sessions in high-risk areas. The IPC team monitors compliance across the Trust. Directorate teams falling below the 95% target are provided tailored ad-hoc IPC training to increase training compliance. IPC team attend local away days and have consistently received positive feedback.

Figure 10. *below shows Statutory & Mandatory Training Compliance during 2024-2025:*

Directorate	Infection Control - Level 1	Infection Control - Level 2
Trust wide	92.85%	85.94%

**Data provided by Learning & Development team*

12.2 IPC training & awareness campaigns

During 2024-2025, the Link Champion network, led quarterly by Band 7 IPC nurses, focused on estates, environmental cleaning standards, PPE, and gastrointestinal outbreak management. Quarterly training sessions were delivered across all services in London, Luton, and Bedfordshire, covering both community and inpatient teams. A Trust-wide lessons learned webinar was held on October 2024 to share serious incident lessons learnt reviews from the previous financial year.

Throughout 2024–25, IPC campaigns maintained strong staff engagement and reinforced key practices. The Hand Hygiene Roadshow in May featured interactive events involving staff, contractors, and service users. National IPC Week in October included multidisciplinary roadshows addressing infection risks such as vape sharing, supported by active social media engagement. In November during World Antimicrobial Resistance Awareness Week featured webinars and communications promoting antimicrobial stewardship.

13. IPC Projects 2024–25

In 2024–25, the Infection Prevention and Control Team (IPCT) led several Trust-wide initiatives to reduce infection risks, enhance audit systems, and strengthen staff engagement.

Key projects included the “Gloves Off” campaign, rolled out at multiple sites in London to reduce cost supporting the Trust Financial viability & NHS Net zero carbon footprint agenda. The project was supported from NEL ICB and as part of the ELFT Qualities Improvement leaders programme project. A focused QI project on catheter-associated UTIs was implemented on Fothergill Ward, alongside C. difficile and MSSA reduction plans delivered in partnership with North East London ICB. The Air Disinfection study continued at Fountains Court, involving academic stakeholders and Air Purity.

The team collaborated with the ELFT Quality Assurance Team to address issues in the InPhase audit system and contributed to the Trust-wide transition of risk register management processes onto the InPhase platform. A new investigation tool was co-developed with the Patient Safety team to align Infection investigations to the new Patient Safety Incident Response Framework (PSIRF) model for IPC investigations and conducting After Actions Reviews (AARs).

14. Policies, SOPs & Communications

In 2024–25, the Infection Prevention and Control Team (IPCT) aligned Trust-wide policies, SOPs, and communications with national guidance and emerging infection risks. Key updates were issued on *COVID-19, Influenza, Respiratory Syncytial Virus, Norovirus*, and LFD supply changes. The team contributed to SOPs for Bedfordshire Podiatry, Newham Occupational Therapy, and medical device use, and revised *Mpox* procedures in response to national guidance and CAS alerts.

IPCT also supported business development department by providing IPC content for new service bids. In response to CAS alerts, the team addressed risks such as *Burkholderia stabilis* infections from contaminated ultrasound gel & water hygiene issues linked to coliforms. Staff engagement was maintained through bulletins, factsheets, and seasonal campaigns, including winter planning and Trust-wide IPC roadshow weeks to boost awareness across the Trust.

As part of a wider rebranding effort, the IPC team also launched a new communications plan to re-brand the IPC services. This included, co-produced materials with corporate service-users on common infections leaflets/ posters & refreshed intranet page. The quarterly IPC newsletter was also launched during the year, receiving positive feedback. These initiatives reflect the team's continued focus on infection prevention, service improvement, and staff engagement across the Trust.

15. Freedom of Information (FOI) Requests

In 2024–25, the Trust received six IPC-related FOI requests. All were responded to within the statutory timeframe, in accordance with the Freedom of Information Act (2000).

16. Seasonal Influenza Vaccination Campaign

The 2024–25 flu vaccination campaign achieved the highest staff engagement on record, reaching 7,423 staff with 94.87% either accepting or formally declining the vaccine. Targeted support and regular engagement led to improved uptake in historically low-performing areas, including City & Hackney (52.05%) and Bedfordshire CHS (58.76%). The expansion of mobile and roving clinics helped reach hard-to-access groups and increased visibility across both clinical and non-clinical teams.

The campaign also strengthened collaboration with NHSE and other Trusts, with ELFT strategies shared in regional webinars and forums. A wellbeing-focused approach integrated flu promotion into wider staff health initiatives, boosting relevance and engagement. Continued use of the NIVS system ensured accurate data capture and streamlined alignment with national reporting requirements.

Figure 11. *below shows data for the Seasonal Influenza Vaccination Programme for Healthcare workers in 2024-2025:*

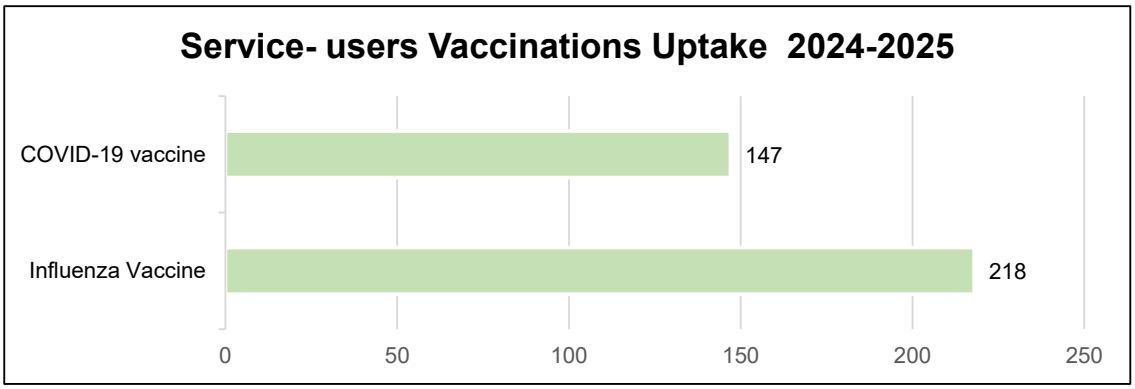
Influenza Vaccination data						
Directive	**Yes**	**No**	**Total (Yes & No)**	**Total Staff**	**% Vaccinated (front line staff**	**% including declines**
Bank	84	2176	2260	2316	3.63%	97.58%
Bedford	303	381	684	863	35.11%	79.26%
Bedfordshire CHS	258	179	437	504	51.19%	86.71%
City & Hackney	202	213	415	706	28.61%	58.78%
Community Services - Tower Hamlets	106	105	211	243	43.62%	86.83%
Corporate	166	153	319	810	20.49%	39.38%
Forensic Services	157	446	603	609	25.78%	99.01%
Luton	92	273	365	366	25.14%	99.73%
Newham CHS	86	81	167	463	18.57%	36.07%
Newham	132	181	313	656	20.12%	47.71%
Primary Care	84	75	159	217	38.71%	73.27%
Specialist CHS	51	74	125	204	25.00%	61.27%
Specialist Services	208	464	672	1395	14.91%	48.17%
Tower Hamlets	221	415	636	788	28.05%	80.71%
Vaccination clinic	1	56	57	215	0.47%	26.51%
Grand Total	2151	5272	7423	7824	27.49%	94.87%

16.1. Servicer- user Influenza and COVID-19 Vaccination Uptake

During 2024-2025 winter planning dual outreach clinics delivered both *Influenza and COVID-19* vaccines to staff and patients. A total of 323 staff and 365 patients were vaccinated. Staff COVID-19 uptake, including both internal and external vaccinations was 10.9%. Patient vaccination numbers were recorded, but total uptake cannot be confirmed due to lack of external data if they were vaccinated in community by GP/Community pharmacist.

Compared to the previous year, patient vaccinations increased by 37%, while staff vaccinations delivered via outreach clinics dropped by 70%. This shift was expected, as the team focused resources on inpatient vaccination and directed staff to external providers such as GPs and national booking services.

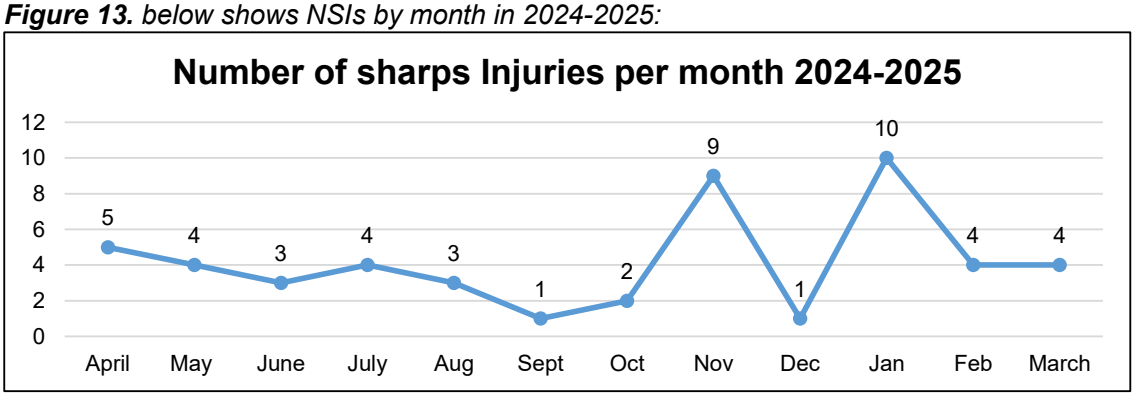
Figure 12. *below shows data for the Seasonal Influenza/COVID-18 Vaccination Programme for Service-users:*



17. Staff Health /sharps injuries

In 2024–25, Optima Health, ELFT's Occupational Health provider, reported 50 sharps injuries, up from 33 the previous year. The IPC team provided follow-up, education, and training to reduce needle stick injury (NSI) risks. All incidents were reviewed through ELFT systems and Optima Health, with a focus on learning and prevention. The IPC team also supported staff during the transition to a new safer sharps device (BD Eclipse) after the Vanish Point retractable needle became unavailable on NHS supply chain.

Figure 13. *below shows NSIs by month in 2024-2025:*



18. Antimicrobial Stewardship Programme

The ELFT Antimicrobial Stewardship Programme aims to ensure the safe, effective, and appropriate use of antimicrobials across the Trust. Guided by the ELFT Antimicrobial Stewardship Policy, the programme supports continuous monitoring and improvement of prescribing practices to help limit antimicrobial resistance and preserve the long-term effectiveness of these medicines.

The pharmacy team conducts quarterly antimicrobial prescribing audits across all ELFT sites, including community health services & mental health in-patient units. Over a two-week period, clinical notes and medication charts are reviewed for compliance with local or national guidelines or microbiology advice. Key areas assessed include appropriate treatment choice and documentation of course length. Audit findings are analysed using a Power BI dashboard linked to electronic patient records, which was refined in collaboration with the pharmacy team and the IPC doctor.

The AMR policy has been updated to reflect recommendations from the North East London ICB Catheter Passport steering group, particularly regarding the treatment of asymptomatic patients with low inflammatory markers. Quarterly AMR meetings are held to review audit results and prescribing trends, supporting the Trust-wide antimicrobial stewardship strategy.

19. Decontamination

Effective decontamination is essential to prevent the transmission of infections, including blood-borne viruses, bacteria, and fungi. ELFT follows strict decontamination protocols in line with national standards and European legislation, particularly regarding the use of single-use medical devices, which are discarded after a single procedure. While most Trust services use non-invasive, single-use equipment, some services such as Podiatry utilize reusable instruments decontaminated through external sterile service providers.

All reusable equipment, including beds, sphygmomanometers, and commodes, is cleaned between uses according to the Trust's Decontamination Policy, with compliance monitored through annual environmental audits.

A joint Duty of Care visit involving IPC and Medical Devices teams identified decontamination concerns at Enabled Living Healthcare. Meetings and follow-up actions have been ongoing. Further visits and reviews are scheduled to ensure continued compliance. Additional support visit was provided to Newham Foot Health Service to external decontamination service (Steris) to review decontamination processes before contract was sought. The IPC team also reviewed the Transcranial Magnetic Stimulation device and collaborated on procurement of improved decontamination solutions.

20. Estates & Facilities

20.1 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 14. *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	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	OCS
Bedfordshire community Health services	NHS Property Services & Mitie

20.2 Cleaning Audit Scores for 2024-2025

Figure 15. *below displays cleaning Audits scores for 2024-2025:*

Cleaning audit results *Target is 95%	Q1	Q2	Q3	Q4
OCS (Forensic John Howard Centre - London)	98.1%	97.19%	96.9%	97%
OCS (Forensic Wolfson House - London)	98.2%	97.49%	94.7%	96.8%
ISS (City & Hackney Centre for Mental Health)	96.58%	96.91%	97.79%	*97.44%*
Bart's Health (Mile End Hospital)	99.02%	96.9%	95%	98.26%
GFM (Newham Centre for Mental Health)	-	90.1%	92%	96%
NHS property services (Bedfordshire)	-	-	-	95%
CHP –East Ham Care Centre	-	97.6%	98%	97%

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

20.3 Cleaning Performance

Between April 2024 and March 2025, cleaning services across ELFT sites delivered by five contractors across various property types and achieved an average audit score of 97%, exceeding the 95% national benchmark for inpatient wards. Performance is monitored by Facilities Officers and managed by Area Facilities Managers and the Assistant Director of Facilities Management.

While standards remain high overall, the Newham Centre for Mental Health (NCfMH) continues to pose challenges, with repeated low scores particularly in Emerald and Opal wards this resulting in a high-risk classification for IPC. In response, contractor GFM implemented an improvement plan, appointed a new soft services manager, and introduced enhanced audits. Emerald Ward has since shown improvement, while Opal Ward remains under close review.

Efforts to improve food hygiene and reduce pest risks include promoting safe food storage among service users and implementing a new ward kitchen standard. Three new kitchens are planned for 2025–26 under the capital programme. Graffiti removal issues have been linked to inconsistent contractor escalation, and providers have been reminded to use the full range of approved products.

The IPC team supported the approval of the Trust adopting D10 disinfectant for stainless-steel kitchens and replaced GOJO with SJ Johnston & SCOTT® Control Foam for hand hygiene. OdorBac Tec4 was not approved due to lack of supporting evidence. Despite isolated issues, cleaning services remain compliant, with no major infection concerns reported across the estate.

20.4 Patient-Led Assessment of the Care Environment (PLACE)

PLACE is a national assessment programme required for all NHS-funded providers, evaluating inpatient environments on cleanliness, food, maintenance, privacy, and accessibility for people with disabilities and dementia. ELFT's 2024 inspections took place in October and November, with some wards at the John Howard Centre excluded due to a bed bug incident. All data was submitted by March 2025, and action plans were developed and shared to address identified issues.

The Trust's average cleanliness score was 94.18%. While East Ham Care Centre and Cedar House scored highly (100% and 99.21%), lower results at Newham Centre for Mental Health (85.41%), Bedfordshire sites, and parts of the John Howard Centre affected the overall average. Immediate actions were taken, including follow-up meetings with facilities contractors, clinical teams, and IPC staff.

Findings underscored the impact of clinical staff practices on cleanliness outcomes, such as waste management, laundry organisation, and timely issue reporting. Ongoing engagement is underway to reinforce the clinical role in supporting a safe environment. Areas scoring below the Trust average have been prioritised by the Estates Senior Leadership Team, with progress tracked through Directorate Management meetings.

PLACE results also confirmed the need for continued joint efforts between Facilities, IPC, and clinical teams. Pest control remains a focus in specific London sites, with targeted interventions in place.

Figure 16. *below displays the scores for the two domains most relevant to Infection Prevention and Control:*

PLACE Domain	National Average Score	ELFT Average Score
Cleanliness	98.31%	94.18%
Condition, Appearance & Maintenance	96.36%	92.60%

21. Pest Control

Pest control remains a priority for ELFT, particularly at several London sites requiring ongoing intervention at City & Hackney Mental Health Centre. The current service level agreement with Homerton Hospital, which includes pest control, has not met expectations. ELFT is working with the contractor, Ecolab, on a monitored improvement plan. Construction activity at the Homerton Hospital site has worsened pest issues, prompting ELFT to escalate concerns to Homerton's senior leadership, including the CEO.

At Mile End Hospital, pest activity has also been reported, but joint efforts with Bart's Health NHS Trust have led to progress through targeted action plans and estate improvements. The Estates team continues to support wards in improving housekeeping and addressing behaviours such as improper food storage and eating in bedrooms, to minimise pest risks across the Trust. IPC team have also circulated the Pest / Rodent factsheets reminder of food hygiene measures. The Trust pest control policy has also been updated to include strategic pest control plan.

22. Ventilation Safety

22.1 Management of Ventilation System

ELFT's Ventilation Safety Group (VSG), chaired by the Director of Estates, ensures compliance with HTM 03-01 and oversees ventilation risk management across the Trust. The group includes representatives from IPC, Health and Safety, staff-side, and the Trust Microbiologist. Workplace Risk Assessments (WPRAs) are reviewed and escalated as needed, with guidance from an appointed ventilation engineer/ expert advisor. Ventilation remains a key element of outbreak control, with FFP3 masks recommended in areas with poor air circulation.

During 2024-2025 the IPC team assessed ventilation at multiple sites, including podiatry clinics at Shrewsbury Road Health Centre, 71 Johnstone Clinic, and reviewed phenol use in Newham and Tower Hamlets.

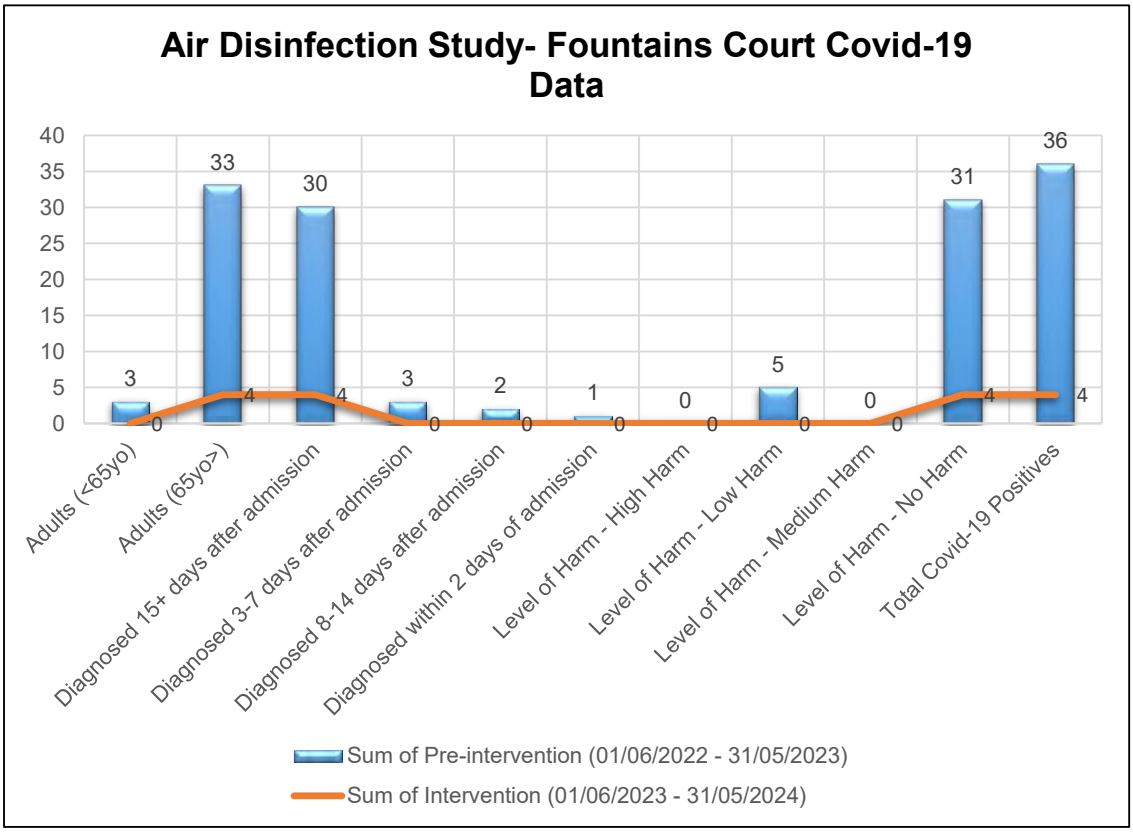
Annual servicing of ventilation and air conditioning systems was completed by Estates suppliers. All outstanding reactive repairs were resolved, bringing systems to full functionality and significantly reducing callouts. Filter upgrades and thorough cleaning of air-handling units (AHUs) have improved airflow and indoor comfort. Suppliers now conduct quarterly planned maintenance, with six-monthly inspections scheduled. All checks, including filter condition, are recorded and carried out in line with HTM 03-01. This proactive approach is expected to prevent issues before they escalate, providing assurance of safe and efficient ventilation across the Trust. At the time of writing report 12 ventilation assessment programmes are in progress.

22.2 Air Disinfection Study

ELFT's IPC Team, Estates, and Luton and Bedfordshire Mental Health clinical teams are working in partnership with Cambridge University Hospitals (Addenbrooke's) on the Air Disinfection Study. Launched at Fountains Court in June 2023, the study evaluates air purifying units designed to reduce airborne pathogens including COVID-19, in older adult mental health wards. Units were co-designed with ELFT service- users to meet safety and ligature requirements for mental health settings. Findings have been presented at 12 regional and national conferences by the IPC & Estate team during 2024-2025.

The study has shown a significant reduction in hospital-acquired infections and staff sickness. In 2022–23, there were five COVID-19 outbreaks affecting 36 individuals across multiple wards. During the study period in 2023–24, only one outbreak occurred, affecting four individuals. Staff sickness dropped by 31.5%, contributing to better staff well-being and service delivery. Feedback also confirmed acceptance and tolerability of the units, with noise levels remaining below 50 decibels. Further breakdown is show in graph below.

Figure 17. *below demonstrates there was an 89% reduction in Covid-19 patient infections.*



The air cleaning units are now embedded in ELFT's capital planning, with three additional wards at Mile End Hospital site in the forthcoming financial year. The study supports improved air quality, reduced infection risk, and aligns with net zero targets. It is recommended that the project be expanded to include other mental health wards, staff offices, and community settings to strengthen outcomes and broaden collaboration.

23. Water Hygiene

23.1 Management of Water Systems

The Water Safety Group (WSG) provides oversight of water safety governance, meeting quarterly to review reports from the Estates and Facilities Team. An Authorised Engineer ensures compliance with legal standards and works closely with the IPC Team and contractors. Legionella risks are managed through proactive and reactive measures, with regular updates shared with the IPC Committee.

23.2. Water Safety and Monitoring

Water quality across ELFT sites is managed by the Estates and Facilities Department in line with HTM 04-01 and ACOP L8 guidance on controlling Legionella. External contractors and specialist sub-contractors carry out regular monitoring to ensure compliance.

23.3 Water Risk Assessments

Water monitoring services are outsourced to multiple providers across Trust sites, as shown in ***Figure 18:***

Sites	Service Provider	Number of Sites
London Sites – Newham & Tower Hamlets	Aqua Protec	28
	CHP/G4S – Lift Co	6
	NHSPS	12
Forensic Sites + The Lodge & Alie Street	Rydon	4
Tower Hamlets – Mile End & Health & E1 Health Centre	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

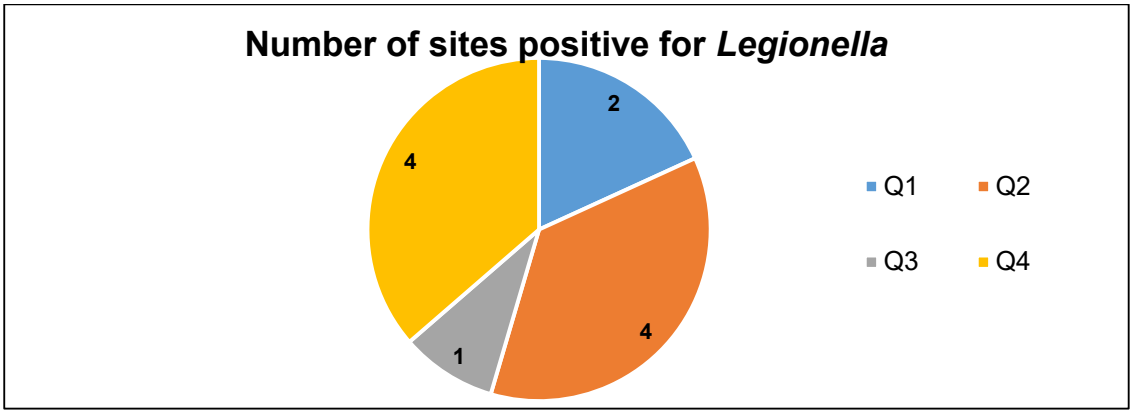
*(*Data provided by Estates and Facilities department)*

23.4 Legionella Testing and Assurance

Legionella risk is actively managed across all ELFT sites through a robust water safety programme overseen by the Estates & Facilities Department, in line with HTM 04-01 and ACOP L8 guidance. External contractors and specialist subcontractors carry out regular monitoring, including monthly temperature checks, water sampling, tank disinfections, and showerhead cleanings. All compliance documentation and site visit records are maintained on secure contractor portals, including Zetasafe for London sites and Rydon/Evolution systems for Luton and Bedfordshire.

Governance is maintained through monthly Water Safety group meetings involving Estates, IPC, and the Authorising Engineer, ensuring timely identification and resolution of any issues. This structured and proactive approach provides assurance to the Board that appropriate controls are in place to mitigate Legionella risks and maintain water safety across the Trust estate.

Figure 19. *below shows sites that reported positive Legionella water outlets during 2024-2025:*



*(*Data provided by Estates and Facilities department)*

23.5 Coliform Incident Response

In 2024, the IPC team provided critical support to the Estates Department following a suspected coliform contamination incident reported by Homerton Hospital, which impacted City and Hackney Mental Health wards. The situation led to staff anxiety and communication challenges between Homerton Hospital and ELFT. The IPC team responded promptly, producing clear guidance and factsheets for staff, visiting affected wards to support & offer reassurance, and participating in Homerton's internal critical incident meetings to represent ELFT and provide expert input.

Subsequent investigations confirmed there was no true outbreak. The coliform detection was attributed to sample contamination, and the drinking water was declared safe. As a precaution, ELFT's water tanks were tested, found negative, and cleaned. Homerton Hospital confirmed that seven of eight tanks were tested, cleaned, and found free of contamination. ELFT also undertook additional cleaning of water fountains, which remained out of use temporarily, while all other water sources returned to normal.

The incident was formally stood down, and a lessons learned process to strengthen future communication and incident response. This effective, coordinated response demonstrates the Trust's commitment to maintaining water safety and provides assurance to the Board that risks are managed swiftly and thoroughly.

23.6 Water Safety Training

In 2024–25, both the IPC team and Estates & Facilities staff received comprehensive water hygiene training delivered by the Trust's Authorised Engineer. This included Water Hygiene Awareness and Responsible Persons Training, further reinforcing the Trust's competence in managing water systems safely and in compliance with national standards.

24. Waste & Sustainability

The Waste and Sustainability Team continues to serve as the Trust's strategic and operational lead for waste, advising on compliance, legislation, and best practice. Waste management remains a key component of the IPC annual environmental audit and is embedded within both

mandatory and induction IPC training, with a strong focus on the correct segregation of clinical waste.

The Trust remains fully compliant with Health Technical Memorandum 07-01 on waste management. All Pre-Acceptance Waste Audits completed during the year met regulatory standards with no high-risk findings. The Trust's Waste Management Policy, which governs all waste-related activities across ELFT, remains current and effective.

Throughout 2024–2025, targeted efforts improved staff awareness of correct waste practices. Updates were integrated into IPC training, and new signage was rolled out across sites. Although temporary waste collection issues arose at Three Colts Lane and Passmore Edwards in Q1, these were promptly resolved.

The IPC and Waste teams jointly supported several sustainability initiatives during 2024-2025. This included the rollout of reusable cutlery and food waste caddies in Forensic Services, and a pilot for reusable sharps bins at the Newham Centre for Mental Health. In Q4, the IPC team also approved the use of anti-ligature collapsible bins for service user bedrooms.

25. Capital Projects

The IPC team played a key role in supporting capital projects throughout 2024–25, providing expert advice to ensure all new developments, refurbishments, and ward moves complied with infection prevention and control standards. Clinical sign-off was consistently considered before any relocations or changes in use. The IPC team also received, reviewed, and approved capital bid submissions across the year.

In Q2, this included approval of projects such as the installation of a new stainless steel kitchen at the City and Hackney Centre for Mental Health. In Q3, the team reviewed and approved projects focused on bathroom standardisation. In Q4, further approvals included modifications such as the Connolly Kitchen Hydration Station Door. All projects were assessed to ensure alignment with IPC requirements and Health Building Note best practice guidance.

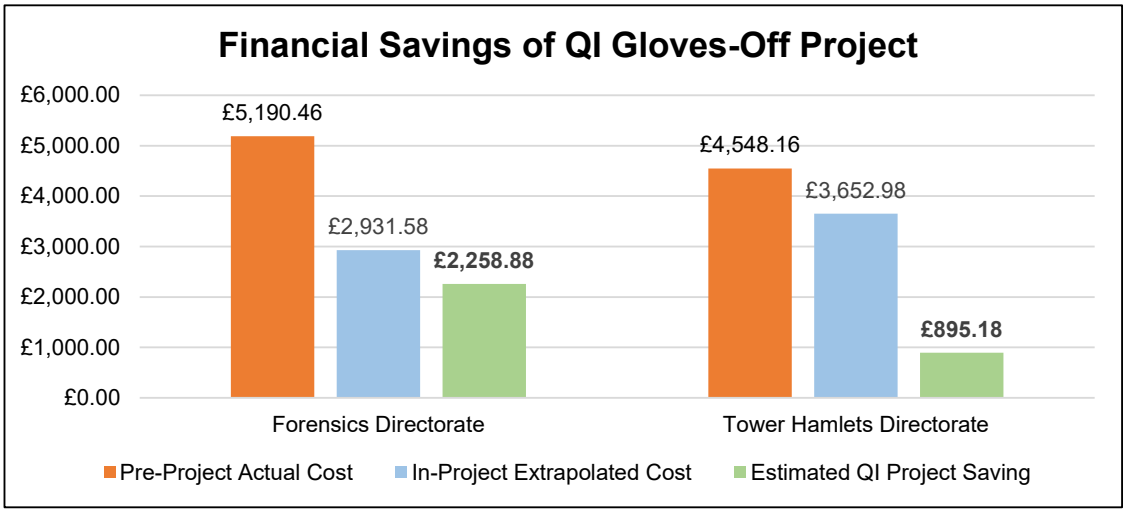
26. Quality Improvement Projects

26.1 Gloves off Project

The ‘Gloves Off’ quality improvement (QI) project, launched in September 2024 at Tower Hamlets Centre for Mental Health (THCMH) and October 2024 at the John Howard Centre (JHC), aimed to reduce unnecessary glove use and promote appropriate risk-based decision-making. Staff were encouraged to ask, *“Am I at risk?”* and use gloves only when contact with blood, bodily fluids, non-intact skin, or chemical hazards was likely. This initiative was delivered in collaboration with NEL IPC, as part of the ELFT Quality Improvement (QI) leaders programme and was supported by an ELFT QI coach.

The project addressed the overuse of gloves, which can increase cross-contamination due to missed hand hygiene opportunities and carries a significant environmental and financial burden. Inappropriate glove use is also widespread, with the NHS using up to 5.1 billion gloves during the pandemic.

Initial outcomes showed promising reductions in glove usage see below f**igure 20** for further information:



In Tower Hamlets, glove use dropped by 34.2%, with an estimated cost reduction of £895.18. In Forensics, glove use fell by 35.8% over four months, with a projected annual cost saving of approximately £2,259. Staff awareness improved, data processes were refined, and the IPC team received recognition from NEL IPC for their contribution.

While the QI cycle was short and financial savings were difficult to quantify precisely, the results indicate a clear cultural shift. The next phase will focus on sustaining progress, embedding leadership within clinical teams, and expanding the project to include broader reviews of clinical supplies. This work supports infection control, improves hand hygiene, reduces waste, and aligns with NHS net zero ambitions and supports ELFT financial viability goals.

27. IPC Risks Register

Throughout 2023–2024, infection prevention and control (IPC) risks were routinely reviewed and monitored via IPCC meetings. The primary ongoing risk relates to the reduction of IPC specialist nurse staffing due to cost-saving measures. This was confirmed through workforce review benchmarked against CNWL and NELFT. The reduction presents significant risks to statutory compliance under the Health and Social Care Act (2015), increased healthcare-associated infections, compromised environmental safety, and diminished regulatory assurance to bodies such as CQC, ICB, and UKHSA. The mitigation strategy was to prioritise the 2024–2025 IPC annual work programme essential areas of the IPC programme were clinical enquiries, outbreak management and supported visits to high risk sites/areas of concern.

A second key risk involves the decontamination of reusable medical devices by Enabled Living Healthcare Services. Although an action plan was issued, progress has been on-going.

28. Other Achievements

28.1 IPC Service & Team Developments

Ongoing development remained a central focus for the Infection Prevention and Control (IPC) team throughout 2024–2025. The IPC service operated consistently, Monday to Friday from 9am to 5pm.

However, a reduction in funding led to the loss of a full-time Band 6 IPCN post. In addition, the Deputy Director of IPC was on extended leave for most of the reporting period. This had a significant impact on service; however a safe effective & quality IPC service was delivered regardless of staffing capacity issues the department faced during the year.

The health and wellbeing of teams across the organisation was also a priority. One of the IPC nurses took on the role of wellbeing officer to provide peer support and restorative practice across the IPC team.

Despite ongoing challenges, staff development continued, two nurses began specialist IPC training at Master's level, and one Band 6 nurse completed a Postgraduate Certificate in IPC. A Band 7 nurse left the team after securing a promotion at another Trust, and recruitment is underway to fill the resulting Band 6 vacancy. A Band 7 IPC Nurse completed ELFT Quality Improvement Leader's Programme. The Trust-wide IPC Lead completed the ELFT Senior Clinical Leadership Programme.

29. Challenges and opportunities for 2025-2026

The IPC workplan for 2025–26 was developed with a focus on supporting clinical teams in delivering safe, clean care. Infection Prevention and Control remains a high priority for the Trust. For 2025–26, the team has outlined an ambitious yet adaptable programme, centred on maintaining low rates of healthcare-associated infections, strengthening assurance to the Trust, and promoting collaborative working with internal and external partners. The team will continue to provide timely, evidence-based guidance while raising the profile of IPC across the organisation. Progress will be reviewed quarterly by the Infection Prevention and Control Committee. Please see Appendix 1 for Annual workplan 2025-2026.

30. Conclusion

This report summarises key Infection Prevention and Control (IPC) challenges and achievements in 2024–25, with a continued focus on managing Healthcare on-set infections within mental health and community settings. Collaborative efforts with estates, clinical teams, and contractors supported high IPC standards, tailored to the unique demands of these environments.

All objectives from the 2024–25 Annual Plan were achieved some objections will roll over to and have shaped the 2025–26 plan (see Driver Diagram, Appendix 1), in alignment with Trust strategic priorities. The CQC Board to Floor assurance document is regularly updated to reflect current evidence and guidance.

The Trust remains compliant with the Health & Social Care Act 2008 and its Code of Practice, maintaining a zero-tolerance approach to avoidable infections. Assurance is delivered through surveillance, audits, outbreak management, and shared learning. IPC continues to be a priority, with strong engagement across services, and this report provides the Board with clear assurance of ongoing performance.

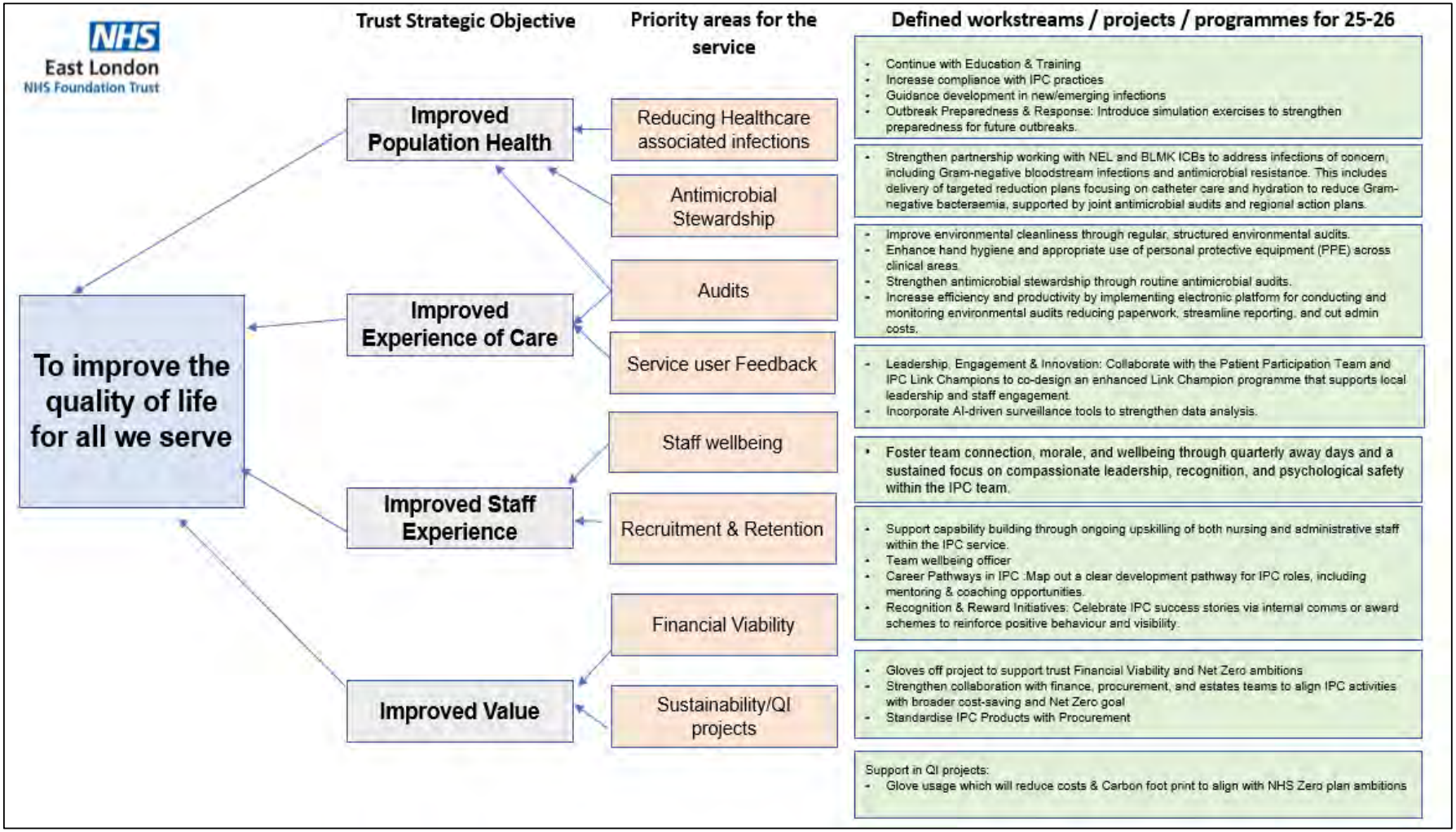
31. Action being requested by Committee:

"The Board is asked to **RECEIVE and DISCUSS the findings of the report and APPROVE the Infection Prevention & Control Annual Report**.

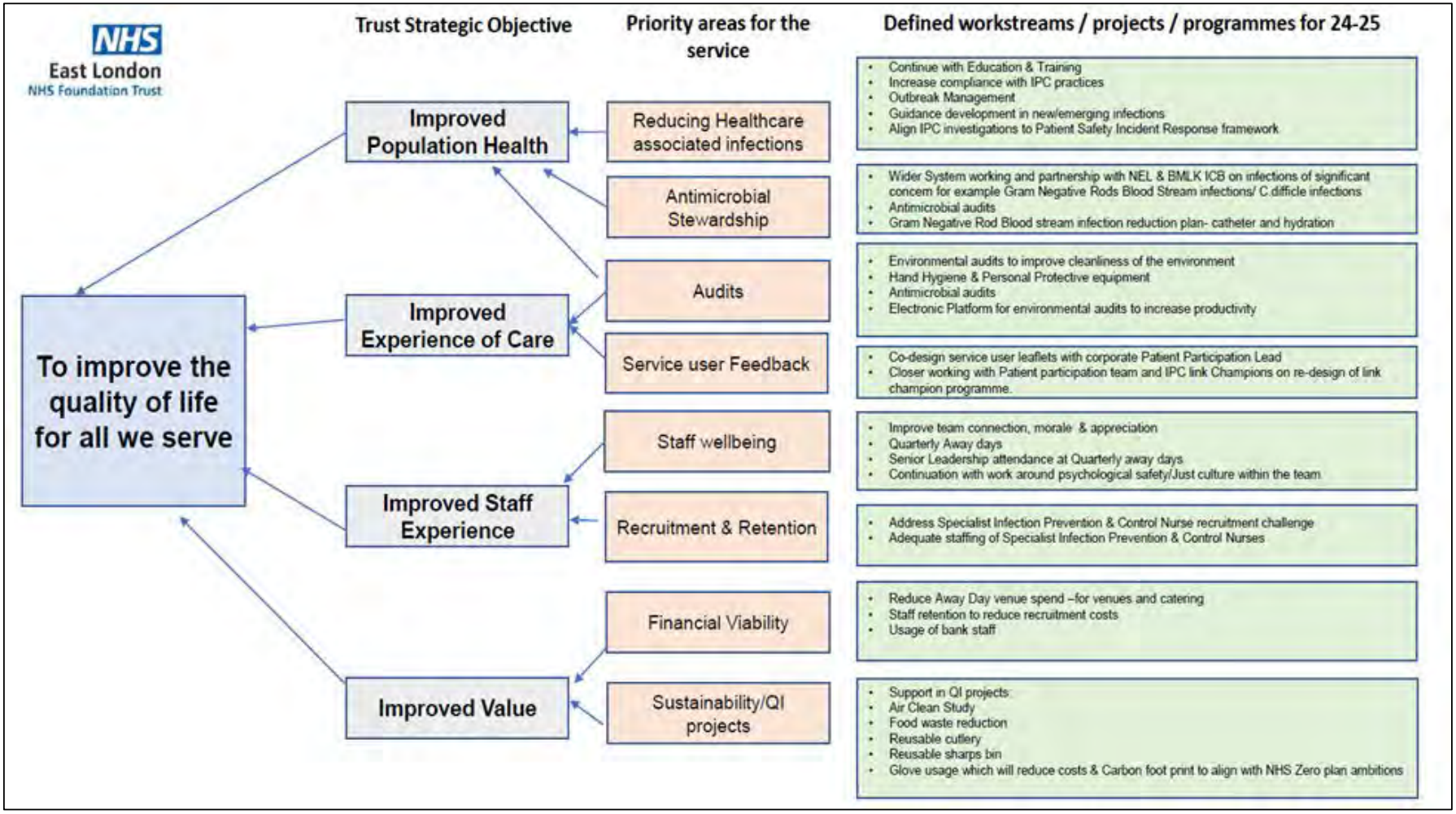
32. References

- 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/
- https://www.rcn.org.uk/Get-Involved/Campaign-with-us/Glove-awareness

Appendix 1- Annual IPC workplan for 2025-26



Appendix 2 -*Annual IPC workplan for 2024-2025*



QUALITY ASSURANCE COMMITTEE - 7 July 2025

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 2024-25 and set out work-plan for 2025-26.

Summary of key issues

The report covers the period from 1 April 2024 to 31 March 2025 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 successfully improved their compliance with Tribunal Rule 32 (Tribunal report timeliness) and identifies issues around compliance with treatment certificate requirements and Section 132A MHA (statutory duty to inform community patients of their rights) – for which action plans are being delivered.

Strategic priorities this paper supports

Improved population health outcomes	☐	
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
17/06/2025	Mental Health Law Monitoring Group
25/06/2025	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 compliance with MHA treatment certificate requirements, S132A compliance and quality ot capacity test recordings.
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 via Mental Health Act Administration and 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 2023/24
Mental Health Bill 2025
CQC Report on Monitoring the MHA in 2023/24

Abbreviation	In full
AHM	Associate Hospital Manager
CAMHS	Child and Adolescent Mental Health Services
CHS	Community Health Services
CQC	Care Quality Commission
CTO	Community Treatment Order
DMT	Directorate Management Team
DoLS	Deprivation of Liberty Safeguards
EPR	Electronic Patient Records
ICB	Integrated Care Board
LA	Local Authority
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 2024 to 31 March 2025 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 Mental Health Law Monitoring Group (MHLMG), which gets quarterly reports from:

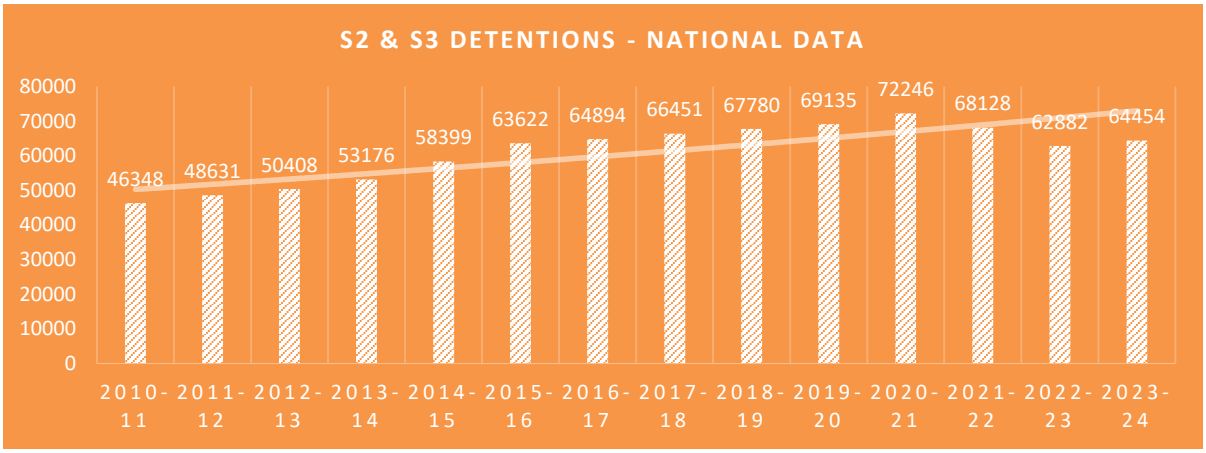
- Each of the 6 mental health DMTs (Luton & Bedfordshire, City & Hackney, Newham, Tower Hamlets, CAMHS and Forensics);
- Each of the 3 Community Health Services' Leadership group/QAGs (Newham, Tower Hamlets, Bedfordshire);
- The Primary Care QAG;
- The Associate Hospital Managers Forum (see para 3.4).

The MHLMG reports to the Quality Committee on a quarterly basis.

3 Use of the Mental Health Act 1983

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

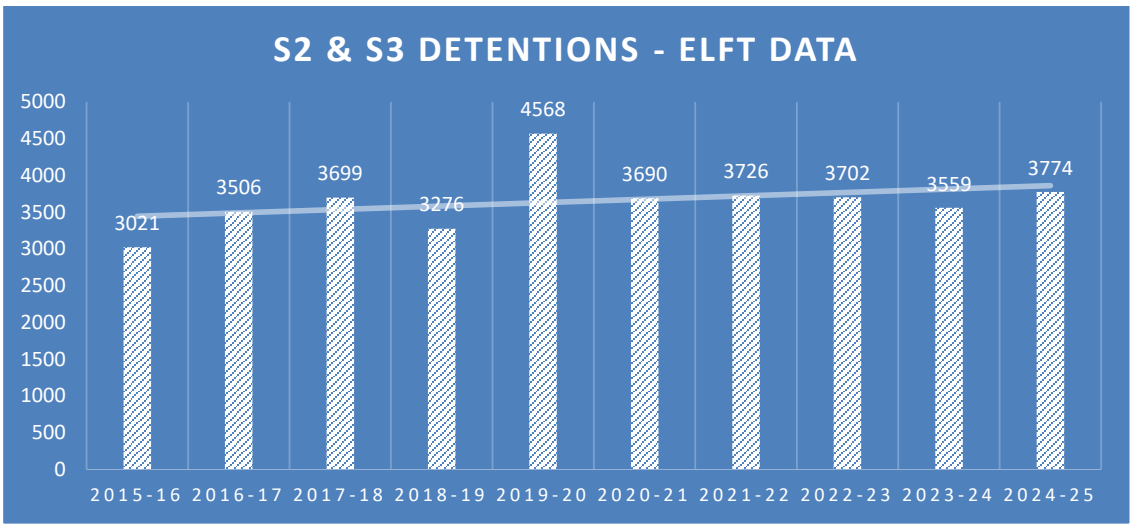
On 12/09/24 NHS Digital published its **MHA Statistics, National Figures for 2023/24**. The figures show an increase in detentions of 2.5% from the previous year. This reverses a recent trend of decreases observed at national level. The figures also show that rates of detention are over 3.5 times higher for the Black and Black British Group than they are for the White group (the rates of CTO was over 7 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.

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

In 2024/25, there were a total of 3774 S2 and S3 admissions to ELFT - a 6% increase from the previous year.



On 31 March 2025, there were a total of **927** people subject to the MHA in ELFT (an increase of 7% from the previous year). Of these people, **217** were subject to a CTO (+8.5%). The remaining **710** were detained in hospital (+7%): **497** were subject to civil sections (+8%) and **199** to forensic sections (-3%). In 2024/25, 409 new CTOs were made in ELFT (+6%). 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 2023, ahead of it becoming mandated across NHS Mental Health Trusts. ELFT implemented PCREF across all mental health directorates and services.

3.3 Legal Developments and Impact on ELFT

3.3.1 Mental Health Act Reform

On 06/11/24 the Mental Health Bill was introduced in Parliament for the purposes of amending the Mental Health Act 1983. This has been an already long process with the Independent Review of the Mental Health Act having been undertaken in 2017 and then reported in 2018, chaired by Sir Simon Wessely.

The Bill proposes to:

- heighten detention criteria;
- shorten detention periods;
- limit the extent to which people with a learning disability or autism can be detained;
- add statutory weight to patients' rights to be involved in planning their care and to make advanced choices regarding their treatment; and
- replace the 'nearest relative' with the 'nominated person', who will be chosen by the patient.

At time of writing the Bill had completed its House of Lords stages and had been presented to the House of Commons.

3.3.2 Moon Case and AHMs' Worker Status

On 22/01/2024 the Employment Appeal Tribunal found that no error of law had been made in concluding that an Associate Hospital Manager, namely a person authorised by the board of the respondent NHS trust under section 23(6) of the Mental Health Act 1983, had been a ***worker*** under the Employment Rights Act 1996. At time of writing the MHLD together with People & Culture are seeking further legal advice on the implications of the Moon case.

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 16 AHMs in ELFT at the start of the year. Three AHMs stepped down in the last 12 months. The MHLMG would like to thank Shahida Ahmed, Stephanie Boyce and Joanne Share-Bernia for their dedication and commitment to the role over the years.
ELFT launched a new appointment campaign in Dec 2024. It proved very successful with 55 applications being received, 21 people being invited to interviews and 15 offers being made. At time of writing 11 new AHMs have gone through their HR checks and are about to receive induction.

3.4.3 AHM Activity and Timeliness of Reviews

There were a total of **430** AHM reviews held in ELFT in 2024/25 – this is an 114% increase on the previous year. 72% of AHM reviews were held within the 10 week target in 2024/25.

3.4.4 Training

A comprehensive training programme was delivered to the AHMs in 2024/25 including refresher training on understanding mental health mecication and considering the views of patients an carers – delivered by People Participation.

3.5 Care Quality Commission Findings

3.5.1 National Findings

The CQC published its report on Monitoring the Mental Health Act in 2023-24 on 13/03/2025. The key messages were that:

- The CQC welcomes the introduction of the **Mental Health Bill** into parliament however notes that legislation alone won't bring the changes needed. Better funding, improved community support and investment in workforce are essential to improving mental health care and providing better outcomes for patients.
- **Systems** – The CQC remains concerned about the high demand for mental health services across the country with individuals not being able to access care and support and becoming unwell waiting for this. Many services told the CQC that patients seem to be more unwell on admission than in the past.
- **Workforce** - Although the mental health workforce has grown by nearly 35% since 2019, shortages in both medical and support roles continue to have a negative impact on patient care. Doctors' shortages continue to affect the delivery of the Second Opinion Appointed Doctor service.
- **Inequalities** - Access to mental health support is challenging for people from ethnic minority groups and those living in areas of deprivation. There are gaps in the knowledge of staff around caring for autistic people.
- **Children and Young People** - Increasing demand is leading to long waits for beds and increases the risk of being placed in inappropriate environments and/or being sent to a hospital miles away from home.
- **Environment** - The CQC is concerned about the impact of poor-quality environments on patients (e.g. no access to outside space) and seeing first hand examples of how ageing and poorly-designed facilities affect people's care.

3.5.2 Findings on ELFT Wards

In 2024/25 the CQC conducted 14 MHA Reviews on the following ELFT wards:

Ward	Directorate	Date	Care Plans	S132	S17 Leave	Treatment	Environment
Poplars	L&B	23/04/24					
Millharbour	TH	19/06/24					
Cedar House	L&B	20/06/24					
Lea	TH	03/07/24					
Roman	TH	03/07/24					
Morrison	Fx	10/07/24					
Victoria	Fx	19/08/24					
Butterfield	Fx	20/08/24					
Bow	Fx	26/09/24					
Gardner	C&H	18/11/24					
Willow	L&B	29/11/24					
Connolly	C&H	05/12/24					
Townsend Court	L&B	17/12/24					
Bevan	C&H	27/03/24					

The top three concerns raised by the CQC were:

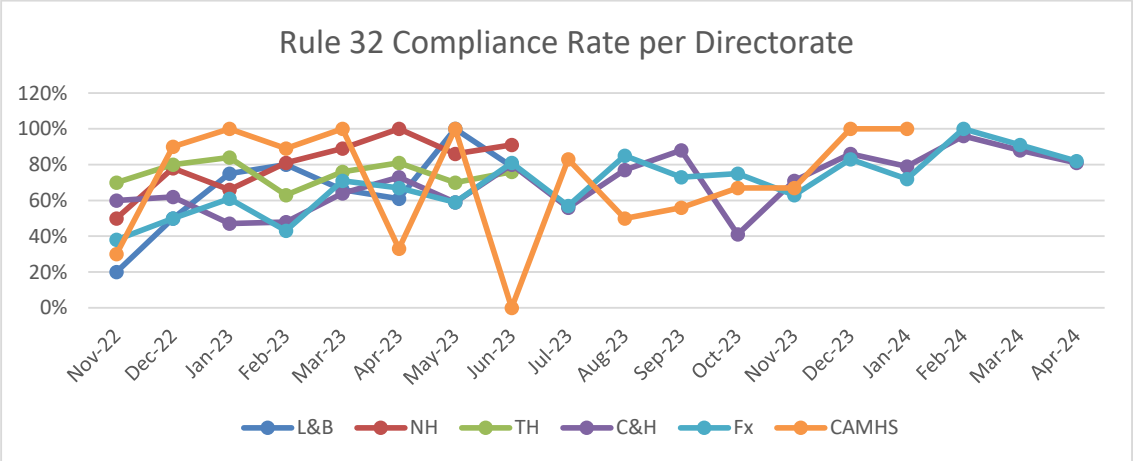
- **Consent**: some patients were treated without a treatment certificate.
- **S132:** attempts made to explain their rights to patients were not always recorded in a timely fashion.
- **Environment issues** e.g. lack of access to fresh air.

The MHLD is working closely with Operations to address these concerns. A Quality Improvement (QI) project on Treatment Certificates Requirements was launched in Feb 2025 and is already driving up compliance (see para 3.6). The Trust's overall compliance with S132 is good (see para 3.6) and ad hoc support is being offered to the few wards where concerns have been raised. Environmental concerns are being addressed together with Estates.

3.6 MHA Related Clinical Audits

- **Tribunal Rule 32**

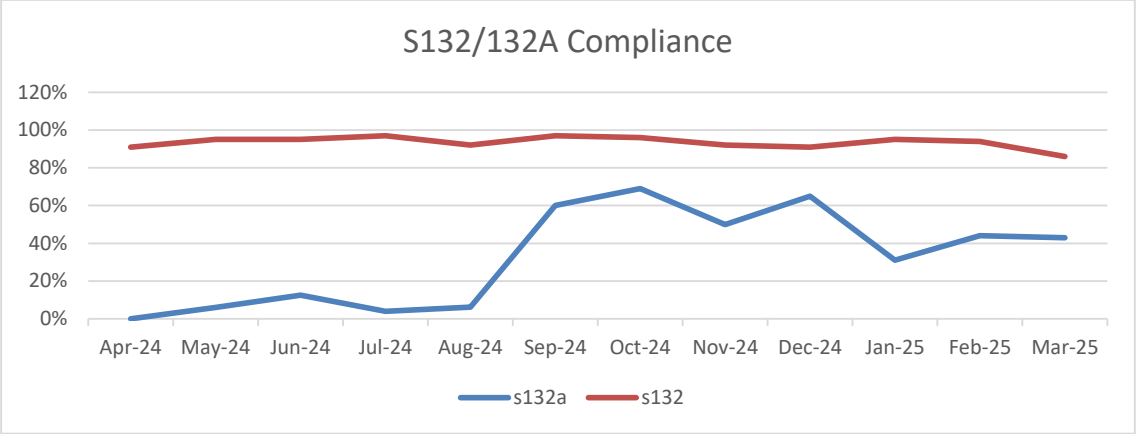
Following tribunal complaints received in 2022 with regards to breaches of Rule 32 (late submission of reports leading to adjournments), a QI project was launched by ELFT to support directorates to improve their performance. The project was successful – and officially closed for all directorates in April 2024.



- **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 those 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, and within 7 days for CTO

patients). Compliance with S132A has significantly improved since Sept 2024. Further interventions are being carried out, in line with the QI approach, to improve compliance further.



- **Audit of MHA Function and Compliance with MHA Treatment Certificate Requirements**

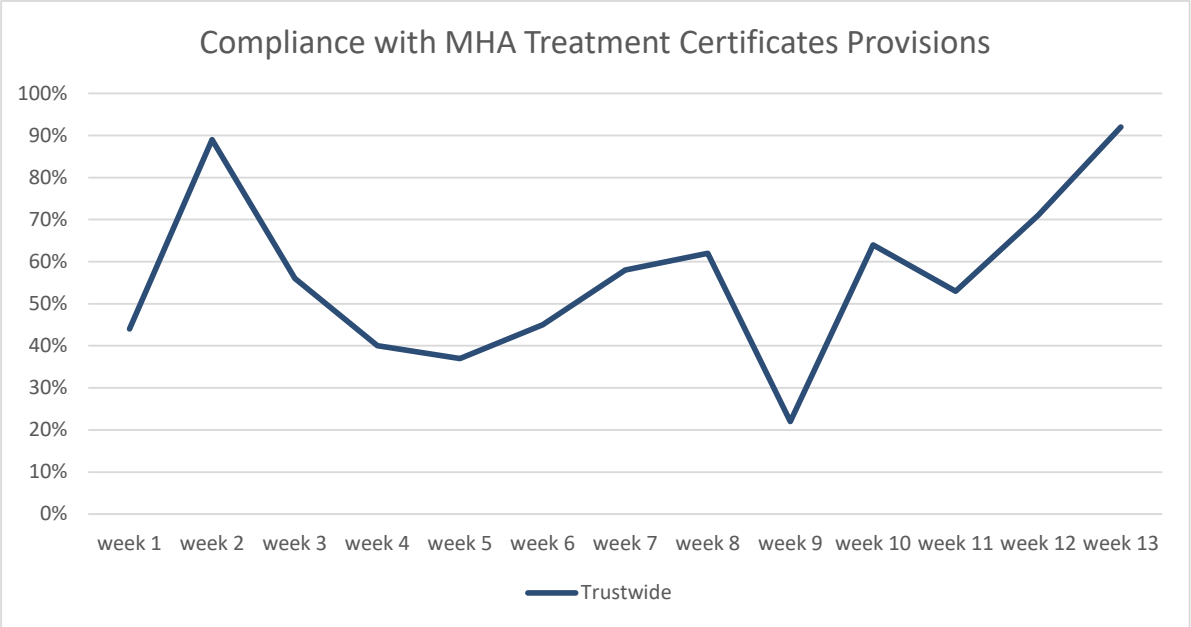
An audit of the MHA function was undertaken by auditors RSM UK as part of the 2024/2025 Internal Audit plan agreed by the Board. The objective of the audit was to assess whether the Trust is complying with its duties under the MHA. The audit highlighted areas of good control as well as areas where the Trust could improve its control:

Areas of Good Control	Areas Where Control Could Be Improved
MHA Training Material & Compliance	MHA Policy Review Schedule
MHA Compliance Reporting & Governance	MHA Treatment Certificate Requirements
Section Expiry Dates & Lawfulness of Detention	Document Upload & Information Governance
	Responsible Clinicians Cover Arrangements
	Letters to Patients and Nearest Relatives
	MHL Newsletter
	AMHP Reports
	MHA Weekly Team Meeting

Due to the risk involved, a **partial assurance** opinion was issued. An action plan was introduced in January 2025, in line with the QI approach, and is in the process of being delivered – focusing principally on compliance with MHA treatment certificate requirements.

Section 58 of the MHA provides for mental health treatment to be administered under the MHA for a maximum of 3 months. A treatment certificate must be issued to continue treatment beyond 3 months, which Responsible Clinicians are responsible for. Patients records were sampled as part of the audit which found that 70% of patients had been treated without a statutory treatment certificate (for over 28 days in 25% of cases). Mitigations via the introduction of a new SOP in 2023 had failed as the SOP was not adhered to and breaches were not systematically reported. Breaching MHA treatment certificate requirements means patients' fundamental rights are not upheld and exposes the trust to a risk of legal challenge as well as to a risk of challenge from the regulator.

The action plan includes comms from the Chief Medical Officer, training for Responsible Clinicians, escalation to Clinical Directors/Medical Directors and weekly compliance reports to Operations.



3.7 MHA Related Incidents, Complaints and Claims

There were a total of 151 MHL related incidents reported in 2024/25 (6% decrease). The top 3 themes were:

- Failure to comply with treatment certificate requirements (40)
- S140 policy triggers (23)
- Failure to receive and accept statutory documents (23)

As mentioned at 3.6, a QI project was launched in Feb 2025 to improve the trust's compliance with MHA treatment certificate requirements. As part of this project, reporting has become systematic which explains the spike in incident reports. Significant improvement has already been observed and it is expected the project will close in 2025/26.

Under section 140 ICBs have a duty to notify LAs in their areas of arrangements which are in force for the admission of patients in cases of special urgency. There are situations where, despite those arrangements, it is difficult to locate a bed. In such situations, the joint S140 protocol provides an escalation pathway. In 2024/25 the escalation pathway was triggered 23 times (53% increase from the previous year). This is being discussed with our ICBs.

A project on Receipt and Acceptance of Statutory Documents under the MHA was launched by the MHLD and the Nursing Directorate in June 2024, which involved training 400+ inpatient nurses. This intervention has not had the expected impact and the MHLD is meeting with the Nursing Directors to agree the next intervention.

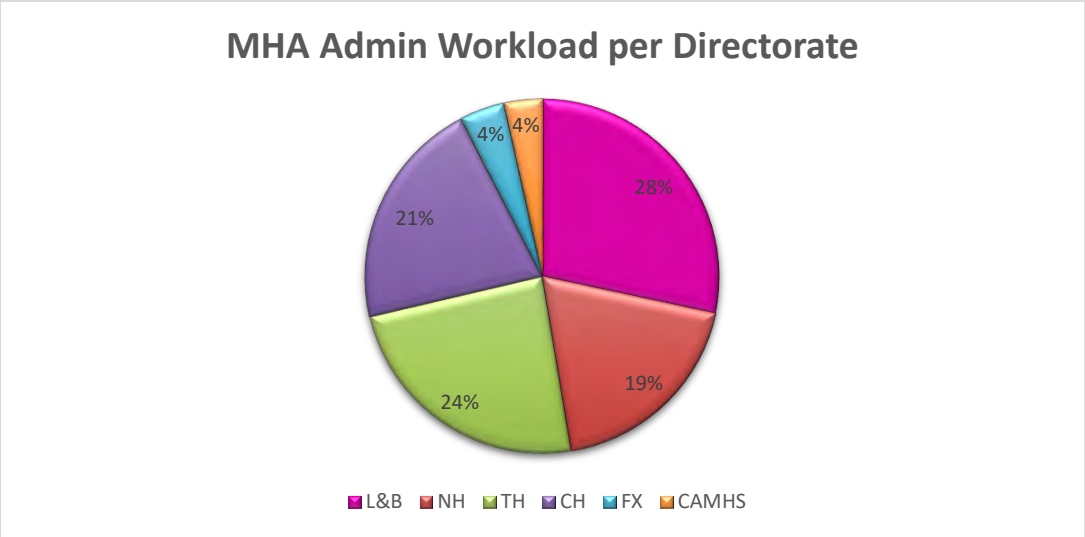
A number of complaints were received from the Ministry of Justice in the summer of 2024 with regards to the late submission of conditional discharge reports. The MHLD has worked closely with Operations to put systems in place to ensure reports are submitted in a timely fashion.

3.8 MHA Training Compliance

At the end of March 2025, **94%** 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

At the end of 2024/25 the workforce establishment for the MHA Admin Service was 5 WTE B5s and 11.8 WTE B4s (1.6 WTE B4 were covered by staff bank workers due to 1 B5 being currently seconded to a B6).
The clerking Service Level Agreement (SLA) with the Tribunals Service generated £5k in 2024/25 - 58% more than the previous year.
ELFT also provides a MHA Administration service to our neighbouring acute trusts, Bedfordshire Hospitals NHS FT and the Homerton Healthcare NHS FT, which generates £50k per annum. The terms of the MHA Administration SLA with Barts Health NHS FT have been revised but due to an ongoing dispute, ELFT has not been in a position to invoice for the service, which has effectively been provided free of charge. Work is under way for the MHLD to recover the costs incurred by the service provision.
The MHA Admin service compiles data to inform resource allocation. Activity levels were as follows in 2024/25:



3.10 eMHA by Thalamos

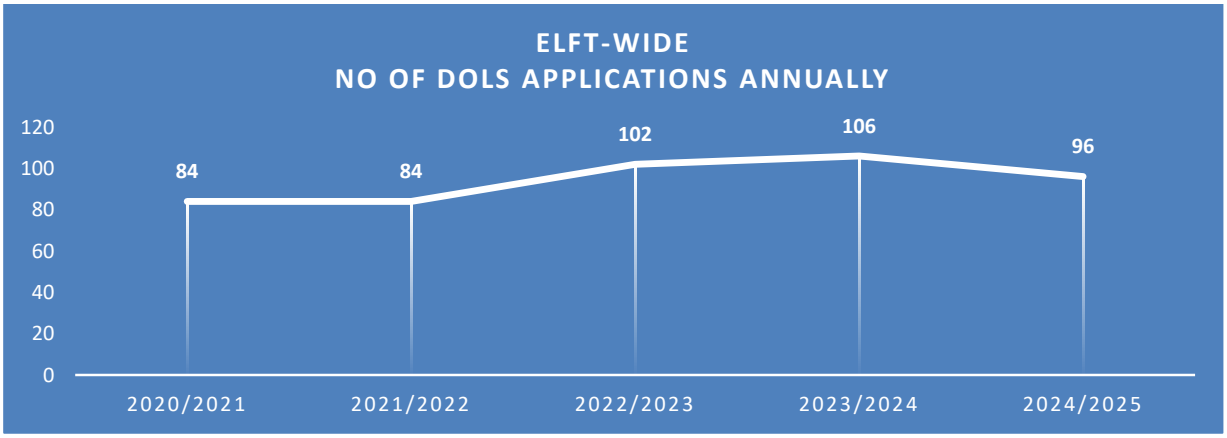
The eMHA software which supports the electronic completion, signature, service and secure storage of statutory forms under the MHA was launched on 20/11/24 as part of the NHSE OneLondon Programme. ELFT was the first organisation to go live in London. NELFT, SWLSG, Oxleas and SLAM have followed since. All five organisations now share MHA status information on the software. Software usage has gone from 33% to 90% since 20/11/24. eMHA is proving popular with ELFT doctors, which have the highest usage rate, closely followed by AMHPs, Ward Nurses/Receiving Officers and S12 doctors.

The MHA Admin service was negatively impacted by the way the software was rolled out. The launch was rushed due to delays with the EPR upgrade and to the terms of the contract with NHSE. Minimal training was offered pre-go live, which put the service under pressure. However the service showed extraordinary resilience in the circumstances and will be working closely with NHSE and with the suppliers to improve the software and tailor it to its needs in 2025/26.

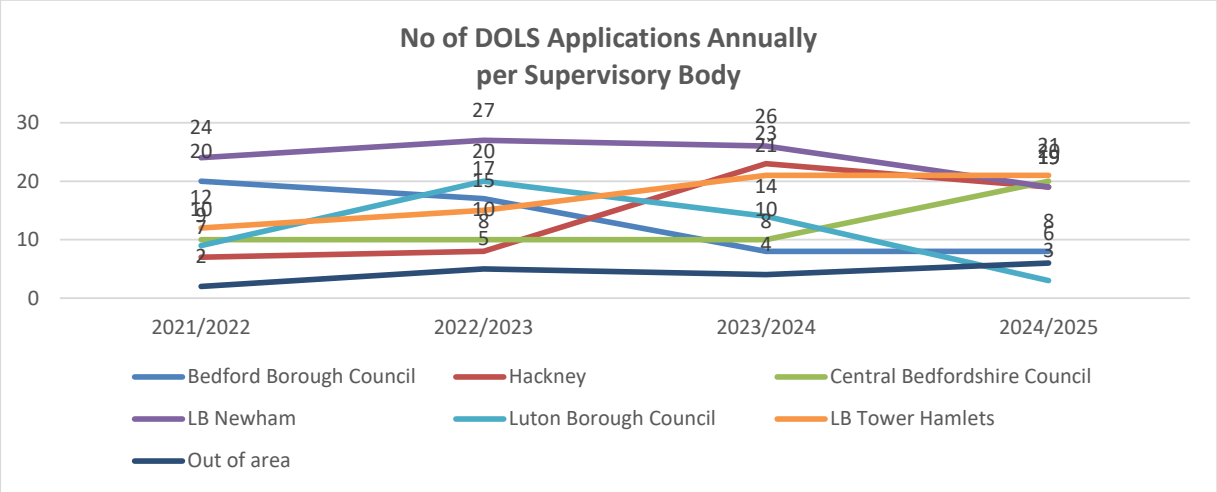
4 Use of the Mental Capacity Act 2005

4.1 MCA Activity

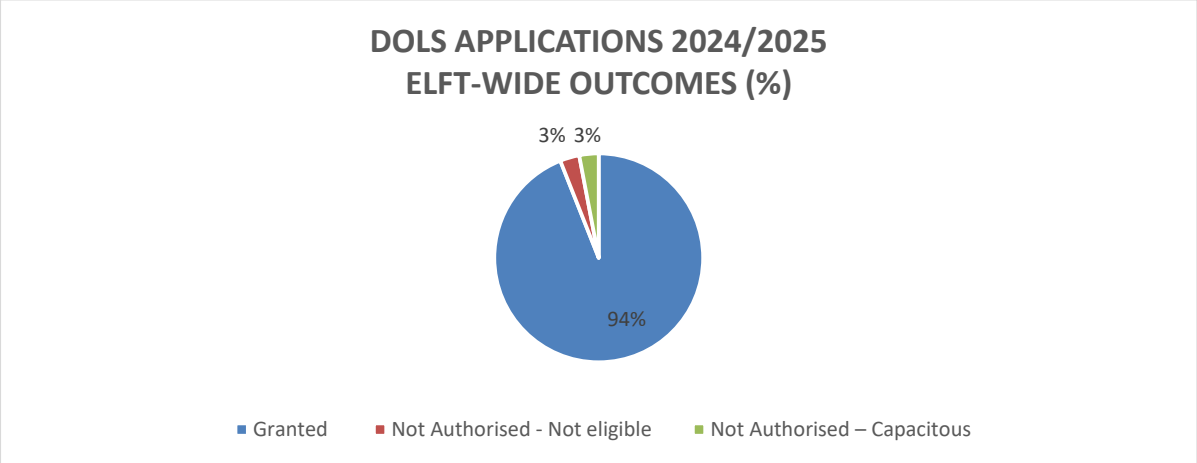
The Trust acts as Managing Authority, under Schedule 1A to the Mental Capacity Act 2005, which implements the DoLS framework. This means that ELFT clinicians must make DoLS applications to the Supervisory Body (the Local Authority) when a care plan amounts to a deprivation of liberty. We have seen a 9% decrease in DoLS applications made by ELFT in 2024/25:



The most significant decrease was for applications made to Luton Borough Council (-79%):



The authorisation rate currently stands at 94% – an increase from 2023/2024 where the percentage was 90%.



3% of applications were rejected due to patients not meeting the eligibility criteria. This is an improvement from the year 2023/24 where the rejection rate on the same grounds stood at 4%. The rejections this year were for two urgent authorisations submitted consecutively. The supervisory body felt that the MHA was the correct framework and rejected the applications on both occasions. Following an MHA assessment where it was determined that the MHA could not be used, the LA granted the authorisation.
The MCA Manager and MCA Officer work closely with Operations and Supervisory Bodies to monitor any outstanding authorisations.

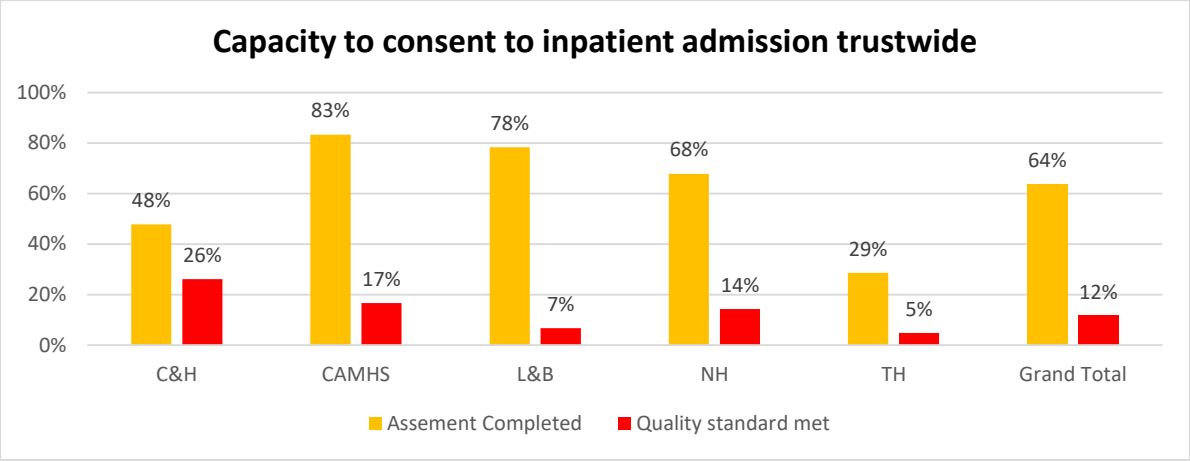
4.2 MCA Administration and Workforce Establishment

Staffing the MCA function adequately remained a concern in 2024/25. Both the MCA Lead/Deputy AD of MHL, Jacek Borek, and the MHL Manager responsible for the MCA, Navelette Green, left the trust following periods of prolonged absence. The MHLMG would like to thank them both for their contributions to the work of the department and of the trust generally.
The B6 MHL Senior Supervisor who was seconded to the B7 Mental Health Law Manager role in Sept 2023 continued running the MCA function together with the B5 Mental Capacity Act Officer under the supervision of the Associate Director of MHL. Their focus has been on policy review, training compliance monitoring and audit strategy. Complex case management work has remained with Trust solicitors. The MCA team will explore whether this may move to Legal Affairs in 2025/26.
A review of MCA staffing needs was undertaken in 2024/25 and found that no additional admin resources were required at this time.

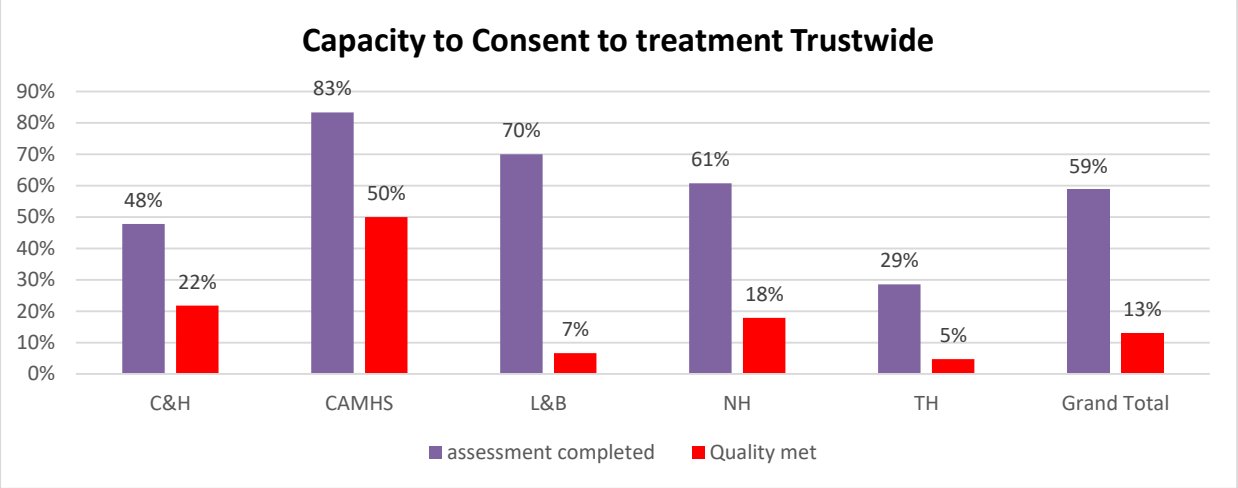
4.3 MCA Audits

An MCA internal audit strategy was introduced in 2024/2025 focusing on the quality of capacity assessment records kept in mental health services and Community Health Services (CHS).

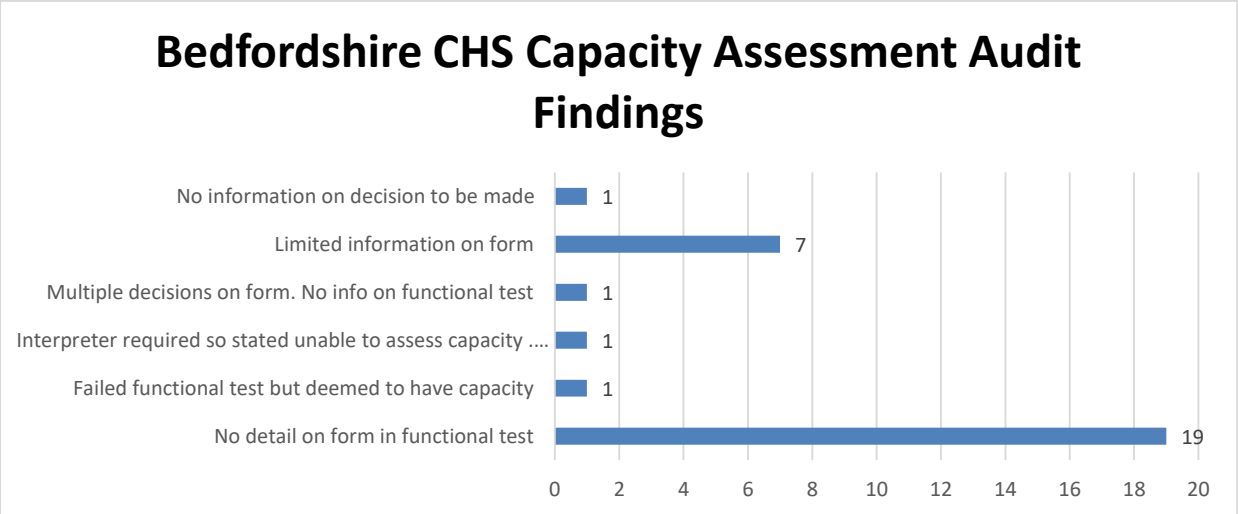
The audit carried out in MH services found that capacity to consent to admission had been tested and recorded for 64% of voluntary inpatients and 12% of records met the quality standard.



It also found that capacity to consent to treatment had been tested and recorded for 59% of voluntary inpatients and 13% of records met the quality standard.



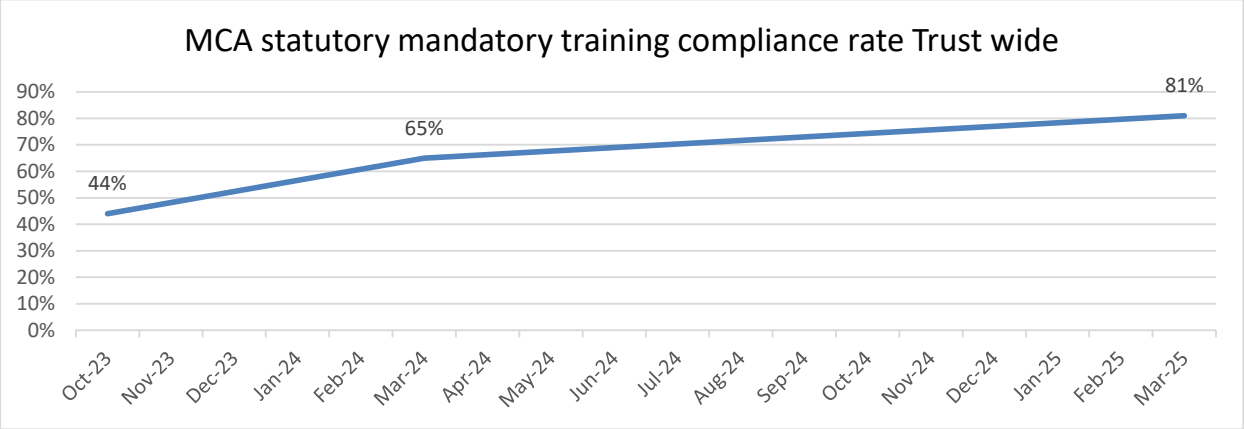
The audit carried out in CHS found that capacity test records did not meet the quality standards – for the reasons highlighted below:



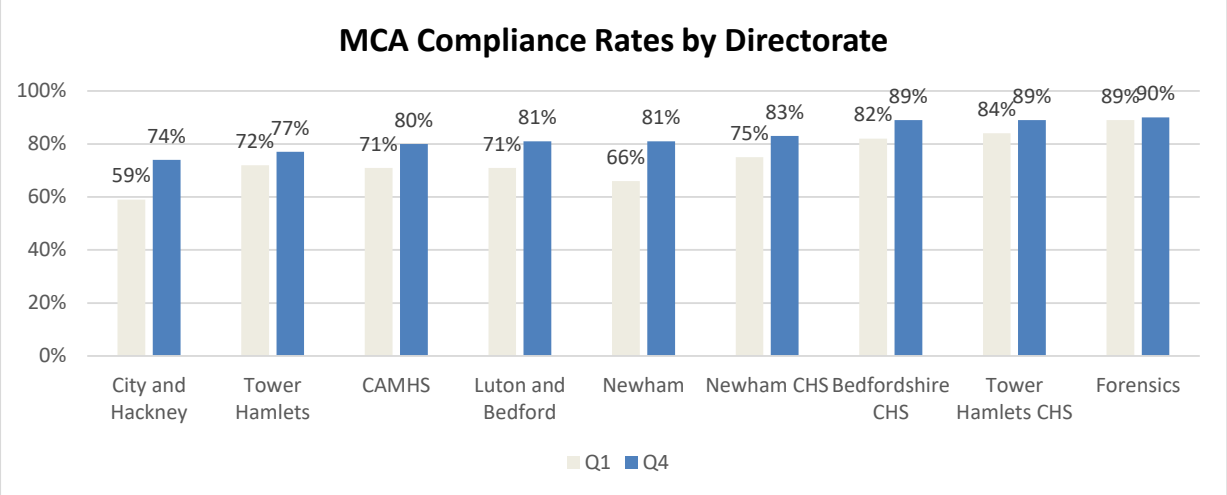
The focus in 2025/26 will be on driving up compliance in making the required records and meeting the quality standard. A QI approach will be taken to support clinicians and the MCA team will work closely with Operations to run a pilot and improve standards.

4.4 MCA Training Compliance

At the end of 2024/25, the MCA training compliance rate was 81% (+16%).



The MHL Manager responsible for MCA reports to DMTs and QAGs/Leadership Groups on a quarterly basis:



5. Progress made against 2024/25 Work Plan and New Work Plan for 2025/26

4.5 Progress made against 2024/25 Work Plan

- **Support to Operations** has been maintained through existing MHL governance, strengthened KPI reports and improved frontline connection. Compliance with Rule 32 has improved (see 3.6). So has compliance with Section 132A and MCA training compliance. Improving the quality of capacity assessment recordings remains an objective for 2025/26.
- The **MCA function** has been given more stability with MCA policies being consolidated, an MCA audit strategy being devised and the MCA team resources being reviewed.
- New **AHM** appointments have been made and 71% of AHM reviews are held in a timely manner. Terms of appointment are yet to be agreed in light of the Moon case (3.3.2) and will remain an objective for 2025/26.
- The **MHL training strategy** has been developed and a combination of eLearning packages and live training (remote or face to face) has been delivered in 2024/25. Over 400 frontline staff received training on Receipt and Acceptance of Statutory Documents under the MHA. The MHLD is also now involved in the delivery of local inductions to resident doctors.
- **Digital solutions** have been introduced to further support Operations and overall governance: eMHA (Thalamos version 2) was rolled out in 2024/25 as part of the NHSE OneLondon programme and allows

clinicians to complete statutory documents under the MHA electronically and to share MHA status information across London.

- **Support MHLD frontline** to deliver effective service: resource allocation is now data driven and new MHA Admin SOPs have been introduced. An IT equipment review was also conducted by the MHL Senior Supervisors and new equipment ordered as needed to support the needs of the service. However JDs were not revised and there has been little appetite for development/leadership pathways. These will remain objectives for 2025/26.
- The **MHL communication strategy** has been strengthened with a review of the MHL intranet page and the re-launch of the MHL newsletter. The public facing webpage will be updated in 2025/26.
- **Audit cycles** have been reintroduced for both the MHA and the MCA. Compliance with Rule 32 has improved (see 3.6). So has compliance with Section 132A and MCA training compliance. Improving the quality of capacity assessment recordings remains an objective for 2025/26.
- **SLAs** have been signed off with Homerton Healthcare and Bedfordshie Hospitals Trust, which have allowed the MHLD to meet its financial viability targets. The SLA with Barts Health remains an objective for 2025/26.

4.6 Work-plan for 2025-26

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 quality of capacity assessment recordings, compliance with MHA treatment certificate requirements, compliance with S132A, receipt and acceptance of statutory documents	AD of MHL MHL Manager (MCA) MHL Mnaager (MHA)	Operations	March 2026
2	Explore possibility of managing Court of Protection matters inhouse with Legal Affairs	Streamlined process Reduced costs	MHL Manager (MCA)	Legal Affairs	September 2025
3	Give induction to new Associate Hospital Managers and improve timeliness of AHM Reviews	Induction delivered Terms of appointment revised NHS mail accounts issued	AD of MHL MHL Manager (MHA)	People & Culture Digital	August 2025
4	Agree joint approach to Receipt & Acceptance of Statutory Documents under the MHA with Nursing Directorate	New approach agreed and delivered	AD of MHL MHL Manager (MHA)	Nursing Directorate	October 2025
5	Further develop digital MHL solutions to support Operations and overall governance	InPhase incident reports InPhase risk register eMHA	AD of MHL MHL Manager (MHA) MHL Manager (MCA)	Digital Programme Office Management Governance & Risk department Analytics	March 2026
6	Support MHLD to deliver effective service (via training, clearer JDs) and recruit to vacant posts	JDs revised Vacancies filled Development Programmes launched	MHL Senior Supervisors MHL Manager (MCA) AD of MHL	People & Culture	March 2026
7	Deliver MHL communication strategy	Public facing website Newsletter	MHL Manager (MHA)	Comms	December 2025

8.	Agree revised terms of MHA Admin SLA with Barts Health	SLA signed Invoice issued	AD of MHL	Contracts Finance	September 2025

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.

5 Action Being Requested

The Committee is asked to approve this report.

ANNUAL REPORT TO THE QUALITY ASSURANCE COMMITTEE

7 July 2025

Title	Emergency, Preparedness, Resilience and Response Annual Report 2024/2025
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 2024/25, 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 2024/25. 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 EPPR Team in November 2024. 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 was rated as FULLY COMPLIANT.
- The Assurance Report from NHS England concluded that ELFT highlighted a high quality of plans, schedule of training and exercising. Noted as good practice was the explicit reference to psychological support for staff in our Incident Response Plan
- 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 a critical incident on 19th July 2024 in response to the global crash of the Microsoft Windows system - Trust implemented a range of measures to manage the situation effectively
- The Trust ran Exercise Blackout (table-top) in order to evaluate how the Trust responds in the event of an ICT major incident, requiring the implementation of a strategic, tactical, and operational command structure. This exercise provided valuable insights and lessons that will inform future training and preparedness activities.

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
- Fuel Plan

2.4 Business continuity plans have been refreshed by all Directorates and will be reviewed again considering any lessons learnt and in response to exercises.

3.0 Annual EPRR Assurance

3.1 London

3.1.1 The Trust participated in the Assurance exercise carried out by NHS England (London) EPPR Team in October 2024. 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.

3.1.2 Based on the 2024 annual assurance submission to NHS England (London), the Trust did not receive any amber or red ratings and therefore rated as **FULLY COMPLIANT**.

3.1.3 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. Noted as good practice was the explicit reference to psychological support for staff in our Incident Response Plan Furthermore, the Trust's Incident Response Plan and EPRR Policy continue to be identified as being of a very high standard and continue to be included on the national EPRR database of good practice.

3.2 Luton and Bedfordshire

Organisations which operate across Local Health Resilience Partnerships (LHRP) borders present their completed EPRR self-assessment return to their lead ICB and host LHRP as appropriate. Our self-assessment and subsequent report was shared with BLMK ICB.

4.0 RSM Business Continuity Planning Audit 2024/25

4.1 As part of the approved 2024/25 internal audit plan, a review was undertaken of the Trust's Business Continuity Planning (BCP) arrangements for non-digital services. The audit formed part of a broader assessment of the Trust's corporate approach to business continuity, with the objective of evaluating preparedness and resilience in the face of disruptions or major incidents, and ensuring the continuity of essential operations while minimising potential impacts.

4.2 As part of the audit, the Trust was asked to submit a broad selection of BCPs covering services across mental health, community health, primary care, wellbeing, and inpatient care — supporting young people, working-age adults, and older adults across the City of London, Hackney, Newham, Tower Hamlets, Bedfordshire, and Luton. Training and exercising materials were also submitted for review.

4.3 The audit resulted in one high-priority, seven medium-priority, and two low-priority findings. The high-priority issue related to the absence of business continuity provisions and Service Level Agreements (SLAs) within supplier contracts.

4.4 The Trust has addressed the high and medium priority issues by resolving the lack of third-party business continuity and SLA provisions in supplier contracts. As regards outstanding actions, work is ongoing to support teams in transitioning to the updated Trust-wide BCP template and to address the lack of a centralised BCP register, the Trust plans to use its version of Power BI to store, monitor, and report on BCP data across services.

5.0 Business Continuity

5.1 New Business Continuity Plan Template and Off-the-Shelf Exercise

5.1.1 Given the ongoing pressures and challenges faced by the Trust, there is a growing need to ensure the continuity and resilience of its services. To address this, a new Business Continuity Plan (BCP) template and an accompanying BCP handbook were developed, offering a more user-friendly and streamlined approach.

5.1.2 Throughout 2024/2025, the EPRR team has been, and will continue to be, actively supporting directorates in completing their BCPs through a series of workshops and tailored support. These workshops have been crucial in encouraging directorates and teams to adopt a localised and focused approach to testing their resilience in the event of a business continuity incident. The EPRR team remains committed to providing ongoing BCP support and workshops to strengthen overall preparedness.

5.2 Governance of Business Continuity Plans

5.2.1 To ensure comprehensive oversight and support for Business Continuity Plans (BCPs), the Trust has decided to store all BCPs on the Power BI platform, as the initially chosen InPhase system was found to be unsuitable. This centralized approach will simplify access, management, and updates across all services. Once the Trust's version of Power BI is set up, it will provide a user-friendly interface with accurate update timelines, ensuring all BCPs remain current and reflect the latest risk assessments and operational needs.

5.2.2 By utilizing Power BI, the Trust will be able to 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.

5.2.3 This move to Power BI will not only streamline the process of managing these critical documents but also ensure they are readily accessible 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.

5.3 Business Continuity Workshops

5.3.1 The EPRR team has been running an ongoing series of Business Continuity Workshops aimed at supporting teams in effectively managing their Business Continuity Plans (BCPs). These workshops are designed to provide comprehensive guidance and strengthen the preparedness of our teams across all areas of business continuity.

5.3.2 The workshops have covered a wide range of critical topics, including:

- Incident Classifications: Participants have been educated on the different types of incidents that could disrupt operations, from minor disruptions to major emergencies. Understanding these classifications is essential for tailoring responses and allocating resources appropriately.

- Command Structures: The workshops offer detailed insights into establishing and operating command structures during emergencies. This includes defining roles and responsibilities, ensuring clear lines of communication, and maintaining effective leadership throughout the incident response.

- Legalities: Participants have been briefed on the legal frameworks and obligations related to business continuity and emergency response. This segment includes statutory requirements, regulatory compliance, and the legal implications of decision-making during crises.

5.3.3 In addition to these core topics, the workshops continue to address other key elements of business continuity planning, such as risk assessment, resource management, and

recovery strategies. Through interactive sessions, case studies, and scenario-based exercises, teams are encouraged to apply their knowledge practically, fostering a proactive and resilient approach to managing potential disruptions.

5.3.4 The level of interest and participation from various directorates has been encouraging, feedback from participants has highlighted the value of these workshops in enhancing understanding of business continuity principles and improving the ability to develop and implement robust BCPs. Moving forward, the Trust is committed to maintaining this as an ongoing work stream, with regular workshops ensuring that all teams remain prepared and capable of responding effectively to any business continuity challenges that may arise.

5.3.5 Teams participating have included Communications, Estates, CAMH teams, Newham CHS,Tower Hamlets CHS and Primary care.

6.0 Training

6.1 On-Call Director and On-Call Manager Training

The EPRR team has developed an On-Call Director training package that will be added to the Trust Learning Academy portal. All On-Call Directors will be required to complete this online training to support them in their role. Originally scheduled to go live in October 2024, the launch was delayed and is now planned for September 2025.

7.0 Testing and Exercising

7.1 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 2024	July 2024	Aug 2024	Sept 2024	Feb 2025
Response Time	10	32	34	7	32

To ensure a timely response to these exercises, 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.

7.2 Exercise Blackout

7.2.1 The exercise took place at Trust HQ on 15th May 2025 and allowed a significant number of participants across the Trust to come together to test how effectively the Trust responds to a major incident. Participants included representation from the Strategic (Gold) and

Tactical (Silver) on call rotas, information governance, communications, People and Culture and the Trust ICT department.

7.2.2 The aim of the exercise was to evaluate how the Trust responds in the event of an ICT major incident, requiring the implementation of a strategic, tactical, and operational command structure, together with the activation of the trust IT Disaster Recovery and Trust Business Continuity Plans. The exercise would also test business continuity impacts and escalation processes in a major incident affecting IT, Information Governance (IG), Estates and People & Culture.

7.2.3 The opening scenario involved The Trust being victim of a ransomware encryption, ransom demand and clinical data exfiltrated.

7.2.4 Further injects were included –namely failure of the air-conditioning system in the main server room and loss of water supply to many Trust sites.

7.2.5 This table-top exercise provided a realistic and very worthwhile exercise with each participant playing a pivotal role in the exercise. This exercise was well received and found extremely valuable by participants when questioned at the conclusion of the hot debrief.

7.2.6 The objectives of the exercise (ensuring the ICT Disaster Recovery and departmental Business Continuity Plans were fit for purpose and to devise appropriate routes of escalation) were both achieved. In addition, further opportunities have been identified to increase and augment effective information communication, command and control in the Trust's emergency response and preparedness.

7.2.7 Taking into account the exercise feedback received, the following lessons and actions were identified and have been incorporated into the annual work plan.

- Develop e-learning package for both directors and managers on-call
- Develop generic e-learning introduction to emergency planning for all staff.
- Complete audit of all emergency response boxes in local incident control centres
- Develop summary of the Trust Incident Response Plan for all on-call staff and keep in multiple storage locations
- Schedule six-monthly cyber security exercise to involve all levels of staff and outside agencies affected by ICT outage as mandated by the DSP (Data Security and Protection Toolkit)
- Local business continuity plans to be reviewed and updated using the new template and handbook.

7.2.8 This exercise also provided 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.

7.3 Exercise Keystone

7.3.1 Exercise Keystone was a tabletop exercise held for the Estates team. Its purpose was to test business continuity impacts and escalation processes during a critical incident. The objectives were to assess incident impacts and understand escalation pathways and contingency measures.

The scenario centred on civil unrest and riots at the John Bunyan Centre, with damage to systems and compromised security doors. Additionally, an inject was included about pest infestations at several ELFT sites, making those sites unusable for patients and staff.

7.3.2 Exercise Keystone successfully challenged the Estates team to consider the impacts of critical incidents and tested their escalation and contingency plans. The scenarios highlighted the need for robust systems and effective communication pathways to ensure continuity of services in challenging circumstances.

7.4 Exercise Beacon

7.4.1 Exercise Beacon was a communications exercise for our communications team to enhance our emergency preparedness and response capabilities. The exercise was structured as a table top activity, allowing participants to engage in dynamic discussions and decision-making processes. The focus was on strengthening our ability to respond effectively during a crisis by testing and refining our existing plans and procedures.

7.4.2 The exercise was well-received by the participants, who actively contributed their insights and suggestions. It provided an excellent opportunity for cross-team collaboration and highlighted the importance of clear, timely communication in emergency situations. We identified several areas where communication protocols could be improved, and these will be incorporated into our ongoing planning efforts.

8.0 Declaration of Critical Incident

8.1 On July 19, 2024, CrowdStrike released a faulty software update for their Falcon Sensor, causing widespread IT outages. This update affected numerous industries, including banking, airlines, and healthcare, by crashing Microsoft Windows systems globally. The issue was quickly identified as a defect in the update and not a cyber-attack. CrowdStrike deployed a fix later that day to resolve the problem. The impact was significant in North East London and multiple trusts and the ICB declared incidents in accordance with the NHS EPRR Framework.

8.2 Multiple GP practices, pharmacies, and NHS Trusts experienced significant IT outages, particularly those using the EMIS clinical system. Access to electronic patient records, prescribing tools, appointments, and test results was lost or severely limited.
A number of NHS Trusts (including ELFT) declared critical incidents - reverting to paper-based systems to maintain essential services.

8.3 CrowdStrike issued a mitigation patch within hours - NHS England and NHS Digital coordinated a national response, providing technical guidance and support to local IT teams. Our Restoration efforts continued through the weekend, with the majority of our systems recovered by midweek.

8.4 While there were no incidents of direct patient harm, the outage resulted in missed or postponed appointments, inability to access or update clinical notes and delays in processing repeat prescriptions.

8.5 The Trust initiated an internal review by way of a de-brief to assess the clinical impact and to develop further resilience measures for future cyber or IT-related incidents.

8.6 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. Furthermore, 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.

9.0 Impact of NHS Industrial Action on Services in 2024/25

9.1 From April-June 2024 there were multiple rounds of strike action by junior doctors, including a five-day walkout from June 27 to July 2, amid stalled negotiations. In September 2024, junior doctors voted to accept the 22.3% pay rise over two years and industrial action was formally concluded.

9.2 ELFT did experience disruption, especially in outpatient and elective services, though no impact on patient or staff safety. Ongoing vigilance remains necessary due to unresolved ballots and potential future action.

9.3 The industrial action of 2024 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.

10.0 Impact of August 2024 Civil Unrest on ELFT

10.1 Following the unrest across England from 30 July to early August, Bedfordshire Police deployed additional officers to key public sites to prevent disorder and reassure communities. Across the Trust’s acute hospitals (particularly Luton & Dunstable), threats of targeted protests prompted security reviews and precautionary measures—though no direct actions were reported.

10.2 While major cancellations were not recorded within our Trust, other regions nearby saw early closures to safeguard patients and staff—a cautionary trend mirrored locally. Emergency departments remained fully operational, though elective and outpatient services experienced intermittent rescheduling to support staff safety and resource prioritisation.

10.3 Security protocols were reinforced, including risk assessments, increased patrols, and real-time coordination with police to promptly address any threats. Mental health support and flexible work arrangements were encouraged to alleviate stress—reflecting NHS England’s wider drive to support minority staff after the unrest. Workforce wellbeing became a critical focus, with additional occupational health capacity and staff mental health services expanded to respond to the surge in anxiety and strain.

10.4 Despite no major incidents within our specific hospitals, the broader context of unrest triggered a significant internal response:

11.0 Multi-agency Working

11.1 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

11.2 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

11.3 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.

12.0 ELFT EPRR progress against work plan 2023/24

KEY ACTION	STATUS AT 31/03/2025
Review all plans relating to emergencies and business continuity to ensure they reflect current guidance and legislation.	Completed – 21st November 2024
Update emergency contact list to ensure it is up to date.	Completed – 14th February 2025
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 December 2024

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 – 1st February 2025
Conduct six monthly communication exercise – trust wide and directorate level	Carried forward
Carry out an exercise to involve all levels of staff affected by ICT outage, as mandated by The DSP (Data Security and Protection) Toolkit	Completed – 15th May 2025
Quarterly reports to Quality Committee	Completed – ongoing- quarterly

12.1 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.

12.2 The Emergency Planning Team successfully completed 80% of the actions outlined in the work plan for this reporting period as well as planning for both industrial action and the critical incident.

12.3 We have been able to deliver and support against the trust strategy work in relation to population health.

13.0 Work plan for 2025/26

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 2025	Emergency Planning Manager
Continue to review and develop local business continuity plans in conjunction with new template	Local plans in place.	30th November 2025	Service Directors / Senior Managers
Store local business continuity plans on Power BI	Power BI Project completed	31st October 2025	Emergency Planning Manager and Officer
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 December 2025	Emergency Planning Manager with senior managers
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	31st March 2026	Emergency Planning manager and IT
Director and manager on-call e-learning package uploaded to Learning Academy	Learning package uploaded.	30th November 2025	Emergency Planning Manager/Officer
Develop generic e-learning introduction to emergency planning for all staff.	Learning Package uploaded	14th January 2026	Emergency Planning Manager/Officer
Develop summary of the Trust Incident Response Plan for all on-call staff	Summary of IRP in place	1st September 2025	Emergency Planning Manager/Officer

13.1 All progress against the work plan will be reported to the Quality Committee in the form of quarterly reports.

13.2 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.

13.3 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.

13.4 The Emergency Planning Team will also engage with both NEL and BLMK ICBs, our relevant Borough Resilience Forums and both Metropolitan and Bedfordshire Police.

14.0 Action Being Requested

14.1 The Committee is asked to RECEIVE and APPROVE the report and the associated work plan for 2025/26 set out in section 11.

East London NHS Foundation Trust

ANNUAL REPORT TO THE QUALITY ASSURANCE COMMITTEE

7 July 2025

Title	Health, Safety and Security Annual Report 2024-25
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

Key messages

The attached report identifies the work undertaken during the period 01.04.2024 to 31.03.2025. 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 People Participation
- Service Users' and Carers' Health and Safety Working Group has now been established on a monthly basis with 15-20 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.
- The Trust has now launched Operation Cavell - an initiative aimed at increasing prosecutions of those who assault NHS workers whilst protecting frontline healthcare workers. The operation involves collaboration between the NHS, police, and Crown Prosecution Service.
- The Trust has adopted the People Safe Lone working Smartphone App with a full implementation and training programme taking place including extensive publicity on the intranet. A series of webinars has also taken place to further improve compliance and to raise awareness. Of the 1650 available apps which have been distributed to staff, 873 of those have been activated and are being utilised. In an effort to further increase user engagement and ensure the app is being utilised to its full potential, we have initiated an email campaign in collaboration with our supplier
- 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.

East London NHS Foundation Trust

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.

East London NHS
NHS Foundation Trust

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 Health & Safety 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 Health & Safety 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 Health & Safety Policy
- Section 2(4) to (7) Functions of safety representatives and the Health & Safety 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 (Health & Safety) 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.

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 Health & Safety 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 Health & Safety policy and in line with Health & Safety guidance it is recommended that each service area has a risk officer, and each directorate has a risk facilitator who oversees each directorate's Health & Safety issues. Each risk officer is invited to the local Health & Safety 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 Health & Safety Committee if required.

The Health & Safety policy was reviewed in March 2024, in line with HSE guidance, and ratified by the Quality Committee. This periodic review also included the inclusion of the workplace risk assessment template.

7.0 Incident Reporting and Follow Up

The Trust monitors all Health & Safety 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 Health & Safety 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.

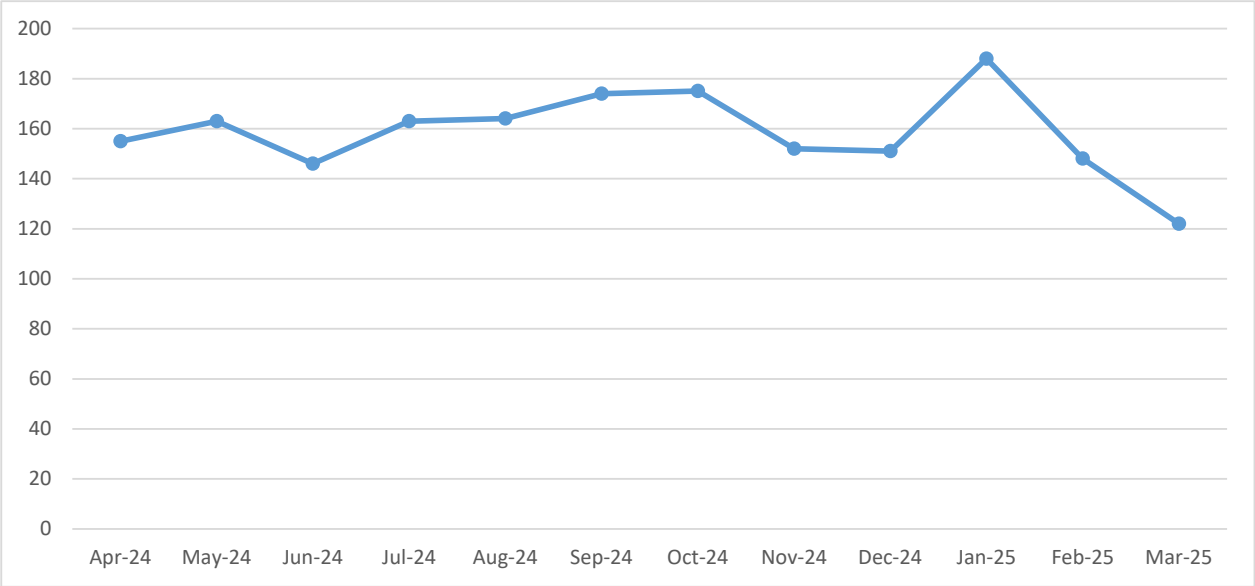
Highlighted below is a summary of the reporting period for:

- 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

East London NHS Foundation Trust

Health, Safety and Security incidents

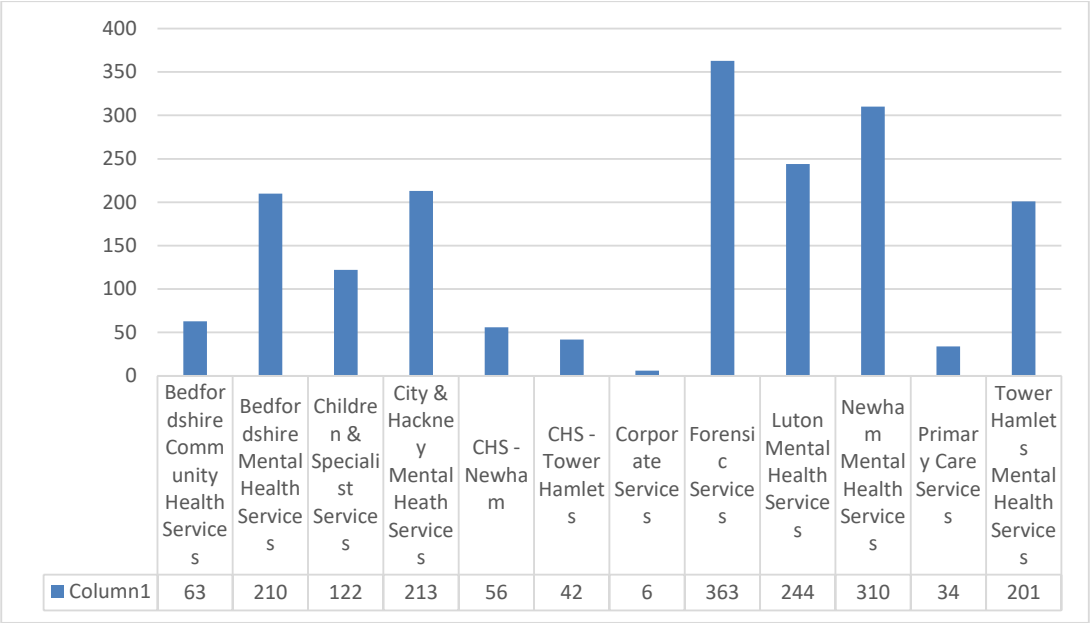
All reported Health, Safety and Security incidents – Trust-wide April 24 - March 25



A total of 1867 Health, Safety & Security incidents were reported for 2024/25. This has risen very slightly in comparison with the 1823 reported incidents in 2023/24.

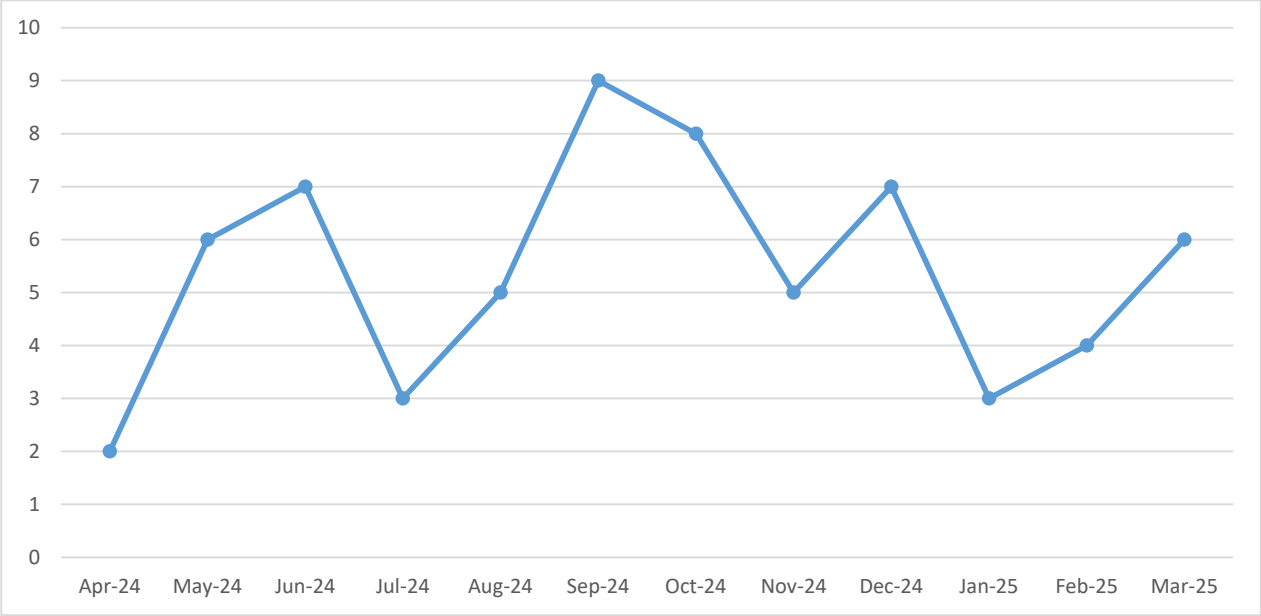
East London NHS Foundation Trust

All reported Health, Safety and Security incidents by Directorate April 24- March 25

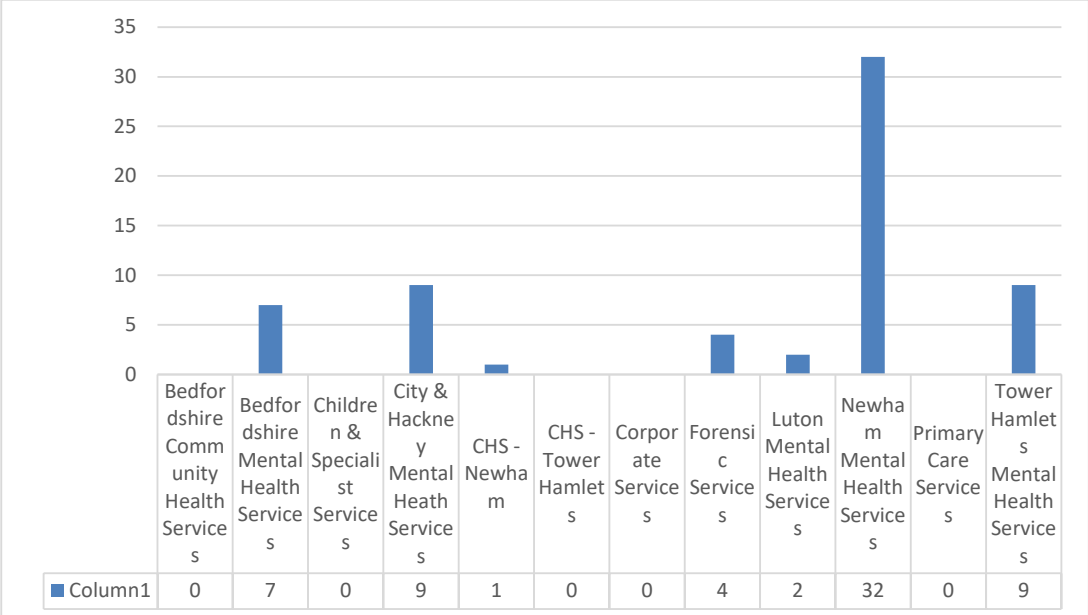


The significantly larger number of incidents within forensic services reflect security breaches such as reports of finding prohibited items as well as other breaches such as doors being left unlocked and associated housekeeping. The comparatively large number of these incidents within forensic services 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 April 24 –March 25



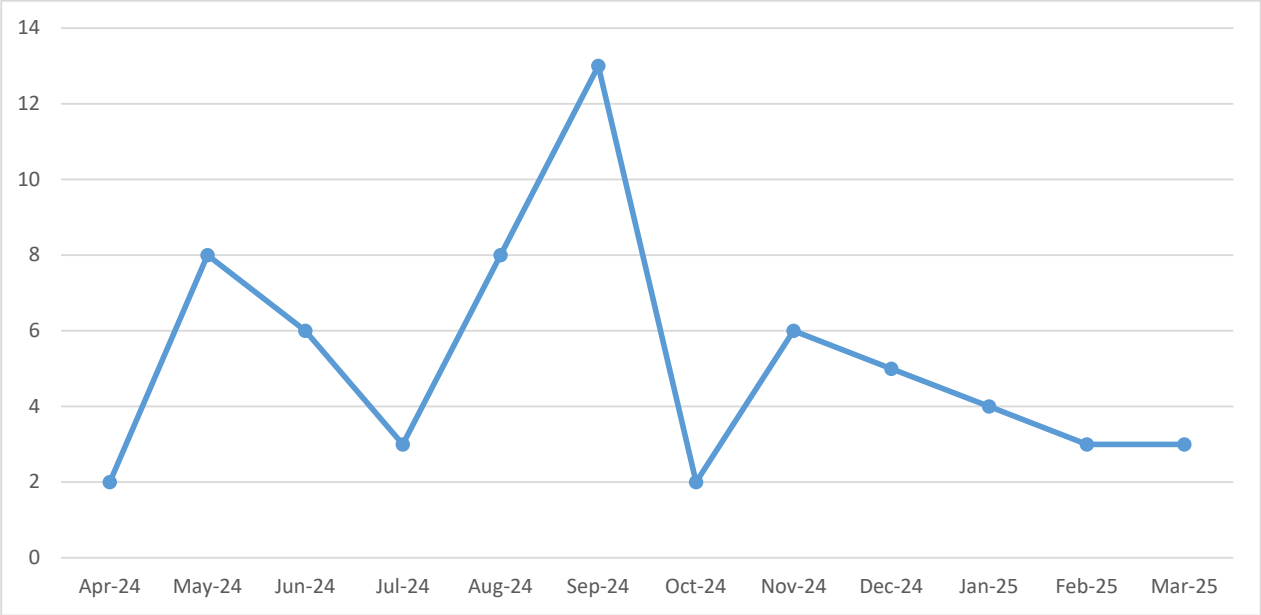
Smoking in an unauthorised area by Directorate April 24 - March 25



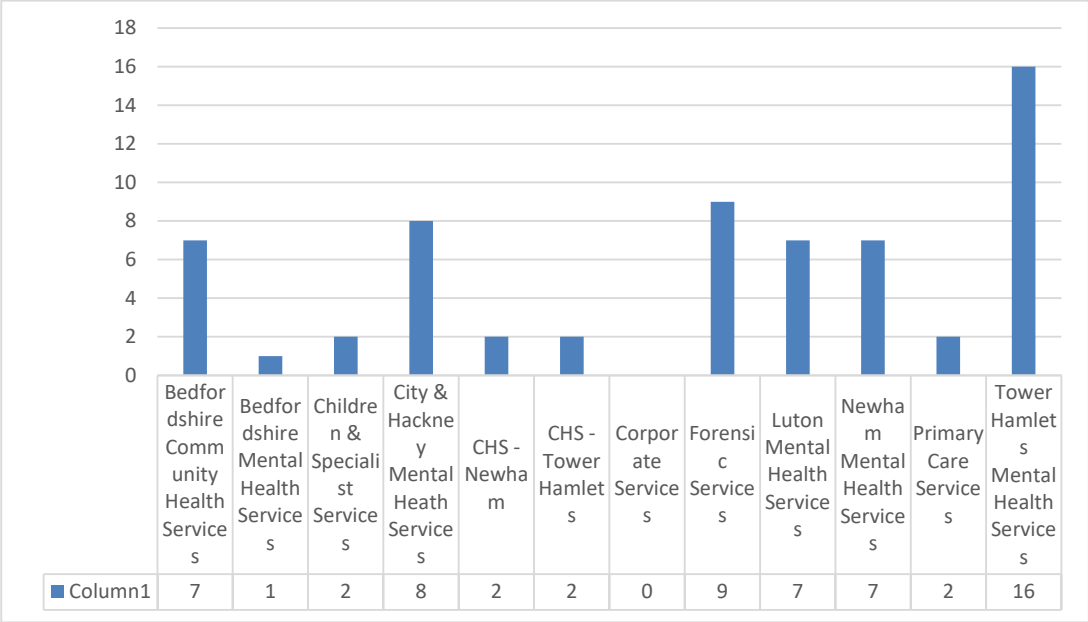
Most incidents of smoking in an unauthorised area have occurred in Newham, reflecting the acuity on the wards there.

East London NHS Foundation Trust

All fire incidents (including false alarms) reported Trust-wide April 24 – March 25

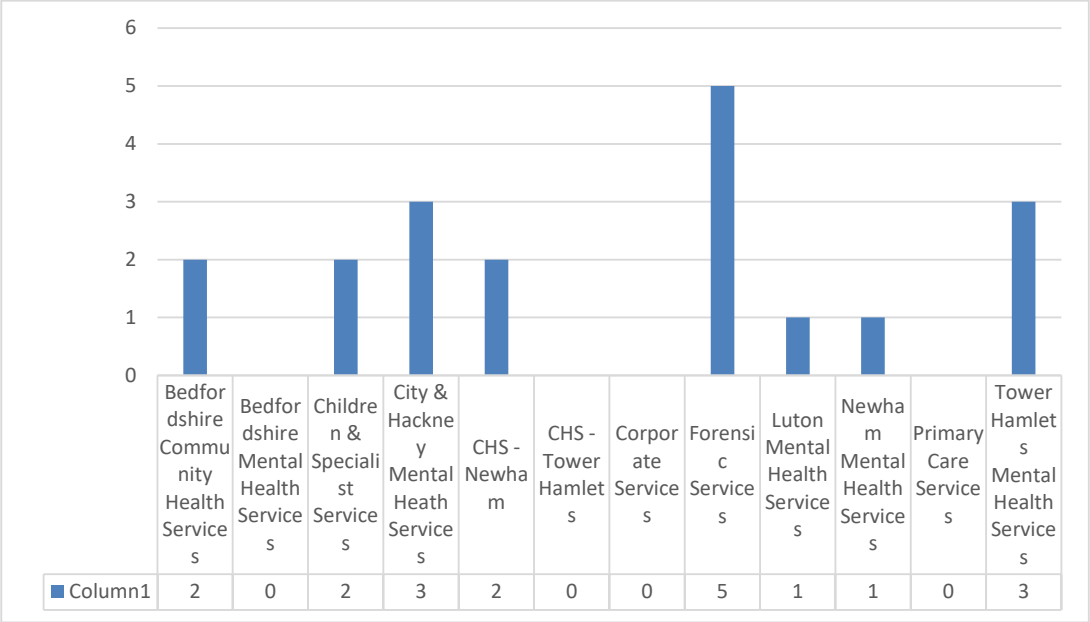


All reported fire incidents (including false alarms) by Directorate April 24 - March 25



Most fire incidents relate to 'false alarms' such as a smoke detector being activated by covert vaping or smoking in bed areas.

All reported as actual fires by Directorate April 24- March 25

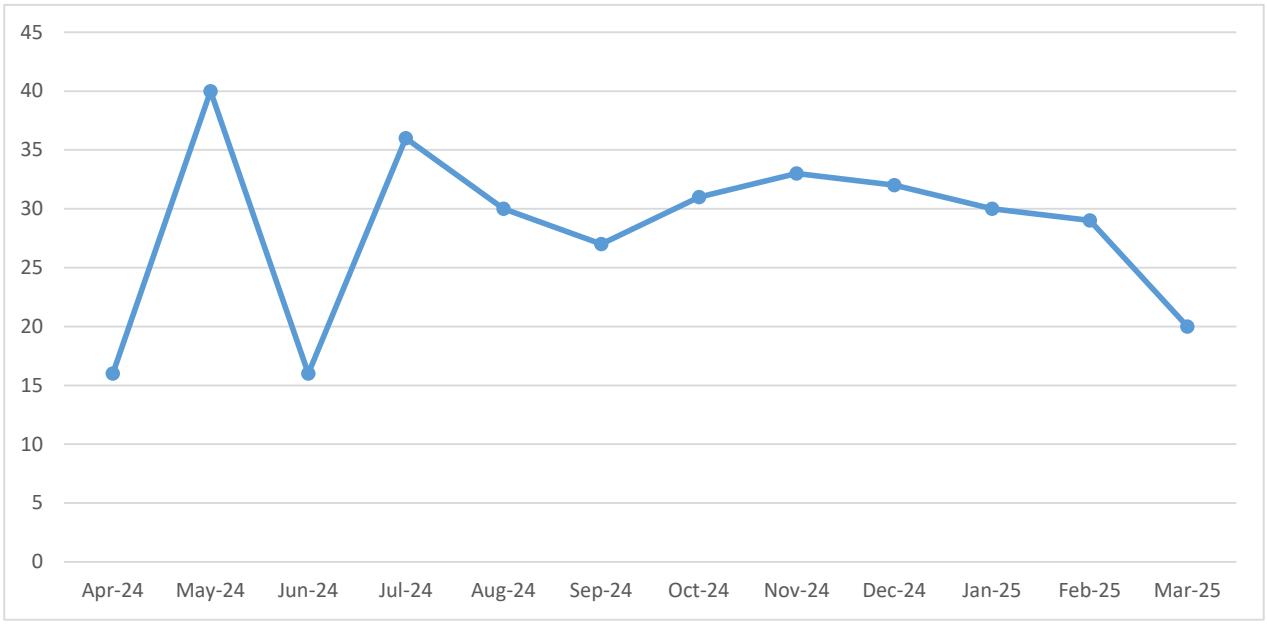


All fire incidents reported are reviewed by the Trust Fire Safety Advisors and, where deemed appropriate, a fire investigation is carried out with a report detailing the details of the occurrence, the cause and any issues relating to building or staff performance. From this, recommendations may arise.

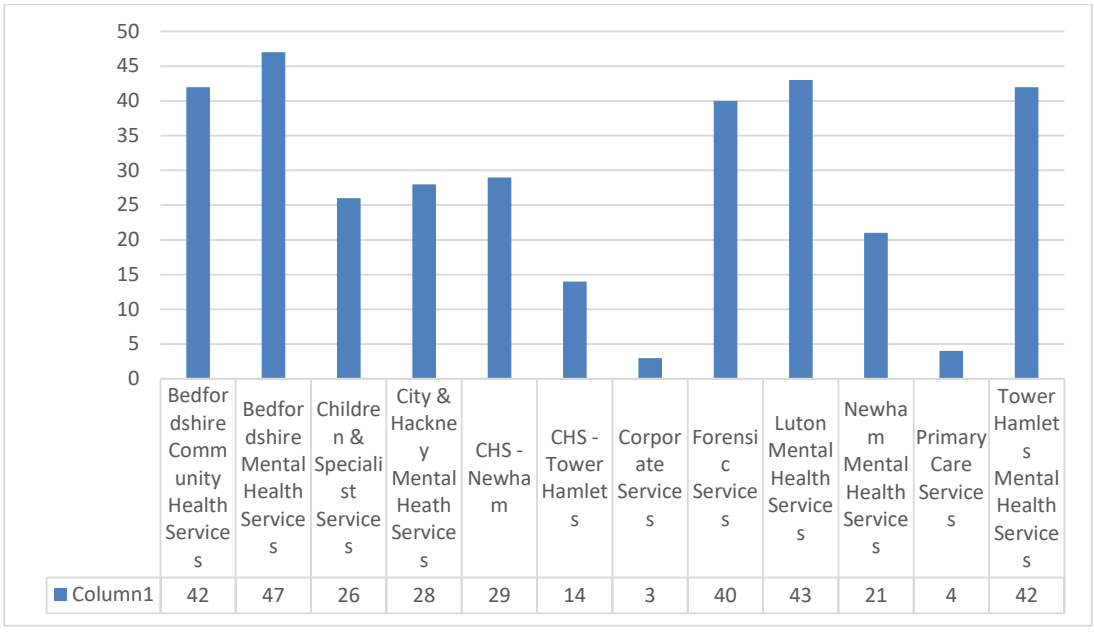
Whilst the number of actual fires in Forensics is more than elsewhere in the organisation there is no prominent attributable cause. The number of actual fires in each Directorate varies in subsequent years and can sometimes be accounted for by repeated incidences involving a small number of individual patients.

There were no incidents within the category of a ‘serious nature’ (i.e. resulting in patient or staff injury or damage caused).

All reported non-clinical slips, trips and falls Trust-wide April 24 – March 25



All reported non-clinical slips, trips and falls by directorate April 24 - March 25



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 Health & Safety leads locally and corporately to investigate, where practicable and helpful, to look at ways to prevent reoccurrence of such incidents.

RIDDOR

Directorate	2023/24	2024/25
Bedfordshire Community Health Services	**0**	**1**
Bedfordshire Mental Health Services	**0**	**3**
Children & Specialist Services	**2**	**2**
City & Hackney Mental Health Services	**5**	**10**
Community Health Services - Newham	**0**	**1**
Community Health Services – Tower Hamlets	**1**	**1**
Corporate Services	**0**	**0**
Forensic Services	**9**	**10**
Luton Mental Health Services	**0**	**3**
Newham Mental Health Services	**4**	**9**
Primary Care Services	**0**	**1**
Tower Hamlets Mental Health Services	**3**	**17**
Total	**24**	**58**

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.

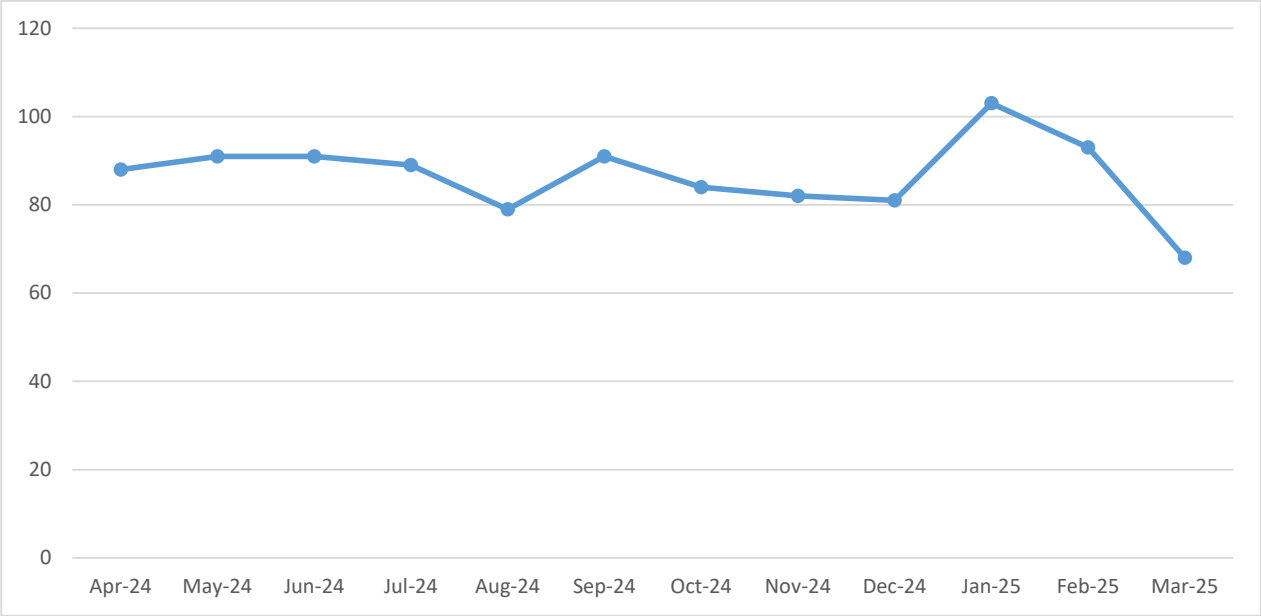
Each RIDDOR report that is submitted to the HSE is categorised by type. Physical assaults on staff are the most widely reported H & S related incident and this is reflected by the number of RIDDOR reports for assaults submitted to HSE.

Between 2024/25, there were 58 RIDDOR incidents overall as opposed to 24 in 2023/24. This can be attributed to the general acuity on the wards and the fact that the Health & Safety team have developed a new process and a dashboard with which to more accurately capture potential incidents which are RIDDOR reportable. Assaults accounted for (46) of all RIDDOR reports in 2024/25 - this is not unusual due to the nature of the services and acuity of the wards.

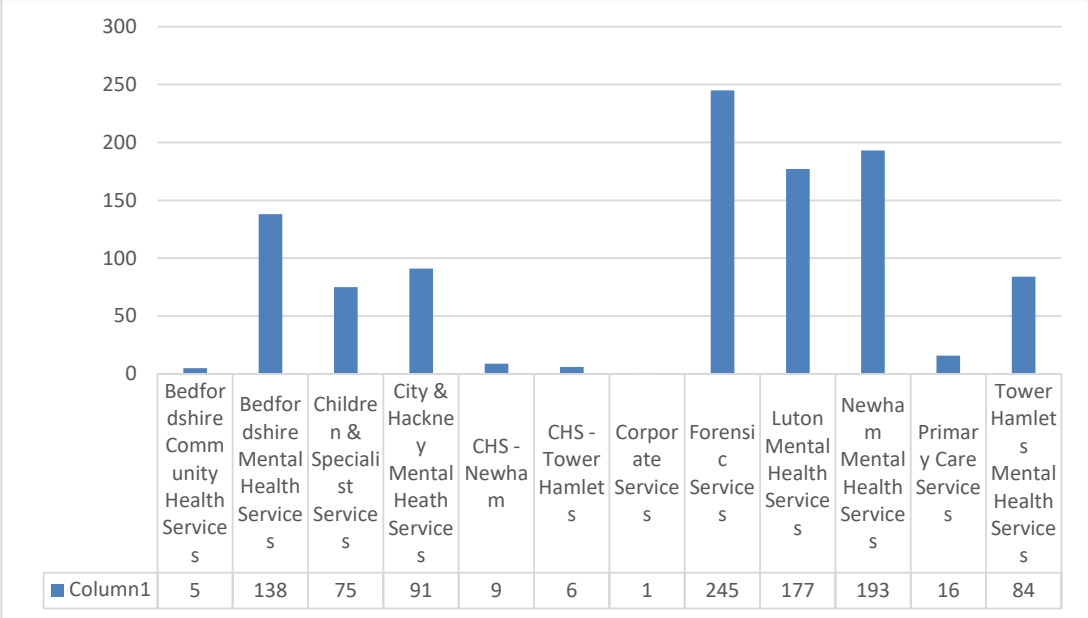
East London NHS Foundation Trust

Security Incidents

All reported security incidents Trust-wide April 24 – March 25



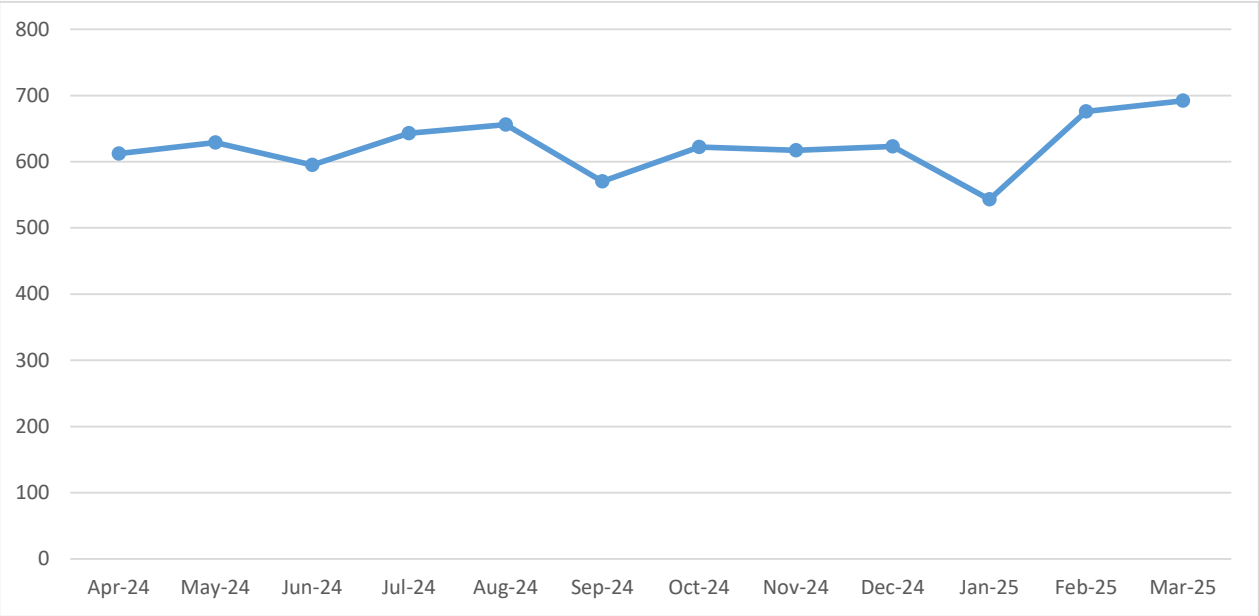
All reported security incidents by directorate April 24 - March 25



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.

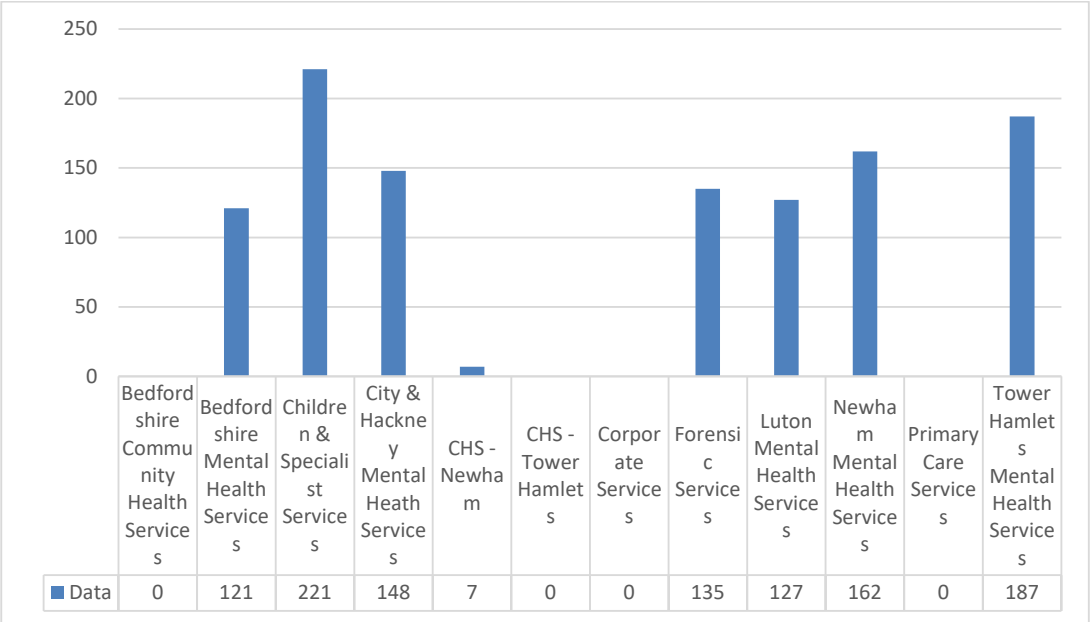
Violence and Aggression

All reported violence and aggression (staff and patients) – Trust-wide April 24 –March 25



East London NHS Foundation Trust

All reported violence and aggression incidents by directorate April 24 - March 25



East London NHS Foundation Trust

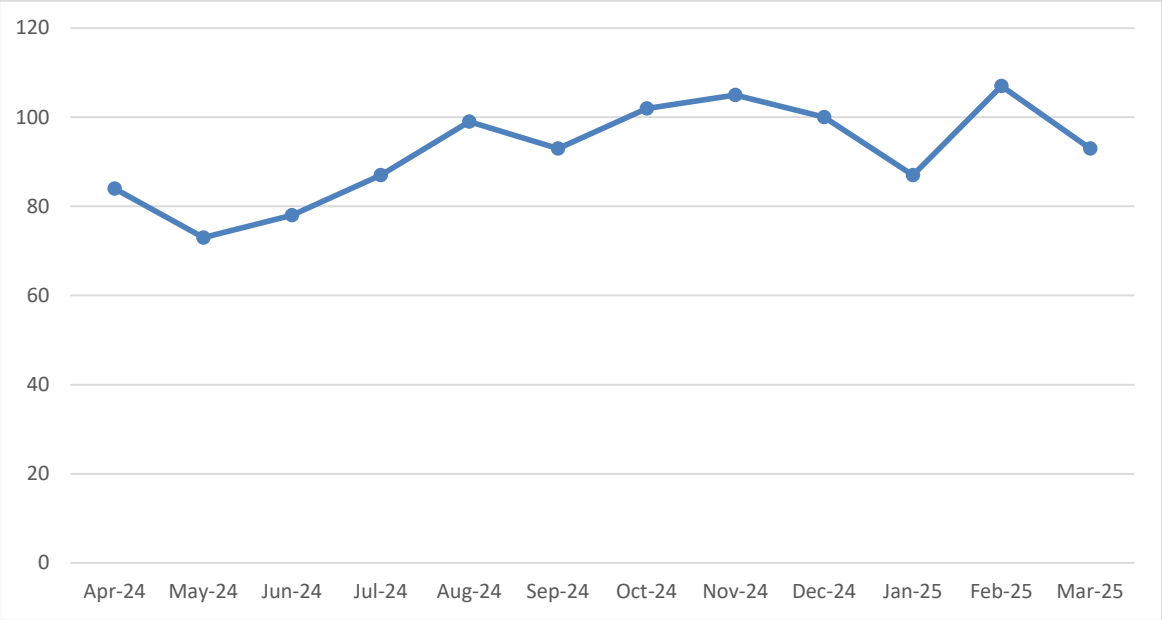
All Violence and Aggression Incidents comparison

Directorate	Incidents Reported 2023/24	Incidents Reported 2024/25
Bedfordshire Community Health Services	**37**	**57**
Bedford (MH)	**546**	**745**
City & Hackney	**1019**	**986**
Community Health Newham	**100**	**90**
Corporate	**1**	**3**
Forensic Services	**1357**	**1371**
Luton (MH)	**606**	**695**
Newham (Mental Health)	**1064**	**1433**
Tower Hamlets (Mental Health)	**1045**	**1136**
Tower Hamlets Community Health Services	**26**	**53**
Specialist Services and CHN Children	**941**	**849**
Primary Care Services	**22**	**60**
Total	**6764**	**7478**

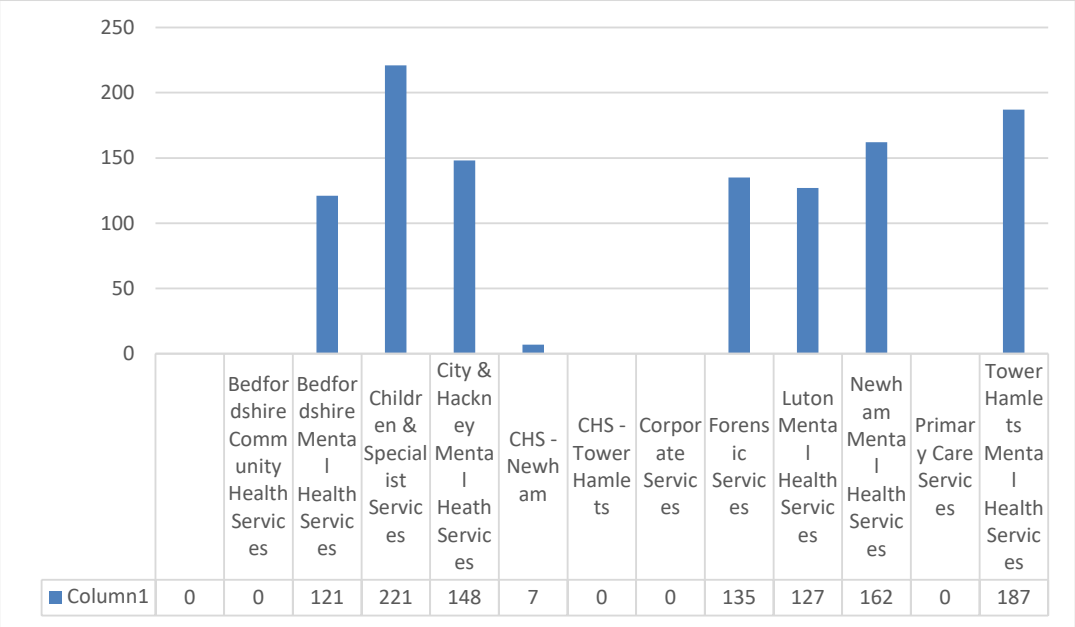
Directorates actively report criminal damage and non-physical incidents, such as threatening and verbally abusive behaviours as well as racial aggression. Furthermore, staff are actively encouraged to report all incidents where they, a colleague or a service user has felt threatened or intimidated.

For the period 2024/25 we have seen an increase in the number of violent and aggressive incidents from 2023/24 in both Bedford and Newham Mental Health Services. This is mainly attributed to those wards being extremely busy by way of the number of admissions, the significant number of patients with challenging behaviours and general acuity on the units.

All reported actual physical violent incidents towards staff – Trust-wide April 24 – March 25



All actual physical violence towards staff incidents by directorate April 24- March 25



8.0 Police Liaison

8.1 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 and improved liaison with police

8.2 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 one officer for incidents occurring in Forensics, City & Hackney and Tower Hamlets. They do not investigate any of the crimes but will generally facilitate a response.

N.E. BCU currently has one MH liaison officer who is part of their safeguarding team.

8.3 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.

8.4 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.

8.5 Operation Cavell

For a number of years there has been 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

Operation Cavell was launched at ELFT on 17th March 2025 with the delivery of 2 webinars for London staff – two further webinars have since taken place for our L&B colleagues. The following measures have taken place to embed this initiative within our services:

- Presented to each DMT with significant appetite for its implementation
- People Participation have provided input via our Health and Safety Service User and Carers' Group – now a standing agenda item at the group.
- People Participation and ELFTAbility have provided support in developing a patient information leaflet
- Standing agenda item at trustwide Health, Safety & Security Committee
- Monthly drop-in session takes place for staff to ask questions or raise any issues
- Toolkit has been developed, which contains crucial resources such as statement templates - a vital part of the ongoing efforts to ensure that all parties are well-informed and supported throughout the process.
- Communications strategy developed for the following months including poster campaign and regular bulletin updates
- Monthly Cavell meeting arranged with police
- A quick reference guide has been developed for front line staff to enable them to respond to police who decline to investigate an assault by a patient.
- 14 incidents referred to Cavell since its launch of which 5 are those had previously been inappropriately closed by police.

9.0 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.

We currently have 1650 available apps for our loneworking staff. In order to continually increase compliance, the Health & Safety team have carried out the following actions:

- Regular attendance at local health and safety meetings across all directorates to raise awareness and present compliance reports.
- Single points of contact have been identified within each directorate. Online training is ongoing, enabling these leads to access team portals and compile reports—supporting local ownership and improving uptake and usage.
- The Trust's intranet page has been updated to highlight key features of the Peoplesafe app and share real-life staff stories on lone working risks and the benefits of the app. All training materials are easily accessible from this page.
- The app has been updated to enable staff to adjust phone sensitivity, helping to prevent accidental activations.
- Monthly Peoplesafe forums and webinars continue to provide a platform for staff to raise concerns, share learning, and promote best practice.

The Trust has also successfully migrated to Peoplesafe's new NEXUS portal, which introduces a range of enhanced features:

- Team-based Escalation Plans, allowing for quicker, bulk updates.
- A visual overview homepage for at-a-glance staff safety monitoring.
- The ability to run and schedule reports to flag non-active users, ensuring managers are kept informed.
- Enhanced administrator functionality to review activity, voice memos, battery status, and closed alarm reports.
- Immediate access to training, advice, and live chat via the Help Centre.

Of the 1650 available apps which have been distributed to staff, 873 of those have been activated and are being utilised.

In an effort to further increase user engagement and ensure the app is being utilised to its full potential, we have initiated an email campaign in collaboration with our supplier, Peoplesafe. The aim of this campaign is to raise awareness about the app's features and benefits, provide usage tips, and encourage more consistent and widespread adoption across the user base.

Furthermore, we are at the early stages of utilising quality improvement by way of establishing a project team to find ways of improving the uptake.

East London NHS Foundation Trust

10.0 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

Eight training sessions have been carried out to date with more sessions booked throughout 2025. In addition, a monthly training schedule has been developed and shared with services to deliver both risk officer training and Peoplesafe Portal training. These are taking place from May-November 2025.

11.0 Heath, Safety and Security Audits.

This year's Health and Safety Audit has been launched via InPhase, enabling staff across the Trust to complete the audit electronically. The audit was circulated Trust-wide to ensure full participation and to promote consistent standards across all services. Completion of the audit will support improved compliance, provide assurance of robust governance, and help identify areas for improvement in line with statutory obligations and best practice. The use of InPhase also allows for more efficient data collection and reporting, enabling the Health & Safety Team to monitor progress in real time and provide targeted support where needed.

The Health & Safety Team is currently reviewing all submitted responses and is actively supporting directorates where completion rates have been low, to ensure full engagement and consistent standards across the organisation.

12.0 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 Health & Safety 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.

13.0 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 Health & Safety 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

14.0 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 Health & Safety Committee. Its current work plan includes:

- Guest speakers are invited to each meeting and have included our 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
- Developed patient/carers' leaflet for both Operation Cavell and CCTV

The group and its achievements were featured in an article for 'What's New in ELFT' on 26th March 2025

East London NHS
NHS Foundation Trust

15.0 Training

15.1 Health & Safety/Security awareness

The Trust provides several e-learning courses for this area via its Learning Academy including Health & Safety Awareness and Display Screen Equipment Use. The courses are determined by the roles the individual staff member carries out and are pre-agreed by their line manager and the Training and Development Team.

15.2 Risk Officer Training (NEBOSH endorsed)

The Health & Safety team have worked collaboratively with NEBOSH (The National Examination Board in Occupational Safety and Health) to attain their endorsement of the trust's Risk Officer training course. As a result, ELFT is now the first NHS Trust to have its health & safety learning programme endorsed by NEBOSH.

The benefits to ELFT of this endorsement are:

- Recognition from NEBOSH of in-house, tailored learning programs
- More cost effective than delivering an accredited qualification
- Customised certification.
- Focus on the Learning Impact to emphasise the Organisational and Learner objectives with a measurable outcome

15.3 Fire training

There are two alternative pathways for fire training dependent on staff responsibilities, namely ward-based and non-ward-based staff

The structure of training is as follows:

Fire Training	Structure	Content
Fire Safety Mandatory for non-ward-based staff)	• Annual requirement • E-learning programme	• Fire awareness • Fire extinguisher (theory)
Fire Warden Designated staff for non-ward areas / departments / out-patient premises	• Two yearly qualifications • At central venue or online • 1 hour • With Fire Safety Advisor	• Fire awareness presentation • Disability equipment familiarisation • Fire extinguisher familiarisation
Fire Competency Assessment (FCA) All ward-based nursing staff	• On induction to the ward then at 6-monthly intervals • With line manager in supervision / appraisal meeting at site of employment	Q & A on all aspects of fire safety: • Fire alarm system and local operational procedures • Duties and responsibilities in relation to fire incidents on the site of employment • Fire extinguisher (theory)

Fire Course (ward staff) All ward-based nursing and OT staff	• Annual qualification • On site or online • 1 hour • With Fire Safety Advisor	• Fire awareness presentation • Local fire procedures • Disability equipment familiarisation • Fire extinguisher familiarisation

Those with direct responsibilities for patient welfare and safety, undergo a higher standard of training in response to the high-risk environment of mental health in-patient facilities. All courses for ward-based staff are site specific and are currently organised locally according to need.

16.0 Progress against 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 2025
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	Completed –in progress
Ensure completion of all annual H&S environmental inspection forms	In progress
Delivery of Peoplesafe smartphone app training and webinars	Completed – March 2025

16.1 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 for part of the year.
- Providing increased support to services who have a seen a rise in violence and aggression.
- Establishment and development of Service Users' and Carers' Health & Safety Group
- Risk officer training programme endorsed by NEBOSH - the first NHS Trust to have their health & safety learning programme endorsed by NEBOSH.
- Launch of Operation Cavell

16.2 A notable risk is that the trust may not be compliant with Health and Safety Regulations if workplace risk assessments are not completed for trust sites. The Health & Safety 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.

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.

A final layer of governance is that sites are now asked to include a copy of their WPRA as part of their annual Health & Safety audit on Inphase.

17.0 Workplan for the coming financial year

17.1 Workplan 2025-26

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 2025	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 2025	H&S Manager
Risk officer training delivered trustwide	Training delivered and attendance recorded	30th November 2025	H&S Manager
Ensure review of all workplace risk assessments	Completion of review of all workplace risk assessments and included in H&S Audits	30th September 2025	H&S Manager
Continued implementation and governance for Peoplesafe Smartphone App alarm	Trust wide implementation completed.	30th November 2025	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 2025	H&S Manager

Streamline the current DSE Assessment process and procurement of identified equipment	New process in place	1st November 2025	H&S Manager
Lead QI Project to improve uptake of Peoplesafe Loneworker App.	Marked improvement in both compliance and activation of app.	1st November 2025	H&S Manager

17.2 The Health & Safety 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)

17.3 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.

17.4 The Health & Safety Team will also engage with both the Metropolitan Police Service and Bedfordshire Police especially during Operation Cavell

18.0 Action Being Requested

18.1 The Committee is asked to RECEIVE and APPROVE the report and the associated work plan for 2025/26 set out in section

FREEDOM TO SPEAK UP ANNUAL REPORT TO THE QUALITY ASSURANCE COMMITTEE

7th July 2025

Title	Freedom to Speak Up Annual Report
Author	Anita Hynes, Freedom to Speak Up Guardian
Accountable Executive Director	Claire McKenna, Chief Nurse

Purpose of the report

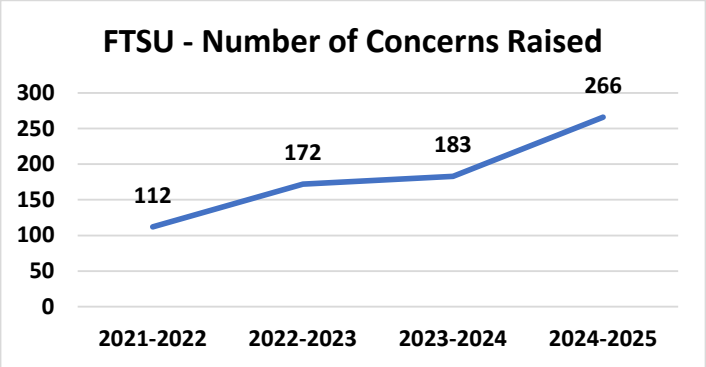
To provide the Board with an annual overview of progress made in delivering the Freedom to Speak Up (FTSU) service at East London NHS Foundation Trust (ELFT) during the period April 2024 to March 2025. This report outlines:

- The number and nature of concerns raised via the FTSU service.
- Key themes, insights, and learning emerging from staff feedback.
- Developments in the FTSU service, including access, visibility, and training.
- Identified risks and actions taken to address cultural or systemic issues.
- The proposed priorities and workplan for the 2025–2026 financial year.

Committees/meetings where this item has been considered.

Date	Committee/Meeting
25/06/2025	Quality Committee

Key messages



Between April 2024 and March 2025, 266 concerns were raised through the Freedom to Speak Up (FTSU) service, an increase that reflects growing awareness and trust in this service. This rise suggests that more staff feel confident in using FTSU and believe their concerns will be taken seriously.

The increase in engagement can be linked to sustained efforts to improve the visibility and accessibility of the service. The FTSU Guardian's contact details are now regularly shared in internal communications, including Trust wide and local staff newsletters and bulletins, and the FTSU intranet page is updated regularly to provide speaking up information, clear guidance and signposting.

A key milestone during the year was the launch of the ELFT Speaking Up Strategy. This strategy sets out a practical framework for building a culture where all staff feel safe and supported to raise concerns. It focuses on three core principles: enabling staff to speak up, ensuring leaders are equipped to listen effectively, and improving how the organisation follows up on concerns and shares learning.

While these developments are encouraging, challenges remain. Feedback from staff continues to highlight concerns around the risk of detriment after speaking up, and there are ongoing frustrations about delays in feedback or resolution. These issues point to the need for further work to strengthen follow-up processes and ensure concerns are addressed transparently, which are incorporated into the FTSU Improvement Plan 2025. The overarching aim is to embed a culture where speaking up is a routine and supported part of everyday working life. FTSU should be seen as a vital safety net, but not the only route available. Staff should feel equally safe to raise concerns through local, day-to-day conversations with their line managers or team leaders. This cultural shift will require consistent leadership, openness, and sustained organisational commitment.

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

1 Background/Introduction

The Freedom to Speak Up Guardian role was created to make sure everyone working in the NHS has a safe, trusted way to raise concerns, especially when it feels difficult to speak up through normal routes.

This recommendation came from a major review in 2015, led by Sir Robert Francis, which found that too many NHS staff were afraid to speak up or felt ignored when they did. That silence was not just frustrating, it could also put patient care and staff wellbeing at risk.

To change this, the NHS introduced Freedom to Speak Up Guardians: independent people in each Trust that staff can go to when something is not right. Their job is to listen, support, and help make sure concerns are taken seriously and acted upon.

East London NHS Foundation Trust appointed its first FTSU Guardian in October 2017 and adopted the NHS-wide 'standard integrated policy' on speaking up. This policy, most recently updated in line with the national FTSU Policy in November 2022, provides a consistent framework for raising concerns. It is designed to promote inclusivity, ensure concerns are captured and addressed appropriately, and support early resolution wherever possible, typically by managers, with support from FTSU where needed.

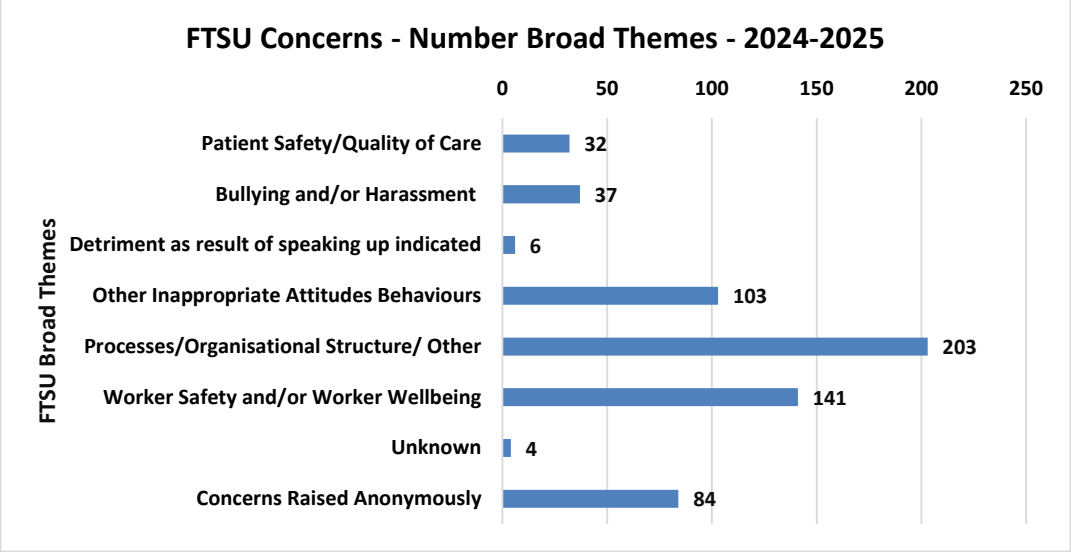
The NGO is an independent, non-statutory body jointly funded by the Care Quality Commission (CQC) and NHS England. While not a regulator, the NGO plays a critical role in leading cultural change across the NHS in England. It does so by training and supporting the network of over 900 Freedom to Speak Up Guardians, promoting best practice, and holding the healthcare system to account for how it responds to staff who speak up.

Within ELFT, there is clear senior-level accountability and oversight of FTSU. The Chief Executive holds overall responsibility for ensuring that speaking up arrangements meet the needs of staff across the organisation. The Chief Nurse serves as the Executive Lead for FTSU, providing strategic leadership and oversight of supportive systems. The Trust also benefits from an independent Non-Executive Director (NED) who serves as a sounding board and critical friend, offering independent advice to the Guardian and Executive Lead when needed.

The FTSU Guardian has direct access to both the Chief Executive and the Executive Lead, ensuring independence and visibility at the highest level of the Trust. This structure is essential in supporting a culture where speaking up is encouraged, heard, and acted upon.

2 Progress against workplan during last financial year

2.1 FTSU Data
FTSU Broad Themes



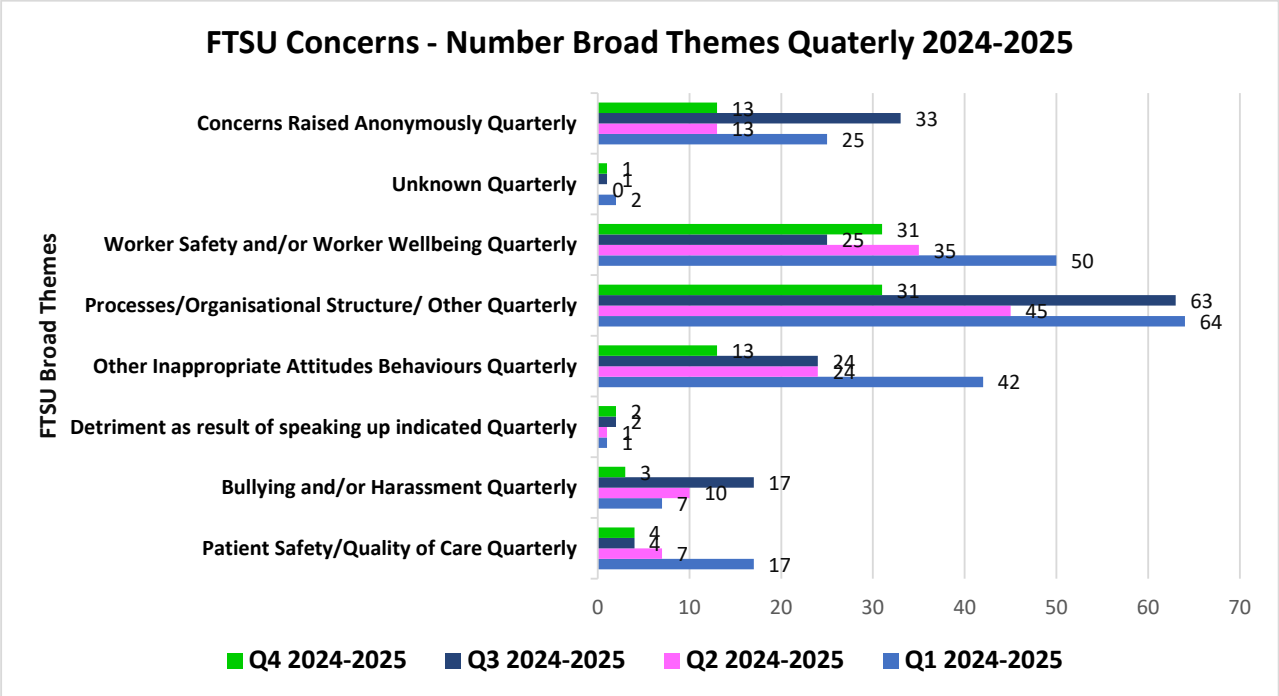
**The number of themes will not correspond with the total number of FTSU concerns raised in the reporting period, as a concern raised by one member of staff can relate to multiple themes.*

During this reporting period, 266 concerns were raised through the FTSU service. The majority of these were not about immediate risks to patient safety, but about wider issues in workplace culture, systems, and behaviours. This reflects a pattern of staff raising concerns about how they are treated, how processes are managed, and how safe they feel within their teams and services.

The most consistently reported broad themes were:

1. **Processes and Organisational Structures:** Staff raised concerns about unclear or delayed formal processes, including how secondments, grievances, and recruitment were handled. There were also concerns about inconsistent application of policies, delays in reasonable adjustments, and unclear consultation procedures. These concerns reflected a desire for more fairness, transparency, and accountability in how decisions are made.
2. **Worker Wellbeing and Safety:** Many concerns focused on staff feeling unsupported when speaking up. Some described poor inductions, challenging team cultures, unhealthy workplace environments, unsupportive team dynamics, or mental health pressures resulting from unresolved conflict. Others spoke about the emotional strain caused by leadership behaviours that lacked empathy or inclusion.
3. **Inappropriate Attitudes and Behaviours:** Concerns about incivility, microaggressions, bullying, and the Trust values not being upheld were common. Staff raised specific incidents involving race, exclusion, and unprofessional conduct, suggesting that some teams still struggle with inclusive and respectful behaviours.
4. **Bullying and Harassment:** Although fewer in number, these cases tended to overlap with other themes. In some instances, bullying was part of a wider pattern of exclusion or unresolved interpersonal conflict.
5. **Patient Safety and Quality of Care:** Fewer concerns directly referenced patient safety. They included missed handovers, delayed care, unclear protocols, and service environments that were not fit for purpose. Some were exacerbated by poor communication or a lack of clarity about who was responsible for follow-up.

Throughout the year, a recurring issue was that many staff had already tried to raise their concerns locally but felt dismissed or ignored. This led them to escalate their concerns via FTSU, highlighting a gap in psychological safety and trust at team level.



Over the three-year period from 2022 to 2025, FTSU concerns increasingly focused on organisational issues and staff wellbeing. In 2024–2025, over 70% of concerns related to Processes, Organisational Structure, or Other. Worker Safety and Wellbeing concerns also grew steadily, reflecting a shift in attention toward staff welfare and their working environment.

In contrast, concerns related to Bullying and Harassment and Patient Safety or Quality of Care declined. Bullying and harassment issues are typically addressed through the Dignity at Work policy, while patient safety and care quality concerns are generally raised within teams and directorates. A similar downward trend in patient safety concerns has also been observed nationally in FTSU data.

There was a noticeable rise in anonymous reporting in 2024–2025, attributed to the introduction of a new anonymous form that allows staff to raise concerns anonymously if wished.

FTSU Concerns - Patient Safety/Quality of Care

32 FTSU concerns were raised relating to Patient Safety or Quality of Care. While smaller in number than other types of concerns, these revealed important issues with how services were delivered, communicated, and led.

Most of these concerns pointed to broader systemic problems, such as staffing levels, breakdowns in communication, and service environments that were not suitable for safe care. In several cases, staff felt that even when they raised these issues, their concerns were not listened to or followed up. Leadership response and team culture played a significant role in how safe staff felt to speak up and how effectively issues were addressed.

Themes Identified:

Staffing and Service Pressures

- Staff raised concerns about low staffing levels (2), unbalanced skill mixes, and workloads that felt unsafe for both staff and patients.
- Service changes where frontline teams were not consulted, leading to confusion and service disruption.

Communication Failures

- Breakdowns in communication were a common issue, particularly when teams had to coordinate care or respond to protocol changes.
- In some cases, patients were put at risk because of unclear handovers or confusion over who was responsible for follow-up.

Clinical Risk and Missed Care

- Missed handovers, delays in treatment, and unclear procedures.
- In one case, the removal of a communication tool (MS Teams chat with ambulance liaison) contributed to delays in care coordination.

Leadership and Culture

- Some concerns were exacerbated by how they were managed. Staff spoke about being ignored or feeling excluded after raising issues.
- Ineffective response to dignity at work concerns in in-patient settings also led to some staff feeling silenced rather than supported.

Complex Patient Settings

- One example involved a patient requiring frequent, intensive support from a multidisciplinary team. This placed significant emotional and professional pressure on staff.
- However, it led to positive outcomes, including better team collaboration, tailored safety planning, and adopting communication practices that are trauma informed.

Where a significant patient safety concern involves an immediate risk, it is escalated immediately to the Chief Nurse and Executive Lead for Freedom to Speak Up.

If the concern does not present an immediate risk, it is escalated to the appropriate Directorate Lead, Lead Nurse, or Clinical Director for further review and action.

Outcomes and Learning:
Many of these patient safety concerns prompted action at both team and organisational level. In some cases, new or revised Standard Operating Procedures (SOPs) were introduced to improve clarity, especially around escalation pathways and discharge planning.

Teams also held reflective learning sessions to discuss what happened and what could be done differently next time. These sessions helped staff process difficult events and contributed to a stronger culture of learning and support.

Concerns around poor communication and lack of consultation during change led to important reflections from senior leaders. These conversations resulted in a renewed commitment to more transparent and inclusive ways of managing change.

With some cases, governance reviews revealed that key decisions had not been communicated clearly to staff. These reviews led to improvements in how accountability and operational decisions are shared across teams.

In one particularly demanding case, the organisation provided structured debriefs and pastoral support to help the team recover and learn. This kind of support reinforced the Trust's commitment to psychological safety, especially after difficult or distressing events.

FTSU Concerns - Staff Experience

A large portion of the concerns raised through the Freedom to Speak Up service this year related to how staff experience their work environment, especially in terms of behaviour, team dynamics, and leadership.

Staff shared experiences of feeling excluded, ignored, or treated unfairly. Staff described environments where communication was poor, a sense that leadership operated in an authoritarian manner, or decisions around issues like annual leave or shift patterns were applied inconsistently. These concerns were often linked to power imbalances, particularly where junior team members felt unable to challenge behaviour or speak up through local routes.

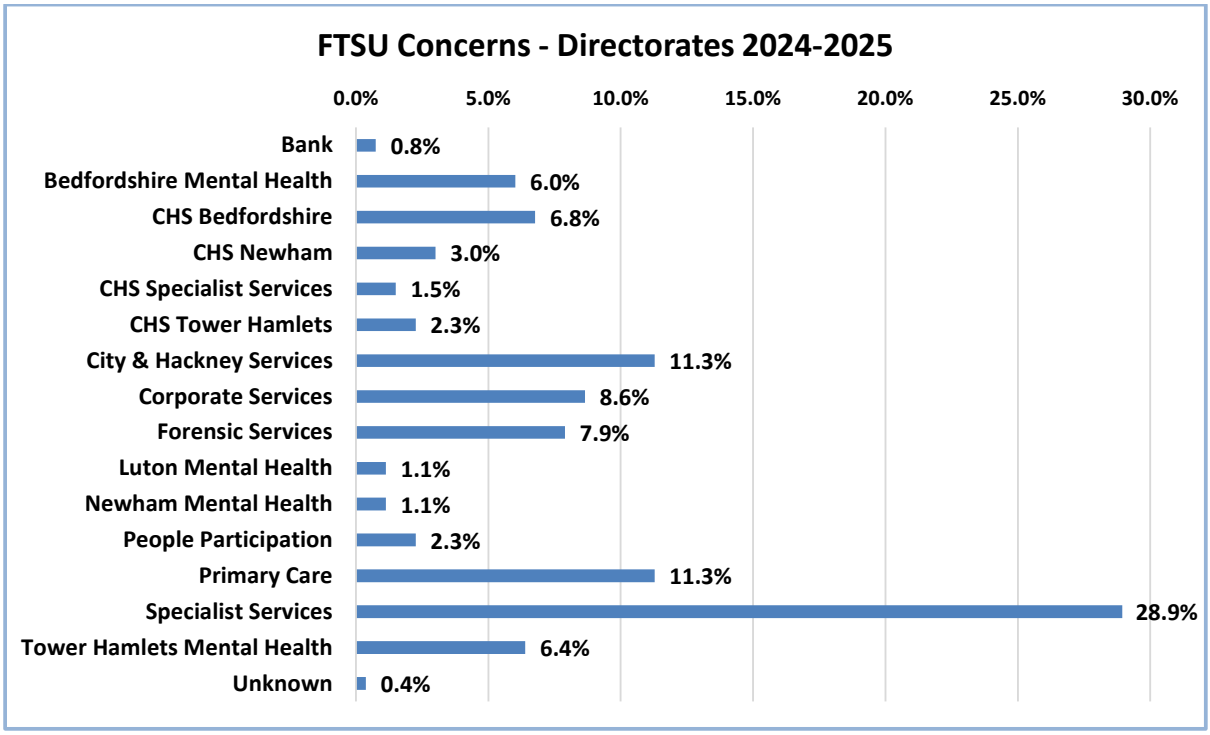
Some concerns described behaviour that did not align with the Trust's values, including bullying or unprofessional interactions. These concerns reflected not just isolated incidents, but deeper concerns about the tone and culture within some teams.

When concerns were raised, the FTSU service helped facilitate conversations, connect staff with the People & Culture team, and in some cases initiate formal processes (5% of FTSU concerns raised) such as Dignity at Work investigations. These interventions led to positive outcomes in several instances, such as managers offering support, senior leaders receiving constructive feedback, and teams being given guidance on improving how they communicate and collaborate.

Looking across the organisation, the highest numbers of FTSU concerns came from Specialist Services, City & Hackney, Primary Care, and Corporate Services. A recurring theme across cases was a noticeable difference in how leadership behaviours were experienced. In some teams, compassionate leadership was lacking or inconsistent, which appeared to contribute to a greater need for staff to escalate concerns via FTSU.

These patterns underline the importance of strengthening local resolution processes, reinforcing leadership responsibility in the handling of concerns, and consistently modelling the Trust's values at all levels. Supporting staff to feel safe, heard, and respected when raising concerns, especially within their immediate teams, remains a key priority.

FTSU Concerns - By Directorate

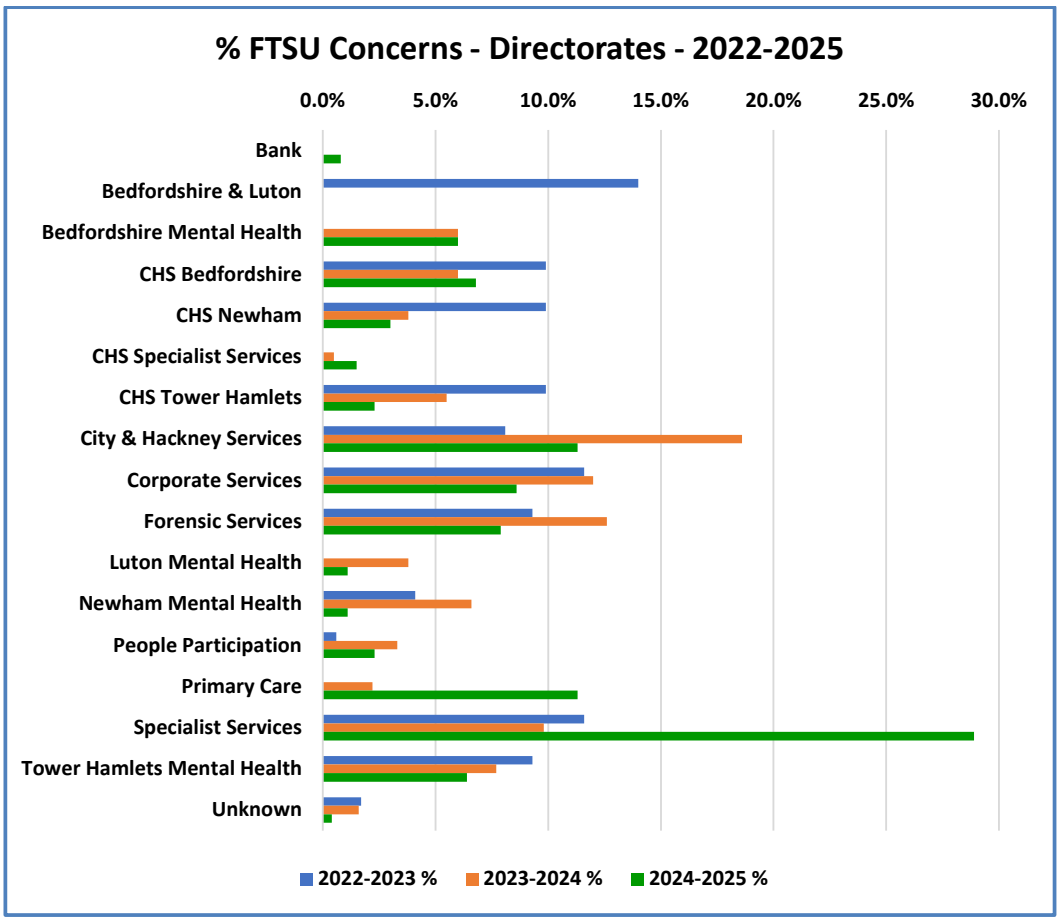


This year's FTSU data revealed variation in the number of concerns raised across directorates. The patterns support understanding where staff might face more challenges or feel less confident using local channels to speak up.

Specialist Services recorded the highest number of concerns. This is an increase over the previous two years (2022-2023, 11.6%; 2023-2024, 9.8%). Many related to team culture, fairness, and unresolved tensions. In one service, 12 concerns were raised on the same issue, which led to targeted support and dedicated follow-up sessions between FTSU and local leadership.

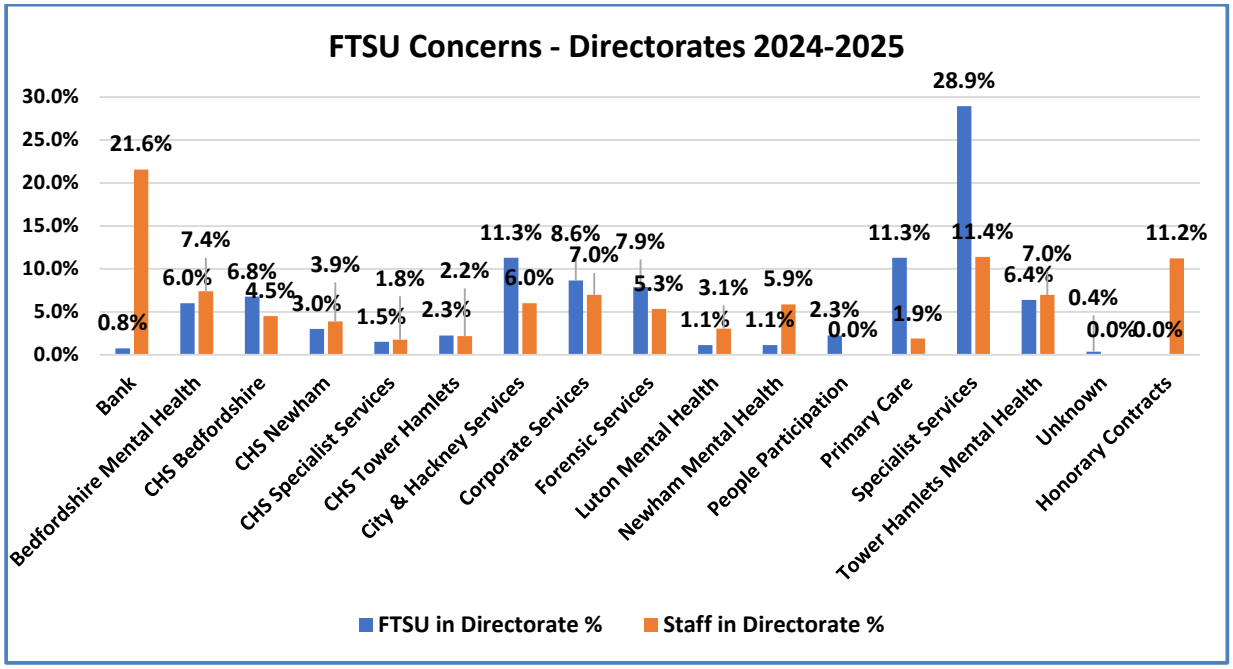
City & Hackney and Primary Care also saw a steady stream of concerns, covering a wide range of issues including team behaviour, formal processes, and wellbeing. The early rise in Primary Care concerns appears linked to active engagement by the FTSU Guardian, showing how visibility can make a real difference in staff confidence to speak up.

Bedfordshire Mental Health and CHS Bedfordshire also saw regular reporting of concerns, mostly focused on how management processes were handled, lack of clear communication, and feelings of exclusion, during for example, induction or service changes.



This graph shows the FTSU concerns raised across directorates from 2022 to 2025.

FTSU by Directorate – Comparing FTSU in Directorates and workforce size.



When we look at the number of concerns raised in each directorate alongside the size of their workforce, some important differences emerge.

Specialist Services accounted for nearly 29% of all FTSU concerns, despite making up just 11% of the Trust's total workforce. This could indicate deeper challenges in these teams, and it may also reflect higher visibility and trust in the FTSU service in these areas.

Primary Care and Tower Hamlets Mental Health also had more concerns raised than would be expected based on their staff numbers. This might suggest those services are under strain, or that outreach efforts, such as targeted engagement by the FTSU Guardian, are supporting with raising awareness and build confidence to speak up.

In contrast, some areas were significantly underrepresented. Bank Staff, who make up over 21% of the Trust's workforce, raised less than 1% of concerns. Similarly, Luton Mental Health, Newham Mental Health, and parts of CHS services showed low levels of FTSU activity. This pattern suggests that barriers may be present around speaking up, such as fear about confidentiality, low visibility of the FTSU offer, or uncertainty about whether speaking up will lead to action.

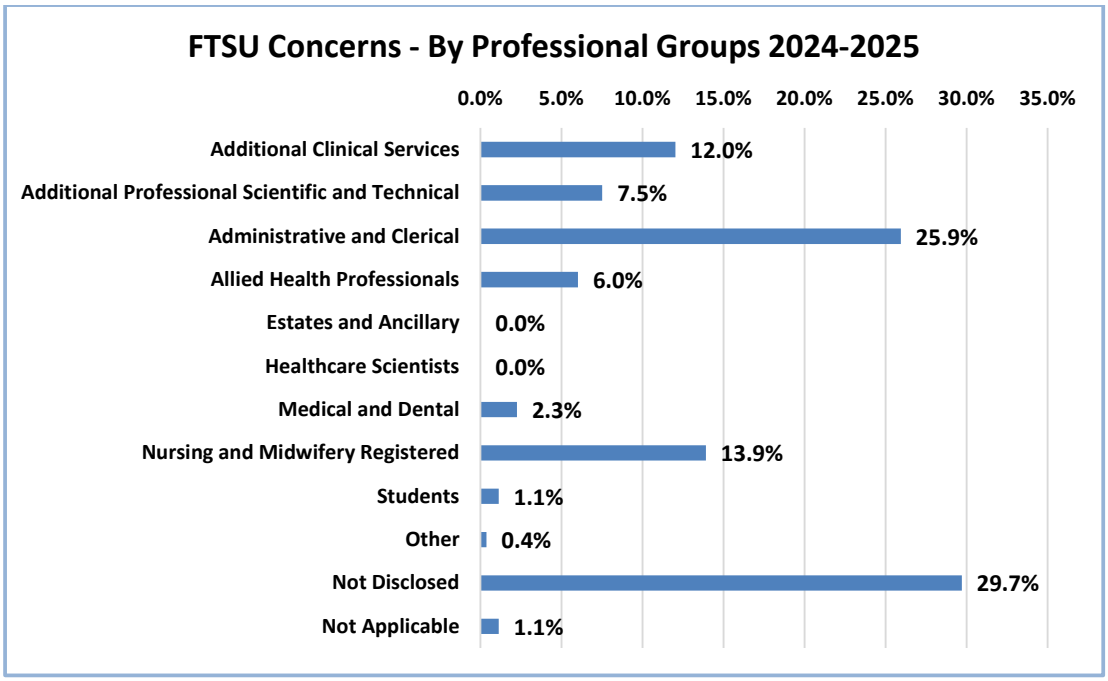
This data shows where additional, targeted engagement is needed to make sure all staff, no matter their role or setting, feel able and safe to raise concerns. This is especially important for groups who may feel less confident speaking up through local channels.

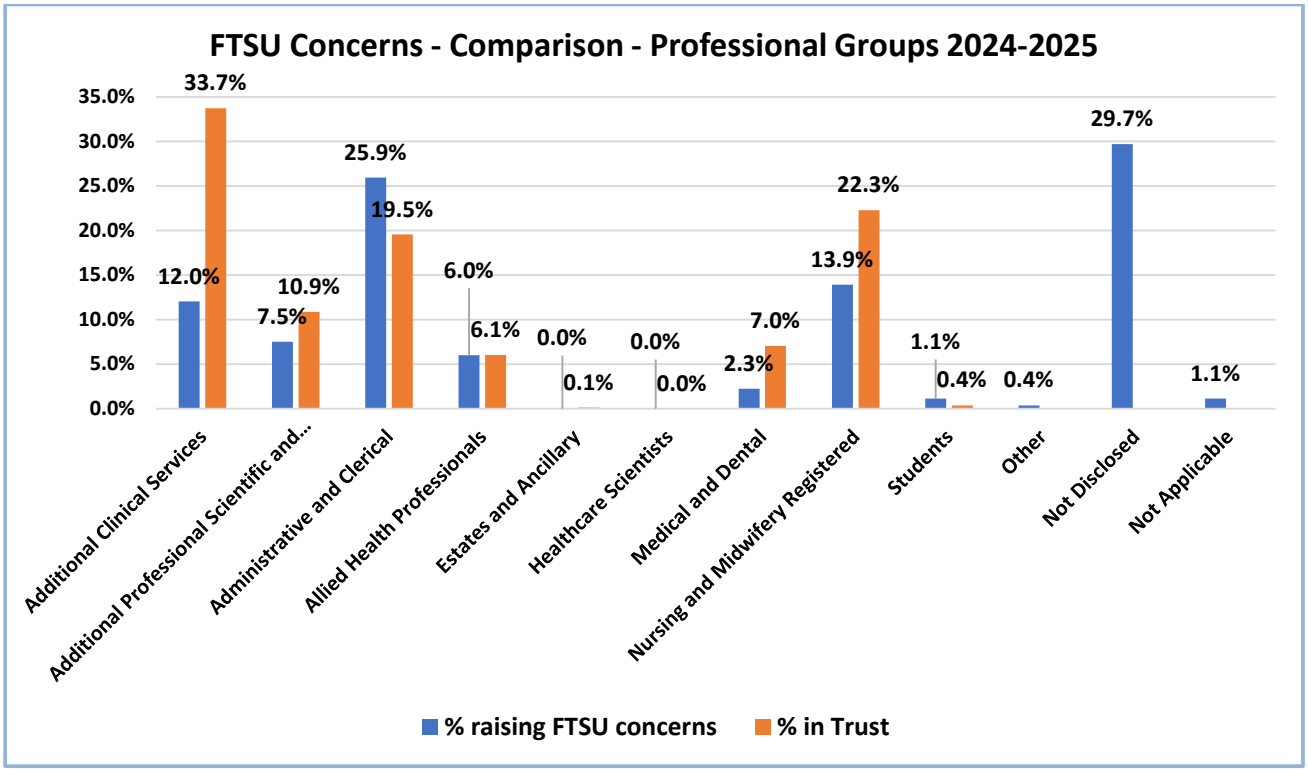
Ongoing efforts, such as the Trust's Speaking Up Strategy, the FTSU Champion network, and close collaboration with People & Culture, will be essential in closing these gaps. These initiatives aim to ensure everyone has access to trusted, visible, and supportive ways to raise issues.

The data reinforces a broader trend: FTSU is frequently used as a secondary route when local processes have not led to resolution or when there is a perceived lack of psychological safety within teams. Notably, in 54% of cases, concerns raised through FTSU had already been escalated locally prior to reaching the FTSU service. This highlights the importance of addressing barriers to resolution at the team or directorate level and ensuring staff feel heard and supported when raising concerns internally.

The Trust is continuing to invest in compassionate leadership, clear accountability, and practical tools for early resolution, such as the Respectful Resolution Pathway. The goal is to reduce the need for escalation and to embed a culture where speaking up is simply how we work; safe, supported, and effective in every part of the organisation.

FTSU Concerns - By Professional Groups





Looking at the FTSU data by professional groups provides useful insights into where the FTSU service is reaching people well, and where there may be barriers to access.

Administrative and Clerical staff raised a notably high number of concerns compared to their size within the workforce. It reflects their frequent exposure to procedural and policy issues, such as leave management, workload pressures, or formal processes. It may also suggest that Administrative and

Clerical staff sometimes feel unheard within their teams or less able to influence decisions at a local level.

Registered Nursing and Midwifery staff were also overrepresented in FTSU reporting. This mirrors national trends, as staff in these roles often work under high pressure and are closely involved in day-to-day patient care. They may also face difficult team dynamics, such as communication issues, unclear boundaries with colleagues, or feeling unable to challenge decisions safely. These kinds of workplace relationship issues can make it more difficult to raise concerns locally, which leads staff to turn to FTSU for support.

In contrast, Additional Clinical Services staff were significantly underrepresented, despite making up a large part of the Trust's workforce. This suggests that some staff in these roles may not feel as able or confident to raise concerns, possibly due to fear of repercussions, lower levels of psychological safety, or limited awareness of how the FTSU service can support them.

Medical and Dental staff were also underrepresented. This may point to hierarchical norms or professional culture acting as barriers to raising concerns via FTSU. Similarly, Scientific and Technical staff submitted fewer concerns than would be expected based on their overall numbers.

This breakdown shows that while some staff groups are using the FTSU service, others may be missing the support available to them. To address this, work will be continued to increase awareness of FTSU across all professional groups, especially those who may feel less confident or less visible within organisational structures.

Key actions include targeted communication, more focused outreach to underrepresented staff, and appointment of FTSU Champions in areas where engagement is currently low. These steps will help ensure that every staff member, regardless of role or background, feels supported to speak up and confident that their concerns will be heard and acted upon.

FTSU Survey Feedback

To better understand the experiences of those who used the Freedom to Speak Up service, a short survey was sent to 165 staff members who raised FTSU concerns during the year (as some concerns were submitted anonymously or lacked email contact information, follow-up was not possible for all individuals). Of those, 35 responded, giving a 21% response rate, which is typical for internal voluntary surveys.

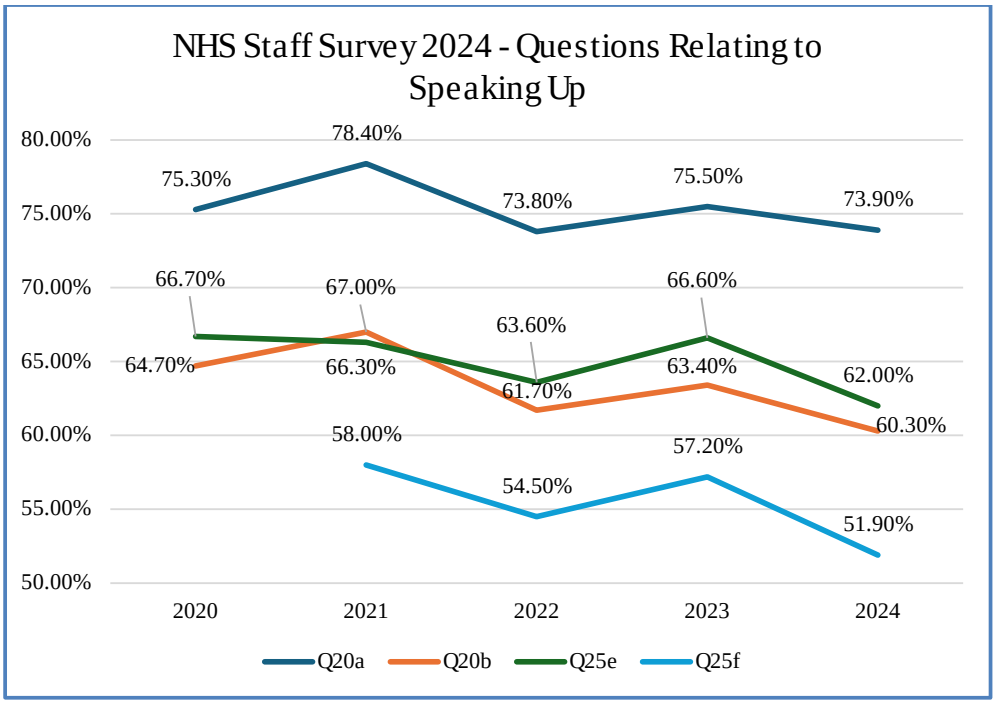
Although the response rate limits how much we can generalise the findings, the feedback was consistent and offers valuable insight. Most respondents reported positive experiences with the FTSU service itself. However, some concerns remain, particularly around what happens after a concern is raised.

Nearly 25% of respondents said they experienced some form of detriment after speaking up, such as feeling sidelined or treated differently. 14% were not sure whether they had been affected. Despite this, 77% said they would still choose to speak up again, showing that many staff value the opportunity to have their voice heard, even when outcomes are uncertain.

When asked about what makes it difficult to speak up, staff mentioned fear of reprisals, doubts about whether anything would be done, and concerns about being labelled a troublemaker. These responses suggest that while the FTSU service is trusted by many, psychological safety and confidence in follow-up action vary across the organisation.

FTSU survey responses came from a demographically diverse group, particularly in terms of ethnicity, which is encouraging. However, lower response rates from men, younger staff, and disabled colleagues show that there is more to do to ensure the service is fully inclusive and accessible to all.

Speaking Up - NHS Staff Survey Results 2024



This year's NHS Staff Survey results show a noticeable drop in how confident ELFT staff feel about speaking up. Across all four questions related to raising concerns, scores declined compared to the previous year, suggesting that psychological safety and trust in the process have weakened.

Here are the key results:

- **Q20a: 73.9%** of staff said they would feel secure raising concerns about unsafe clinical practice (down from 75.5%)
- **Q20b: 60.3%** felt confident their organisation would address those concerns (down from 63.4%)
- **Q25e: 62.0%** said they feel safe to speak up about anything that concerns them (down from 66.6%)
- **Q25f:** Only **51.9%** believed their organisation would act on concerns they raise (down from 57.2%)

These are the lowest scores for all four questions since 2021. The downward trend highlights a need to rebuild confidence in how the organisation handles concerns and supports staff who speak up.

When broken down by demographic group, the survey also showed some significant disparities:

- Staff with a disability consistently scored lower than average, especially when it came to feeling safe to speak up or believing their concerns would be addressed.
- In contrast, staff without a disability generally gave higher-than-average scores.
- Those who chose 'Prefer not to say' for questions about gender, gender identity, or sexual orientation reported the lowest levels of psychological safety overall, 22% lower than the Trust average. This may reflect a lack of trust in how anonymous or safe it feels to share concerns.

Taken together, these results underline the need for renewed action in several areas:

- Rebuilding trust in the speaking up process
- Improving how concerns are followed up and addressed.
- Providing targeted support for staff who feel marginalised or less safe to speak up.

- Reviewing how anonymity and confidentiality are communicated to ensure staff feel protected.

These steps are essential if we are to create a culture where all staff, regardless of role, background, or identity, feel safe, supported, and encouraged to raise concerns. The Trust's Speaking Up Strategy underpins this work, helping to guide actions that improve confidence, fairness, and follow-through at every level.

Governance and Oversight
FTSU provides regular updates to the:

- Quality Committee
- Quality Assurance Committee
- People and Culture Committee
- Service Delivery Board
- People Plan Delivery Board

Themes and escalations are also discussed in regular meetings with the:

- Executive Lead for FTSU
- Chief People Officer (CPO)
- Chief Executive Officer (CEO)
- Non-Executive Director (NED)
- Trust Chair

This governance structure ensures that concerns raised through FTSU are reviewed and addressed at the highest levels, supporting both operational accountability and strategic oversight.

2.2 Key achievements

Over the past year, the Freedom to Speak Up service has seen clear progress, both in the number of staff using the service and in how concerns are being addressed across the Trust. One of the most encouraging signs was a sharp increase in the number of concerns raised early in the year. In April and May 2024 alone, cases rose by over 56% compared to the previous two months. This rise suggests growing trust in the FTSU service and increasing awareness among staff that it is a safe and reliable way to raise concerns.

A major step forward was the successful launch of the Trust-wide Speaking Up Strategy, which is grounded in the NHS People Promise – We each have a voice that counts. The strategy sets out a clear commitment to making speaking up part of everyday culture, where concerns are welcomed, taken seriously, and followed up with care and transparency. It is built around three key pillars: speaking up, listening up, and following up. Together, these principles provide a practical roadmap for long-term cultural change.

The internal audit of the FTSU process also offered reassurance. It confirmed that the system in place is working well overall, providing what was rated as "reasonable assurance." The audit highlighted areas for improvement that are now being acted on to strengthen governance and responsiveness even further.

The way the Trust has handled more complex concerns also reflects positive change. In several cases, issues raised, such as around TUPE, fairness in recruitment, or race-related experiences, not only led to full explorations and investigations when needed, but also to wider learning. These lessons were shared through forums like the Senior Nurse Forum and team debriefs, helping to spread insight across the organisation and encourage open discussion.

Access to the FTSU service has also improved. More staff used the FTSU anonymised reporting form, and the continued promotion of FTSU Champions has helped increase visibility, especially among nursing and administrative teams.

Overall, this year has shown that the Trust is not only engaging more staff in the process of speaking up but is also learning from the issues raised in a deeper and more structured way. The challenge now is to keep building on that momentum, making sure that concerns raised lead to real action, that the learning from is shared widely, and that speaking up becomes a natural and supported part of working life at every level of the organisation.

2.3 Challenges and Next Steps

Even though much progress has been made this year, several ongoing and emerging challenges remain. These will need sustained attention to make sure staff feel truly safe and supported when raising concerns.

One of the most consistent issues raised by staff was the experience, or fear, of being treated differently after speaking up. Survey feedback showed that nearly one in four respondents felt they had faced some form of detriment, with others unsure. Even when not intentional, the perception of negative consequences can make staff hesitate to raise concerns. Tackling this fear is essential and requires strong, compassionate leadership and a culture of psychological safety. FTSU is liaising with FTSU Champions, People and Culture, Organisational Development, Learning & Leadership Development, and Directorate Leads to develop focused initiatives that build trust, ensure fair treatment and safe pathways for raising concerns in all teams, without fear of reprisal. This work also links in with the Speaking Up Strategy.

Delays in resolving cases or giving meaningful updates also caused frustration. Many staff shared that they had already tried raising issues through local channels, only to feel dismissed or left without feedback. Being told that “it’s being looked into” without any follow-up left some feeling uncertain about whether their concerns were taken seriously. These communication gaps can undermine trust, even when action is happening behind the scenes.

Priorities from last year’s improvement plan are still in progress. They are:

- establishing cover arrangements for the FTSU Guardian during prolonged absences
- strengthening how directorates track and manage concerns.
- ensuring staff receive clear and timely feedback after speaking up.

These areas were also identified in the recent internal audit. While FTSU InPhase remains in the testing phase, once operational it will be a valuable tool, providing directorates with real-time reports on open cases, which will enhance oversight, reinforce accountability, and support clearer tracking and leadership engagement. It will also enable faster follow-up and a more efficient escalation process, helping to ensure timely and appropriate action on concerns.

Cultural challenges continue in some parts of the organisation. Despite awareness-raising efforts, a few directorates still struggle to respond constructively to feedback or to model inclusive and respectful leadership. Results from the 2024 NHS Staff Survey showed particularly low levels of confidence among disabled staff and those who preferred not to disclose personal identity details. This points to a broader need for culture change that supports every staff member to feel safe and valued.

While the progress made this year is encouraging, these challenges highlight the importance of ongoing focus. The next step is not just to encourage more people to speak up, it is to ensure that when they do, they are heard, protected, and kept informed about what action was taken. Cultural change depends not only on how concerns are raised, but how they are responded to.

2.4 Actions

In response to the challenges identified over the past year, several actions have been taken, and are continuing, to strengthen the Freedom to Speak Up (FTSU) service and make it more effective, trusted, and responsive.

In March 2025, the internal audit of the FTSU system concluded and gave the Trust a “reasonable assurance” rating. It confirmed that governance and systems are sound but also highlighted areas for improvement. Based on this, a detailed FTSU Improvement Plan was developed and is now being implemented.

The improvement plan includes clear, time-bound goals across seven priority areas:

- Reviewing and updating the FTSU process and guidance to reflect good practice and ensure consistency.
- Appointing and training a contingency FTSU Guardian to ensure cover during prolonged absences
- Strengthening directorate accountability with regular reporting, clearer expectations, and direct escalation routes to Executive Directors when needed
- Improving how outcomes are tracked and communicated, including regular learning updates to the People & Culture Committee
- Increasing visibility and uptake of training, especially the FTSU e-learning modules, and tracking completion rates
- Developing success measures for the Speaking Up Strategy by triangulating data from FTSU, Respectful Resolution, and Employee Relations
- Enhancing case documentation through the FTSU Resolution, Outcomes & Learning Template to support transparency, feedback, and reflection

To support timely follow-up and communication, directorates are now expected to take greater responsibility for updating FTSU and closing cases. Performance expectations are being clarified, and escalation pathways are being reinforced to prevent avoidable delays.

The new FTSU InPhase case management system will enable more timely tracking of cases, easier identification of learning themes, and clearer reporting of trends that need senior attention.

To support transparency and cultural change, the Trust is also putting more focus on showing what happens after concerns are raised. This includes publishing quarterly updates, sharing outcomes in team briefings, and using “You Said, We Did” communications to demonstrate that speaking up leads to real action.

3 Workplan for the coming financial year

3.1 Key priorities

The workplan for the year ahead is guided by the ELFT Speaking Up Strategy and follows the national Freedom to Speak Up framework, which is built around three pillars: Speak Up, Listen Up, and Follow Up. A core function of FTSU is to support the organisation in creating a culture where concerns are raised confidently, heard with empathy, and followed by meaningful action.

Speak Up

Supporting staff to feel safe, supported, and ready to raise concerns.

- Support leaders and teams to understand psychological safety; what it looks like, how it feels, and how to build it, through conversations, training, and regular FTSU engagement.
- Promote civility and respectful behaviour using resources to support discussions and learning around this topic, such as:

  - Civility Saves Lives - a campaign that highlights how respectful, civil behaviour in healthcare settings directly improves staff wellbeing, teamwork, and patient outcomes. Their core message is *how we treat each other matters* and even small acts of incivility can have serious impacts on safety and performance.
  - Civility and Respect Guide - in response to rising reports of bullying in the NHS Staff Survey, the North-West Staff Experience & Retention Team formed a regional working group to tackle inappropriate workplace behaviours. They identified a key gap: practical tools to help staff address such behaviour in the moment. As a result, they developed a series of realistic video scenarios to support confident, constructive conversations and promote a more respectful culture.

- Make the FTSU service more visible and accessible, especially to underrepresented groups, by continuing targeted communication through newsletters, intranet pages, bulletins and team FTSU sessions.

Listen Up

Ensuring that staff who speak up are heard with care and without judgment.

- Strengthen compassionate leadership by embedding FTSU principles into training, helping managers listen well, respond constructively, and supportively handle concerns.
- Empower line managers and team leads to resolve concerns early, reducing the need for escalation and building trust at the team level.
- Actively engage with staff groups and directorates where fewer concerns are being raised, such as bank staff and Additional Clinical Services, to ensure equitable access to speaking up routes.

Follow Up

Taking action, sharing learning, and showing the impact of concerns raised.

- Deliver the 2025–2026 FTSU Improvement Plan, which includes improvements to how cases are handled, how outcomes are tracked, and how directorates are held accountable.
- Strengthen outcome feedback using tools like the FTSU Resolution, Outcomes & Learning Template and “You Said, We Did” updates, so that staff see their concerns are followed up and lead to real change.
- Measure cultural impact by bringing together insights from FTSU, Respectful Resolution, Employee Relations, and staff survey results, and reporting them to key committees.

3.2 **Plan delivery and monitoring.**

FTSU will deliver and monitor using an evidence-informed approach, shaped by what the data tells us and what we hear from staff, tracking:

- the number of concerns raised, and what they are about.
- how quickly and clearly concerns are resolved.
- whether feedback is shared within expected timeframes
- whether the learning from concerns is share and embedded

Attention will be paid to identifying patterns, recurring issues, and any gaps in follow-up or communication, with escalation to Executives taking place when necessary. Experiences of detriment will also be monitored to support the Trust with understand how the speaking up culture is developing across the organisation.

In addition to quantitative data, qualitative insight will be gathered through follow-up surveys, anonymous feedback, and regular engagement with FTSU Champions. These insights will help inform ongoing improvements.

4 Action Being Requested

4.1 The committee is asked to: **RECEIVE** and **NOTE** this report.

NHS East London NHS Foundation Trust

ANNUAL REPORT
TO THE QUALITY ASSURANCE COMMITTEE

7 July 2025

Title	Complaints, PALS & Compliments Annual Report 2024/2025
Author	Evah Marufu, Director of Nursing Michael Toft, 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.

Committees/meetings where this item has been considered

Date	Committee/Meeting
June 2025	Quality Committee

Key messages

- 574 formal complaints were raised in this reporting period, a decrease of 10.03% (64) compared with the previous year of 638.
- The Trust closed 612 formal complaints in total, of which 320 were closed on time - this is a decrease of 4.76% from the previous financial year. One of the reasons for the decrease was the closure of numerous historical cases which stood at a backlog of 70 in January 2025 and now stands at nine cases.
- 246 complaints were breached (not closed within the agreed timeframe) showing an increase of 24.24% from the previous year which was 198. 35.7% of cases breached in 2023/24 and 40.1% during 2024/25, again reflecting the large number of historical cases which were carried over.
- For those complaints breaching within the same year as they were received, 24% of these cases breached in 2023/24 and 25% breached in 2024/25.
- 1,246 PALS enquiries were received by the Trust, an increase of 50.85% compared with the previous year (826). The increase is partly due to effective recording of all PALS contacts.
- 1,413 compliments were formally recorded, an increase of 3.37% compared with the previous year (1367)

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 Care Quality Commission guidelines. Monitoring accidents and incidents. Reducing potential risk where possible by providing robust control measures and in house training.

Implications

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	This report provides assurance that complaints 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 and 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.

1 Background

1.1 East London NHS Foundation Trust has contractual and statutory obligations to report on and appropriately manage all complaints raised to the Trust. This report fulfils the Trust'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 three of the ways in which the Trust receives feedback about its services. Information from the complaints and PALS service is also included in the Trust integrated patient safety report, which triangulates information from other sources including serious incidents, 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 2024 to 31 March 2025.

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 within the Trust and reports to a Director of Nursing. This new arrangement aims to raise the profile and focus of complaints and PALs 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.

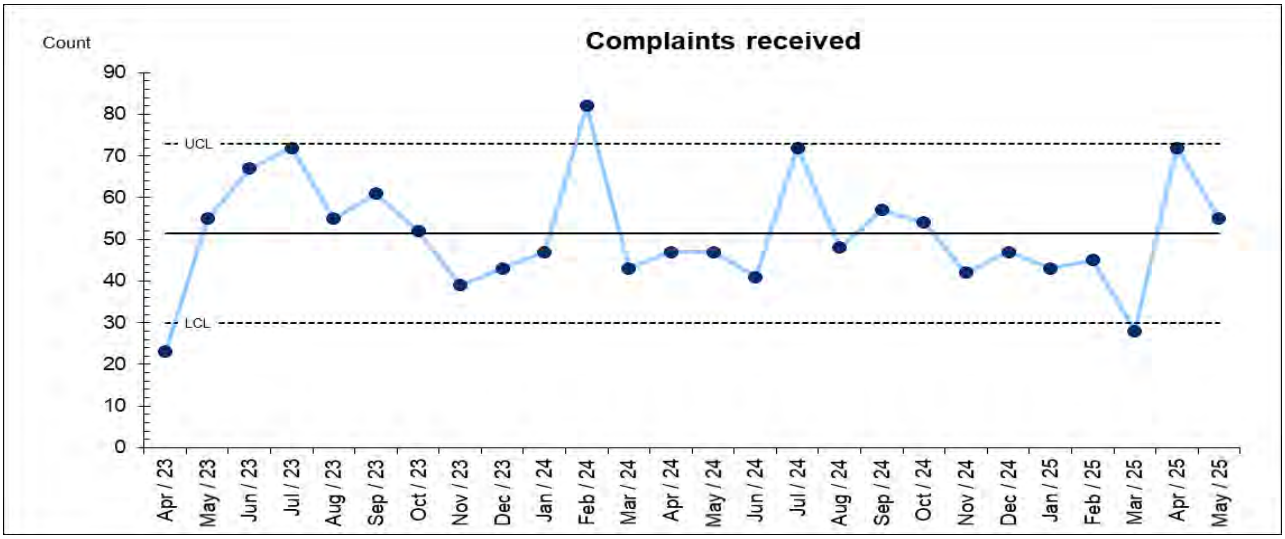
2.3 Complaints are managed in different stages. Prior to formal complaint, the pre-complaint stage seeks to engage service users who may be unhappy with the care they have received before their grievance becomes a formal complaint. At this stage, local teams proactively reach out to understand each individual's experience, creating safe, accessible

channels, whether through face-to-face meetings, telephone calls or online meetings, for service users to raise concerns at the earliest opportunity. By listening, clarifying misunderstandings and offering swift local resolutions, services can often resolve issues informally, repair the therapeutic relationship and capture valuable learning for continuous improvement. Only when concerns cannot be satisfactorily addressed through these early interventions, or the service user requests a formal review, will the matter then proceed to the structured complaint stages described below.

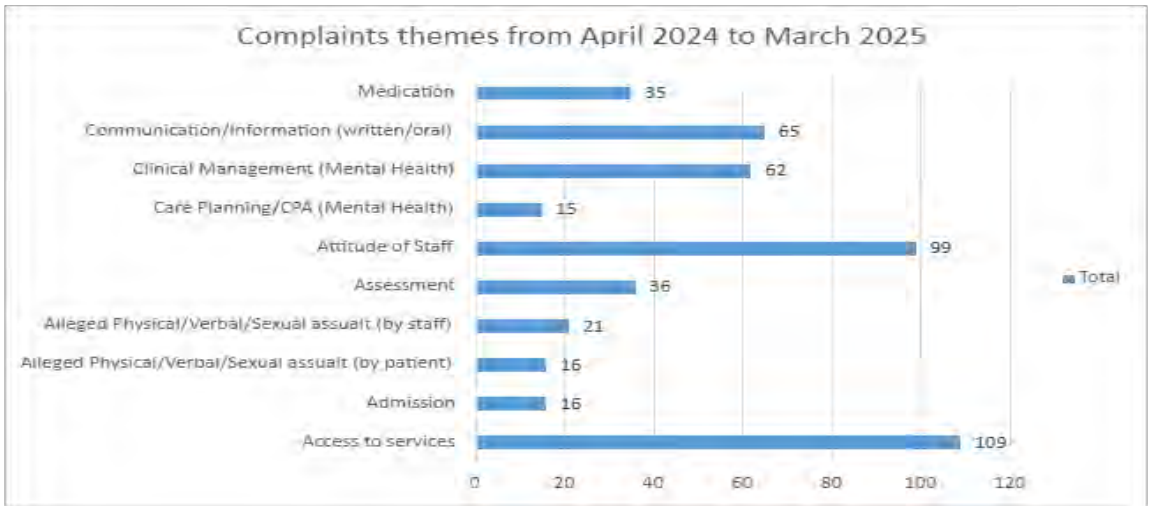
At stage 1, the locality will appoint someone appropriate to review the complaint, conduct a preliminary investigation and contact the complainant to discuss their concerns. At this stage, the service is encouraged to explore the possibility of locally resolving the complaint and identify any learning 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.

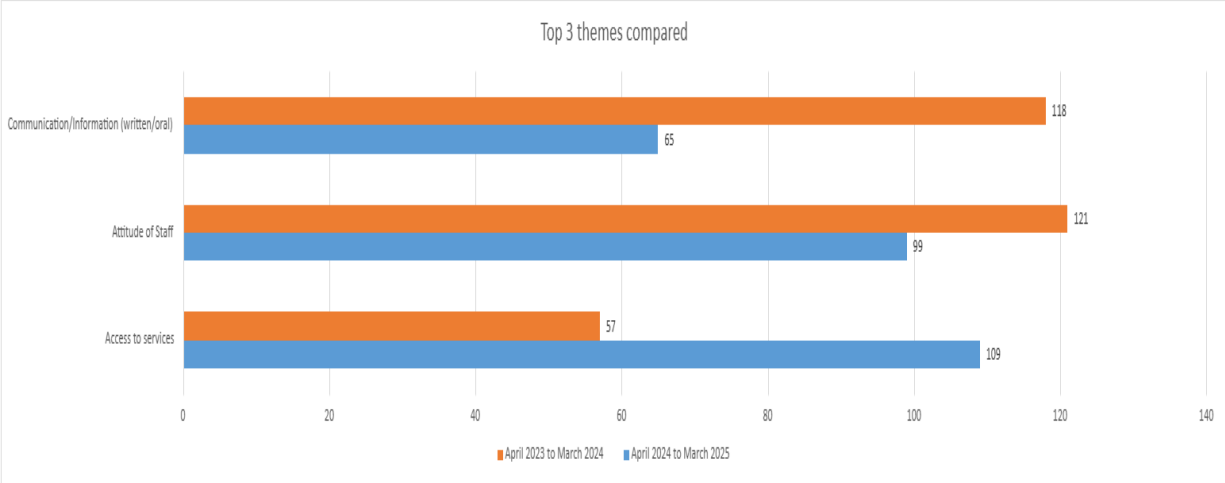
2.4 The Trust's Chief Executive Officer personally oversees and reviews every Stage 2 complaint response. This is to assure service users, carers and families of the importance the Trust places on complaints by having input at the most senior level of the organisation. The Trust also has the support 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.

2.5 574 formal complaints were raised in this reporting period, compared with the previous year of 638.

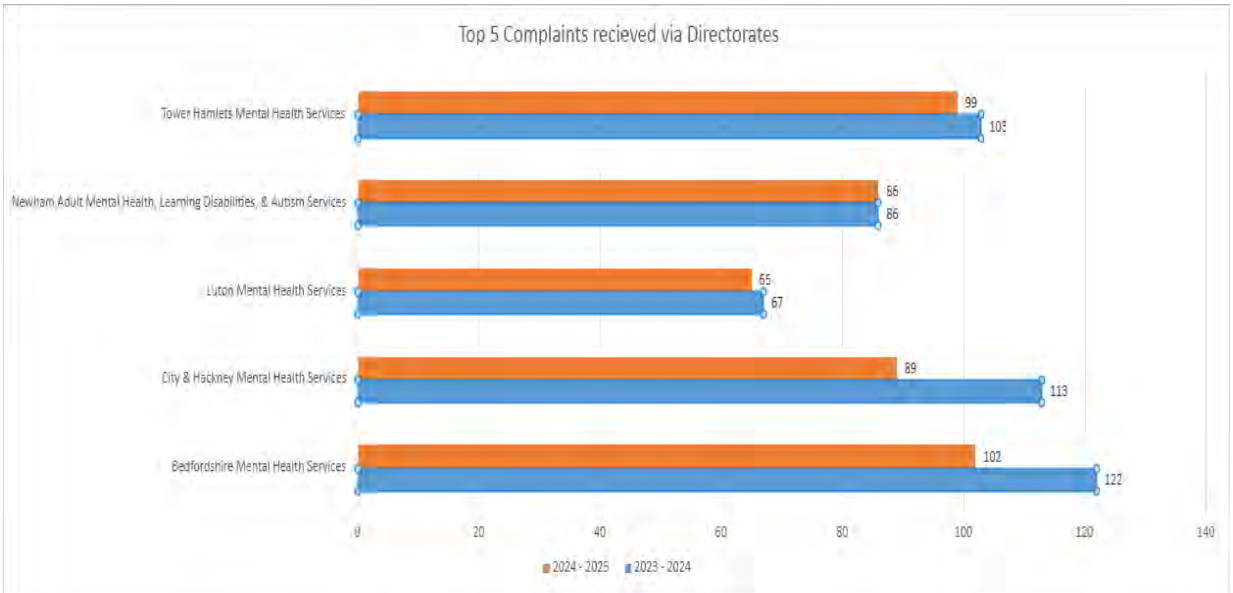


To better understand the underlying drivers of complaints and inform targeted improvement work, the team carried out deep dive exercises and thematic analysis of complaints data. This was done to identify persistent issues, highlight areas of improvement, and ensure that service responses are aligned with the real concerns of service users and carers. From this analysis, we identified the top three recurring themes: Access to Services, Attitude of Staff, and Communication. Notably, these themes have shown some movement over time. Communication, which was previously the second most reported concern, has improved and is now ranked third. However, Attitude of Staff continues to be the most commonly raised issue, reinforcing the need to prioritise relational, respectful, and compassionate care across all settings.





The analysis also showed that the highest number of complaints were reported in Bedford and City and Hackney, followed by Tower Hamlets and Newham.



- To address this, the Complaints Team is working closely with directorates recording the highest volumes of complaints to understand root causes and co-develop targeted action plans.
- Weekly joint meetings have been established with borough teams, and complaints officers are maintaining a visible presence within services through regular site visits and drop-in support.
- We are also providing focused support to directorates with the highest number of breaches, helping them improve complaint handling, response timeliness, and learning from outcomes.
- The Complaints Team now has a regular slot in the Trust's operational meeting to provide real-time feedback, with the first session scheduled for July.

- Additionally, we are planning to hold a Learning Lessons Seminar, in collaboration with the Risk and Governance team, to bring together staff across disciplines to reflect on complaint cases, explore contributory factors, and embed shared learning into practice.
- Insights from the developing complaints dashboard will be used to track progress and evaluate the impact of these initiatives, with the aim of driving proactive, patient-centred improvements and reducing avoidable complaints over time.

- **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 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 5 working days.

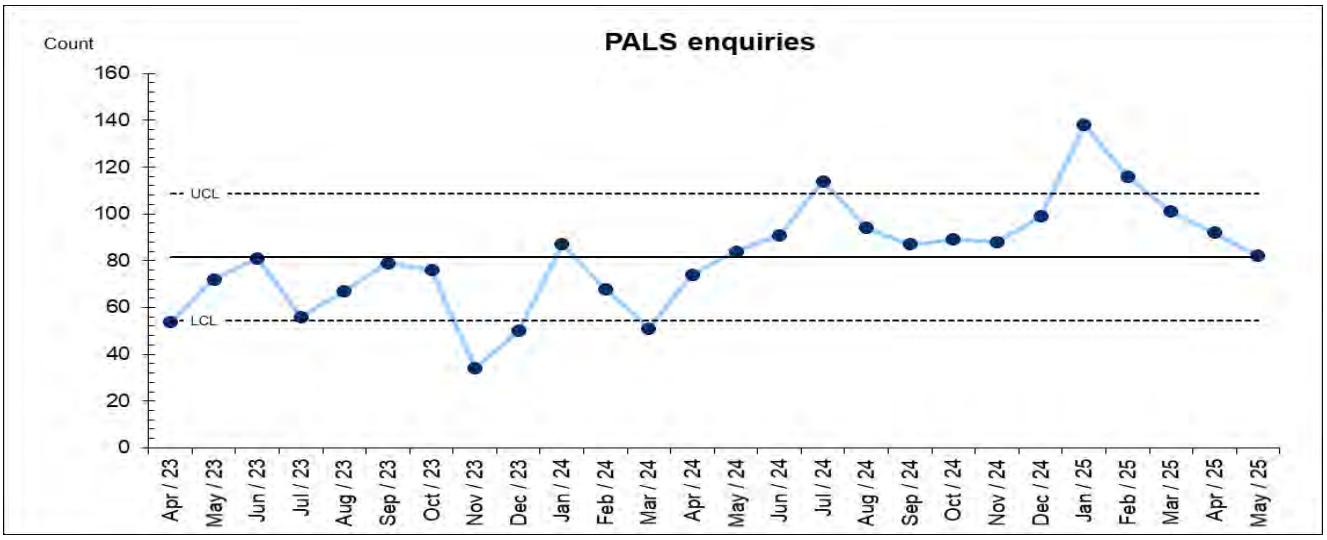
2.8 The Patient Advice and Liaison Service (PALS) plays a vital role in supporting service users, carers, and families to resolve concerns quickly, compassionately, and without formality. PALS helps in a variety of ways, including:

- Answering health-related questions and clarifying information about care and treatment.
- Resolving low-level concerns promptly, often on the same day by working directly with clinical teams.
- Providing information about Trust services, how to access them, and what service users can expect.
- Explaining the NHS complaints procedure, and how to access independent advocacy if someone wishes to pursue a formal complaint.
- Signposting to external services and support groups, both within and beyond the NHS, tailored to individual needs.

In addition, PALS staff play a crucial navigational role, helping people find the right team, service, or professional to respond to their issue. They frequently act as a bridge between service users and clinical or operational staff, ensuring concerns are raised early and dealt with informally where appropriate. This often prevents escalation into formal complaints.

2.9 1,246 PALS enquiries were received by the Trust, compared with the previous year (826). The increase is partly due to effective recording of all PALS contacts. There is now a dedicated member of staff who now looks after the PALs concerns. 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.



The Complaints and PALS team will continue to work collaboratively with services to sustain improvements and build on current progress. Planned developments include:

- Scaling up access to PALS, with pilots of “on-the-day” resolution desks now underway in community mental health receptions in Newham and Tower Hamlets.
- Continuing efforts to meet the target of resolving PALS enquiries within 5 working days.
- Further developing the PALS function over the coming year to strengthen its visibility, accessibility, and responsiveness across all services.

Compliments

2.10 Compliments provide valuable assurance about the quality of care and the positive experiences of patients, carers, and families. While the primary focus of the Complaints and PALS team is to capture and respond to concerns and feedback requiring action or resolution, we also actively encourage the recording and recognition of compliments.

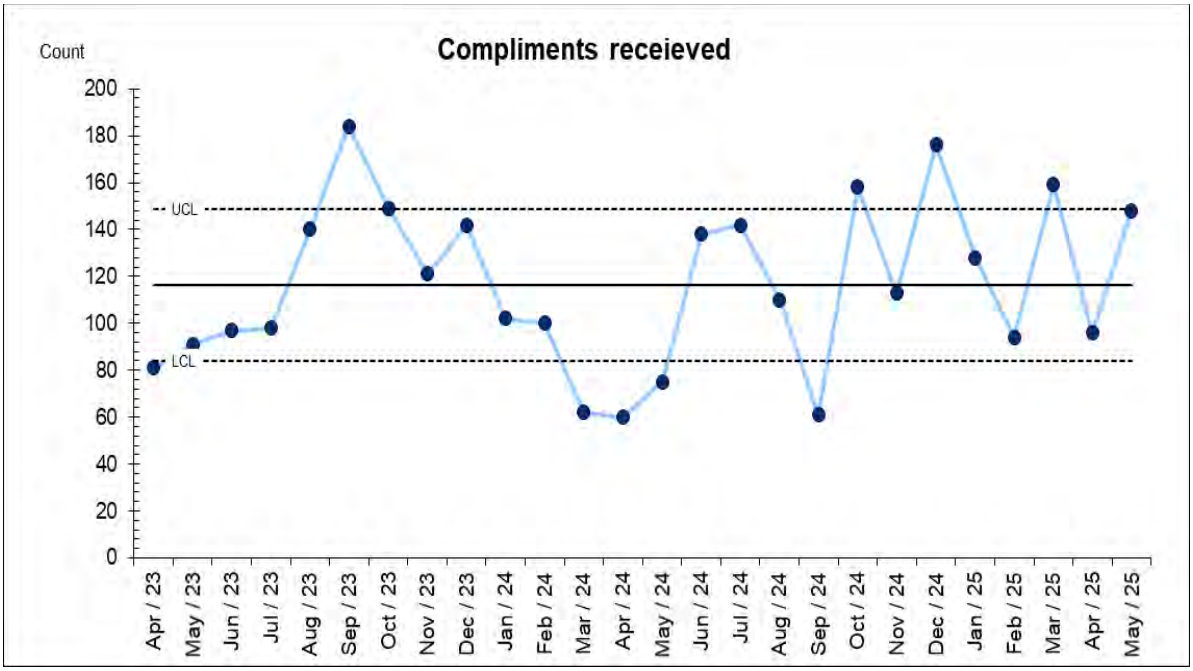
These are collected through formal channels such as emails, thank-you letters or cards, and are logged by the complaints team where possible. However, we acknowledge that many compliments are shared informally at a local level, verbally to staff, cards given to wards, and may not always be systematically recorded. As such, the number of formally

logged compliments likely underrepresents the full extent of positive feedback received across services.

The complaints team continues to work closely with service and encourage the consistent recording and sharing of compliments as this helps to reinforce good practice, boost staff morale, and support a balanced view of patient experience across the organisation.

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 1,413 compliments were formally recorded, compared with the previous year (1367)



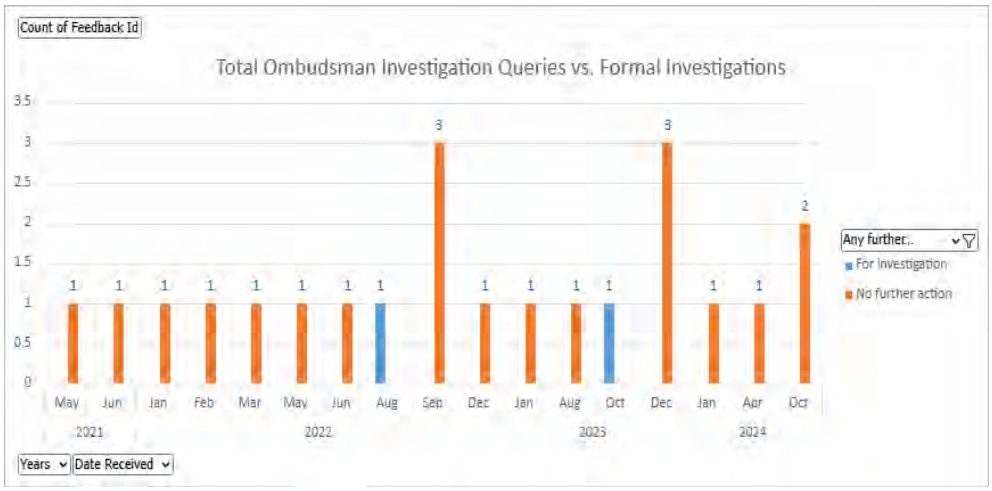
2.12 Parliamentary and Health Service Ombudsman (PHSO)

The Parliamentary and Health Service Ombudsman (PHSO) acts as an independent body that investigates complaints about NHS services in England when individuals feel their concerns have not been resolved satisfactorily at a local level. It provides a final stage for complaints that have already been through the organisation's own processes.

The Trust received three queries from the PHSO during the last financial year. These represent a small proportion of the total complaints received and are typically escalated when a complainant remains dissatisfied following local resolution.

In all three cases, the Complaints Team worked closely with the relevant services to provide timely and comprehensive responses to the Ombudsman. At the time of reporting, none of these cases had progressed to a formal investigation.

We continue to view Ombudsman involvement as a valuable opportunity for learning and reflection. Where recommendations are made, we ensure they are fully implemented and shared through appropriate governance channels. Our ongoing aim is to resolve concerns as effectively and compassionately as possible at the local level, reducing the need for escalation.



3.0 Co-Production: Experts by Experience

We remain committed to embedding co-production at the heart of our complaints and PALS processes. To support this, we have actively involved our Experts by Experience in reviewing and quality assuring our approaches to complaint handling, learning, and responses.

Each month, Experts by Experience representatives provide independent feedback on a selection of complaint responses, offering valuable insights on tone, clarity, and whether concerns have been fully addressed. This collaboration ensures that our responses are more compassionate, person-centred, and genuinely reflective of service users' voices.

We are also working to increase and formalise the use of Expert by Experience input, with the aim of ensuring responses are co-produced wherever possible. Their involvement not

only strengthens accountability and transparency but also plays a vital role in shaping service improvements and building trust with those who use our services

4.0 Progress against work plan during last financial year

Key achievements

The

The number of complaint investigations closed was 612, up from 554 during the previous financial year.

102 cases recognised errors or gaps in care and full apologies were given, compared to 96 during the previous financial year. 269 cases resulted in providing explanations of our services, treatment, plans or processes, compared to 241during the previous financial year.

Action plans were identified and implemented in 94 cases, thereby improving services, enhancing patient safety and sharing learning with staff.

There has been an increase in the number of PALS contacts recorded, from 826 during the previous financial year to 1,246. Of these, 47 progressed to formal complaints.

The number of compliments recorded as received rose to 1,413 from 1,367 during the previous financial year.

The backlog of historical complaints has been reduced to nine cases.

Complaints and PALS team has managed an increase in case closures and a significant reduction in the number of open historical complaints. The rate of cases breaching has been reduced through effective monitoring and communication with the service complained about.

5.0 Quality Initiatives

- We are committed to making sure complaint responses are not only timely but meaningful, compassionate, and easy to understand. We want every person who raises a concern to feel heard, respected, and valued. To support this, we have introduced several measures to improve the quality of written responses. All Stage 1 and Stage 2 response letter templates have been revised to ensure they are clear, empathetic, and accessible. A new style guide helps staff write in a tone that is softer, more human, and avoids jargon. We've also simplified the investigation process by introducing a standardised summary form, so that key issues are identified early and addressed directly.
- A feedback form has been introduced for investigating officers to share their experiences and to identify improvements for the complaints process.

- The QI project will continue in 2025/26 with a renewed focus on improving the quality and timeliness of the Trust's complaint responses, implementing a robust Trust-wide system so as to capture learning from concerns and ensuring service improvements which benefit patients and staff following the conclusion to a complaint investigation.

- Complaints staff have received training on writing effective reports and managing reviews. Additionally, Trust-wide complaints training has been delivered on a bi-monthly basis, with bespoke sessions provided on demand - so far, around 120 staff have attended. These changes are part of our wider aim to make the complaints process more supportive, more person-centred, and ultimately more effective in driving learning and change.

- To address the variability in the quality of complaint responses, the Complaints team has revised the process documentation provided to investigating officers. The updated pack now includes: A Terms of Reference proforma, clearly defining the scope of each investigation and also a style guide to support consistency in the structure, tone, and quality of written responses
- In addition, the Complaints team maintains a regular weekly presence in local services to provide on-the-ground support, respond to queries, and encourage the timely and effective resolution of concerns.

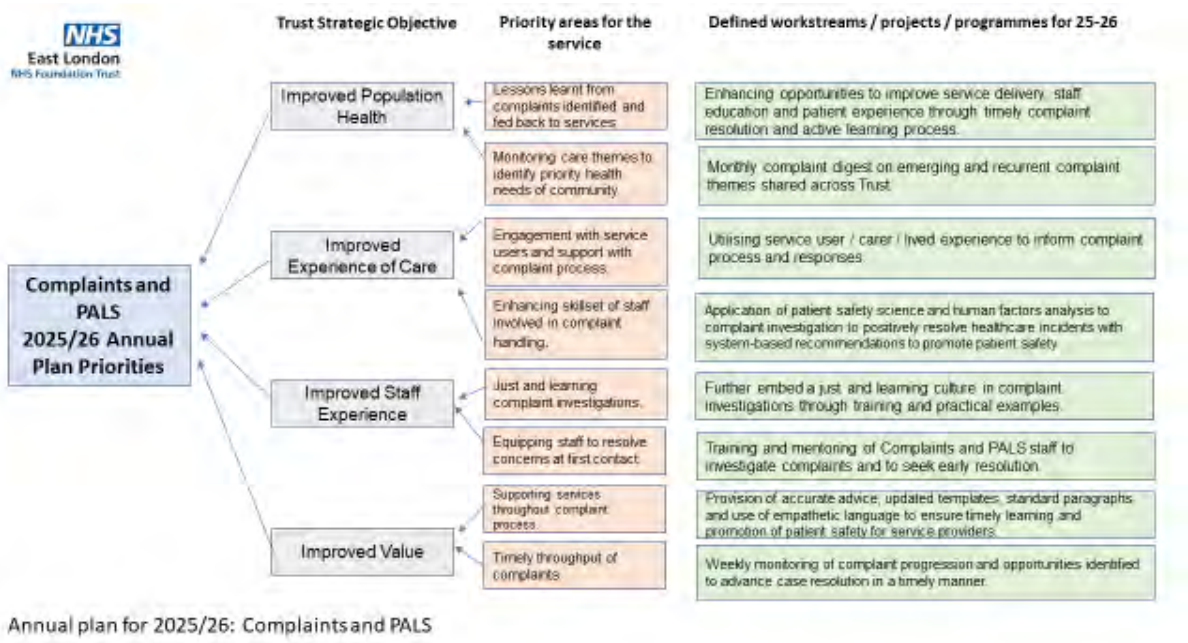
The team is also strengthening cross-functional collaboration to embed learning and improve practice:

1.1..1 The Complaints team will work closely with the Risk and Governance team to ensure active participation in Learning Lessons Seminars, supporting shared reflection and improvement. This is in line with the Patient Safety Incident Response Framework (PSIRF) which sets out the NHS's approach to to developing and maintaining effective systems and processes for responding for patient safety incidents for the purpose of learning and improving patient safety.

1.1..2 A new partnership with the NELFT Complaints team is being developed to facilitate mutual learning and the exchange of best practices, with the aim of enhancing the quality and effectiveness of complaint handling across both organisations.

- We will be using the InPhase system to collect data to help inform progress against plans, while Power BI is being updated to fully and accurately produce complaint and PALS data.

2025/26 priorities driver diagram



To continue improving the experience of service users and ensuring an effective, responsive complaints system, our priorities for the coming year include:

- We will maintain a focus on ensuring complaint responses are completed to a consistently high standard and within required timeframes. This will be achieved through continued collaboration with directorates and alignment with wider quality improvement initiatives.
- We will further develop the PALS function and promote informal resolution mechanisms to support timely responses to concerns. This will reduce escalation into the formal complaints process and improve user satisfaction.
- By increasing visibility of the Complaints and PALS teams, continuing on-site support, and enhancing access to real-time advice, we will support frontline teams in resolving concerns early and effectively.
- Through thematic reviews, learning lessons seminars, and the use of real-time data, we will strengthen our feedback-to-learning cycle across the Trust.
- To support ongoing learning and service improvement, we are developing a complaints dashboard that will bring together key data in one accessible location. This will enable teams to more easily monitor themes and trends, identify areas of concern, and track the impact of changes over time. The dashboard will be used to inform local and Trust-wide quality improvement initiatives, support operational oversight, and strengthen assurance by

providing clearer visibility of performance and outcomes related to complaints. It will also aid in promoting

2 Action Being Requested

3.1 The committee is asked to receive and approve this report.

Appendix A – Complaint and PALS data for 1 April 2024 to 31 March 2025

	2023/24 financial year	2024/25 financial year	Change
New formal complaints	638	574	-10.03%
Total closed	554	612	10.47%
Closed within timeframe	336	320	-4.76%
Total breached complaints	198	246	24.24%
PALS enquiries	826	1246	50.85%
Compliments	1367	1413	3.37%

Chart 1 – Complaints received

574

In this financial year the average monthly number of complaints was 50, reflecting a similar trend compared from April 2023 to March 2024.

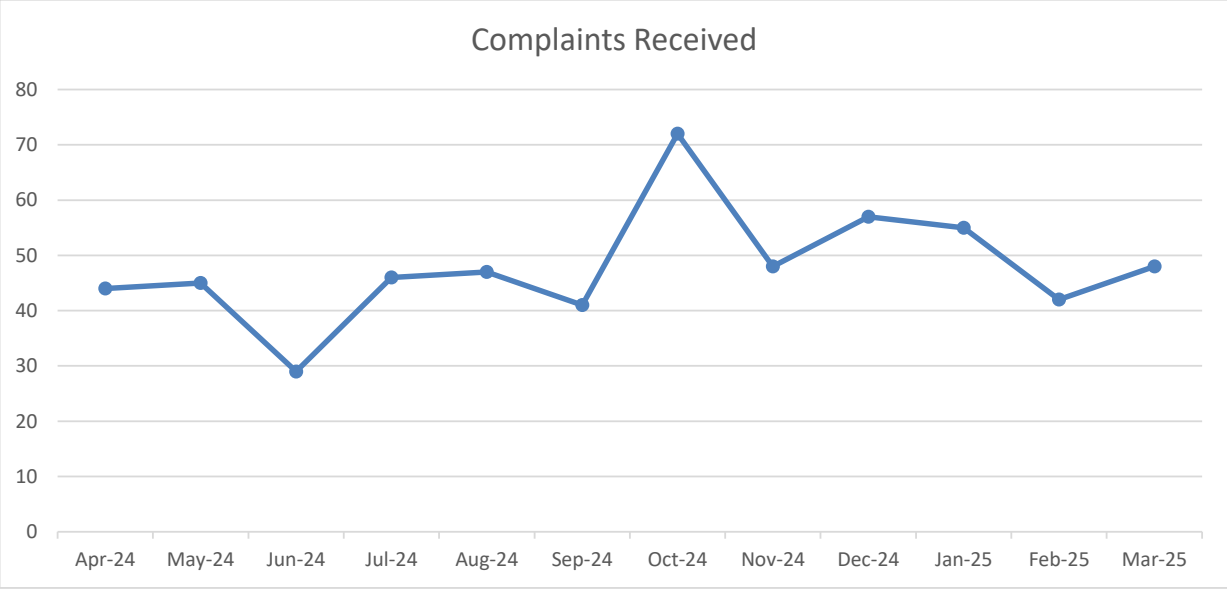


Chart 2 - Complaints by directorate

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Grand Total
Bedfordshire Community Health Services		1	3	2	1	1	3	1	4	1	2		19
Bedfordshire Mental Health Services	7	11	6	14	8	12	11	7	10	6	6	4	102
Children and Specialist Services	5	2	3	2	7	7	9	5	3	3	2	5	53
City & Hackney Mental Health Services	6	9	7	12	8	9	8	3	5	5	12	6	90
Community Health Services - Newham	2	1	2	6	2	2	1	4	4	4	2	3	33
Community Health Services - Tower Hamlets	2						1	1			1	1	6
Corporate Services				1	1	1	1		1				5
Forensic Services							1						1
Forensics Services	1	2		1	1			2	2	1			10
Luton Mental Health Services	5	3	8	5	9	10	4	2	5	10	2	1	64
Newham Adult Mental Health, Learning Disabilities, & Autism Services	5	8	7	13	3	7	4	11	11	8	6	1	84
Newham Mental Health Services				1									1
Primary Care Services	3			2				1					6
Tower Hamlets Mental Health Services	10	10	5	13	8	8	12	5	3	6	12	8	100
Grand Total	46	47	41	72	48	57	55	42	48	44	45	29	574

Chart 3 – Complaints by source and theme

Complaints top 10 themes:

1. Attitude of Staff
2. Access to services
3. Communication/Information (written/oral)
4. Clinical Management (Mental Health)
5. Medication
6. Assessment
7. Alleged Physical/Verbal/Sexual assault (by staff)
8. Alleged Physical/Verbal/Sexual assault (by patient)
9. Care Planning/CPA (Mental Health)
10. Discharge/Transfer Arrangements

PALS top 10 themes:

1. Access to services
2. Attitude of Staff
3. Communication/Information (written/oral)
4. Clinical Management (Mental Health)
5. Medication
6. Patient Records & Information (Living Patients)
7. Appointments delay/cancellation/timing
8. Discharge/Transfer Arrangements
9. Clinical Management (Physical Health)
10. Care Planning/CPA (Mental Health)

Complaints by source	
Advocate	27
Complainant	392
Councillor	2
CQC	43
Forwarded by other NHS Trust	8
Legal representative/solicitor	2
MP	27
PALS	47
Not recorded	26
Grand Total	574

Chart 4 – Formal complaints acknowledged within three working days

Period	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Complaints	55	42	48	46	47	41	72	48	57	44	45	29
No		3		1	2		2					
Yes	55	39	48	45	45	41	70	48	57	44	45	29
Percentage	100%	93%	100%	98%	96%	100%	97%	100%	100%	100%	100%	100%

Chart 5 – Complaint timescales

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Complaints Closed	40	61	46	44	56	49	60	44	43	47	60	62
Number of Responses sent within Agreed timescale	12	27	30	27	35	27	28	22	22	21	28	41
Percentage	30%	44%	65%	61%	63%	55%	47%	50%	51%	45%	47%	66%
Number of Responses breached against timescale	25	30	12	16	16	20	22	19	19	23	28	16

Percentage	63%	49%	26%	36%	29%	41%	37%	43%	44%	49%	47%	26%

Chart 6 – Complaints resolved to timescale

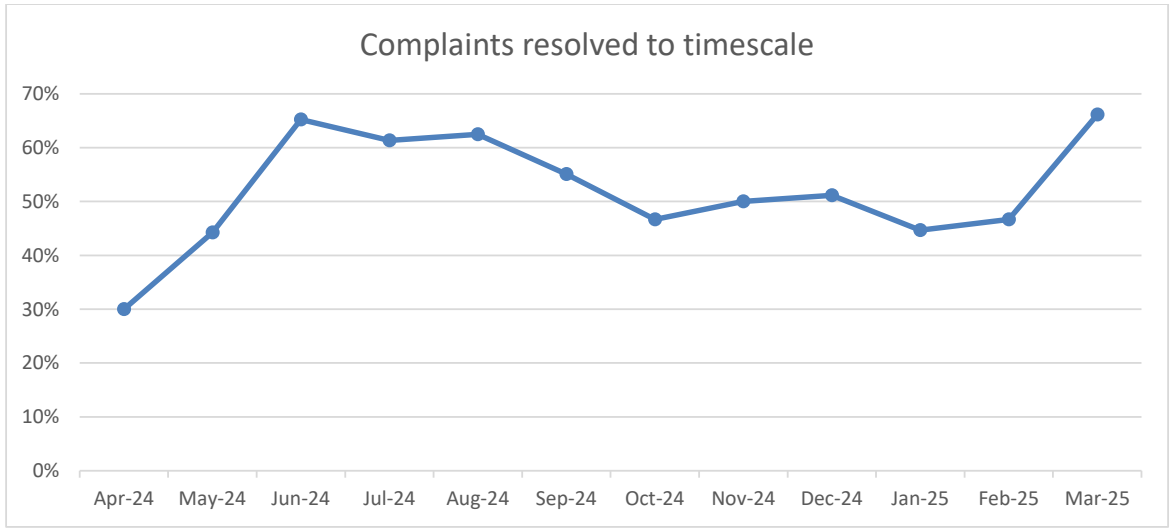


Chart 7 – PALS enquiries by Directorate

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Grand Total
Bedfordshire Community Health Services	5	2	2	6	5	4	2	1	3	3	4	1	38
Bedfordshire Mental Health Services	13	17	9	15	9	12	13	14	22	20	13	19	176
Children and Specialist Services					1	2	11	6	7	16	12	9	64
City & Hackney Mental Health Services	10	8	10	20	12	11	14	14	18	16	11	17	161
Community Health Services - Newham	1	1	7	5	3	4	5	2	3	5	11	9	56
Community Health Services - Tower Hamlets	1	4	3	3	2	2	7	3	1	5	7	1	39
Corporate Services	1	3	1				1	10		1	1	1	19
Forensics Services	2	4	3	2	2	1	2	1	3	4	4	4	32
Luton Mental Health Services	6	7	4	3	11	10	4	5	13	12	17	13	105
Newham Adult Mental Health, Learning Disabilities, & Autism Services		1	1			3	13	5	15	21	12	15	86
Newham Mental Health Services	10	7	10	11	10	10							58
Primary Care Services	6	4	9	5	5	5	8	8	1	1	1		53
Specialists Services	5	5	7	6	7	7							37
Tower Hamlets Mental Health Services	8	8	9	7	10	11	5	19	5	17	14	9	122
Signposting queries	8	13	16	32	18	5	4	9	13	41	23	18	200

Grand Total	76	84	91	115	95	87	89	97	104	162	130	116	1246

Chart 8 – PALS enquiries by month

1246

PALS inquiries were logged and handled, an average of 103 inquiries per month

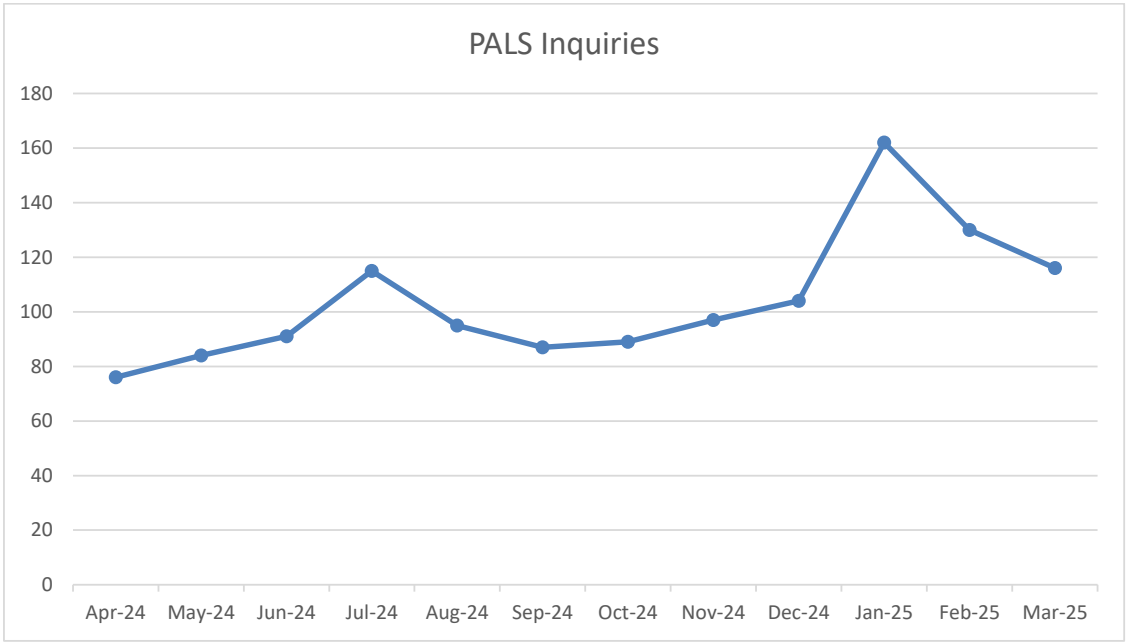
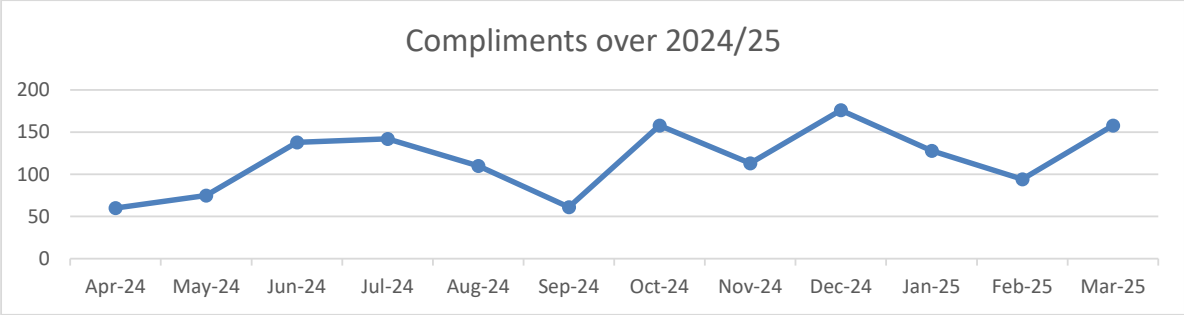


Chart 9 – Compliments recorded by Directorate

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Grand Total
Bedfordshire Community Health Services	7	2	7	6	3	13	10	4	6	6	4	8	76
Bedfordshire Mental Health Services	17	9	5	26	10	10	5	15	11	11	23	24	166
Children and Specialist Services								20	2	55	3	1	81
City & Hackney Mental Health Services	2	1		1	4	3			2	1	1	1	16
Community Health Services - Newham	5	5		1	2	6	8	5	5	2	6	7	52
Community Health Services - Tower Hamlets	5	4	5	7	7	10	4	5	8	1	3	1	60
Corporate Services		1	1	3	1	2	2		2		1		13
Forensics Services	1	1		4			1			1			8
Luton Mental Health Services		3	2		2	1		5	2	4	1	1	21
Newham Adult Mental Health, Learning Disabilities, & Autism Services								1	27	1	1	3	33
Newham Mental Health Services	1				1								2
Primary Care Services	3	8	35	17	20	4	81	4	75	2		37	286
Specialists Services		27	22	26	2								77
Tower Hamlets Mental Health Services	19	14	61	51	58	12	47	54	36	43	51	75	521
General										1			1
Grand Total	60	75	138	142	110	61	158	113	176	128	94	158	1413


Compliments over 2024/25
200
150
100
50
0
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25

NHS East London NHS Foundation Trust

REPORT TO THE QUALITY ASSURANCE COMMITTEE
7th July 2025

Title	Legal Claims Annual Report- 1 April 2024 to 31 March 2025
Author/Role	Christina Helden- 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 2024 and 31 March 2025.

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
7th July 2024	Quality Assurance Committee

The total number of open claims across both the CNST and LTPS schemes is 76. Last year the total number was 72.

There were 12 new CNST claims and 18 new LTPS claims received between 1 April 2024 and 31 March 2025. The number of CNST claims has remained consistent where 13 claims were received in the 2023/2024 financial year but there has been a slight drop in the number of new LTPS claims where 25 were received in the preceding 12 months.

The estimated total value of all claims closed between 1 April 2024 and 31 March 2025 is £950,954. Last financial year all closed claims were valued at £1,843,633.

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

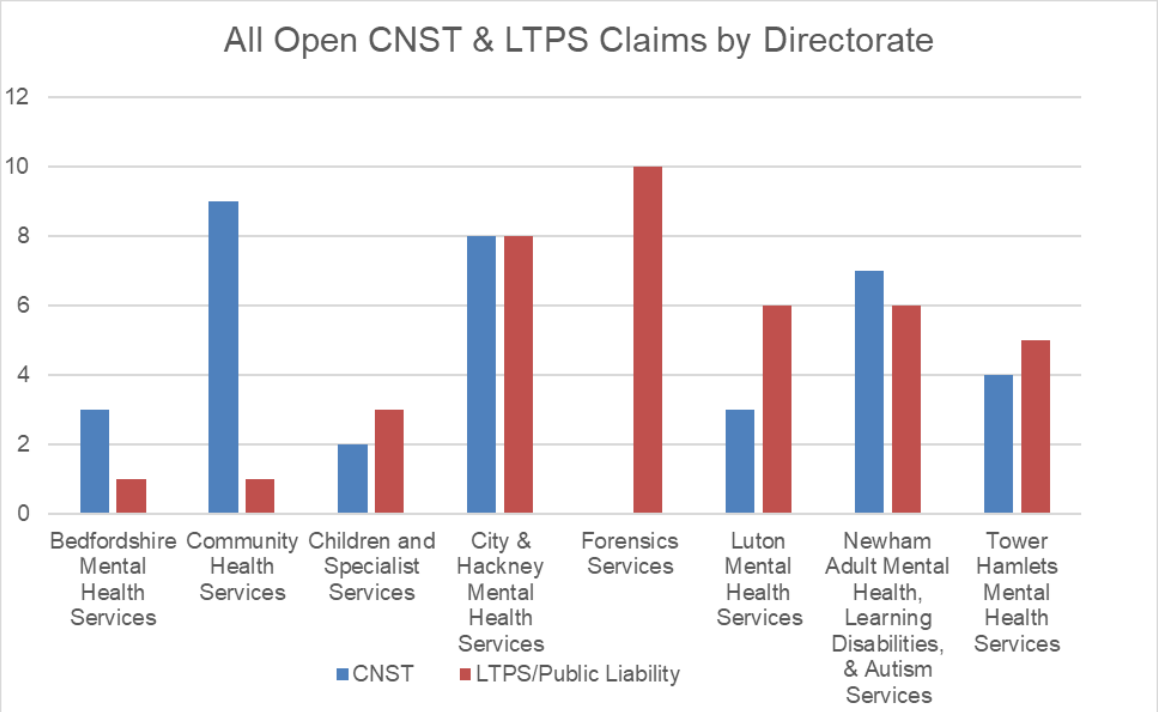
1.1. This report will focus on the claims activity under the Clinical Negligence (CNST), Liability to Third Party (LTPS) schemes between 1 April 2024 and 31 March 2025.

1.2. Please note the LTPS scheme covers both employer's liability and public liability claims.

2. CLAIMS OVERVIEW

2.1. As of 31 March 2025 there were 76 open claims across both schemes. Of these, 36 are CNST and 40 are LTPS claims. In the previous financial year, there were 72 open claims. 32 were CNST claims and the remaining 40 fell under the LTPS scheme.

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.

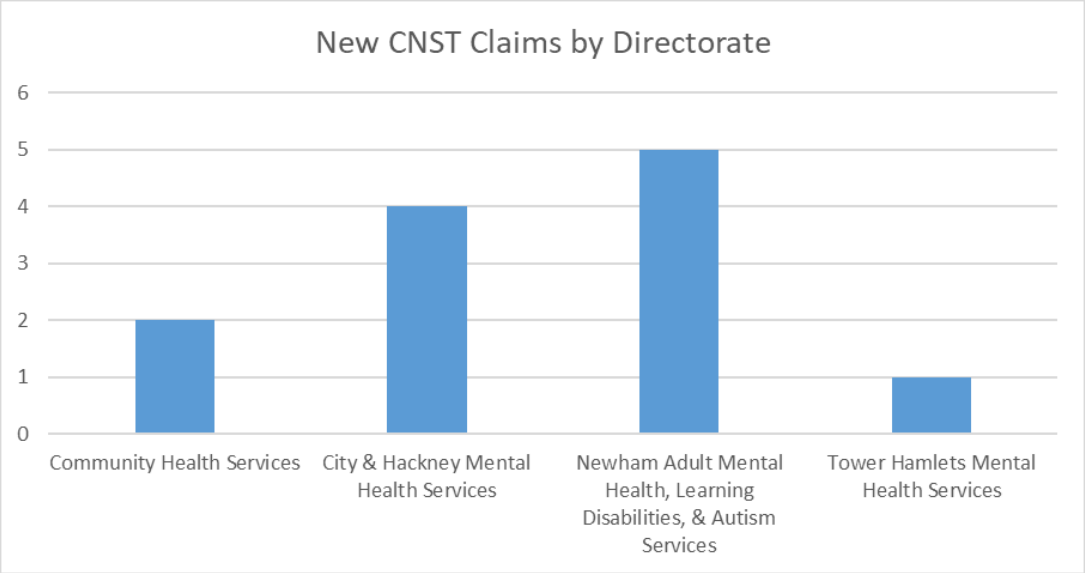
2.4. You will be aware that NHS Trusts make an annual payment to NHS Resolution to be covered by the respective CNST and LTPS schemes, which cover all CNST costs plus LTPS damages above a certain level. Levels of contribution to the CNST and LTPS schemes are determined by the levels of potential damages 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 2023/24 and 2024/2025.

3. CNST Claims

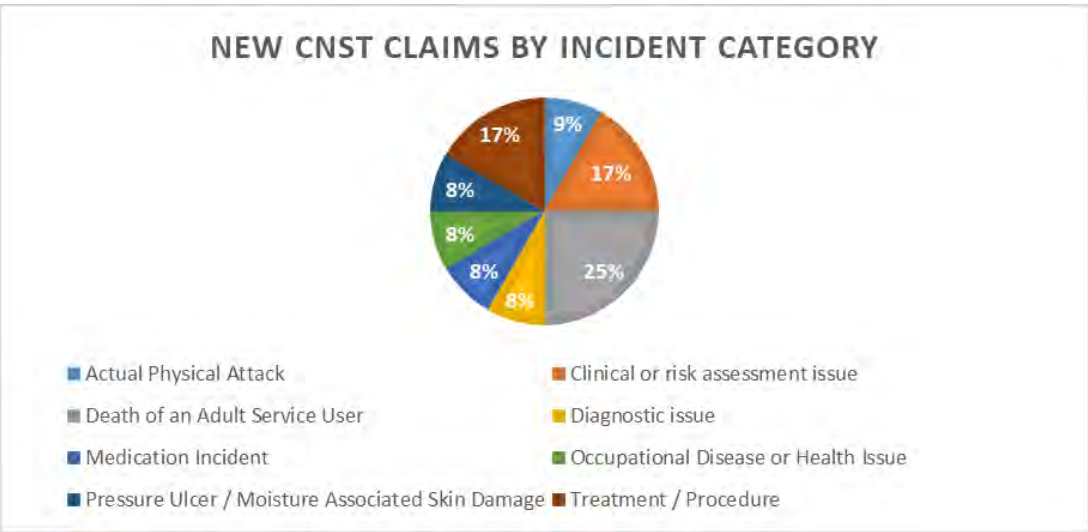
3.1. New CNST claims

3.2. Between 1 April 2024 and 31 March 2025, 12 new CNST claims were received. Last year there was a total of 14.

3.3. The graph below shows the new claims received during this period broken down by Directorate.



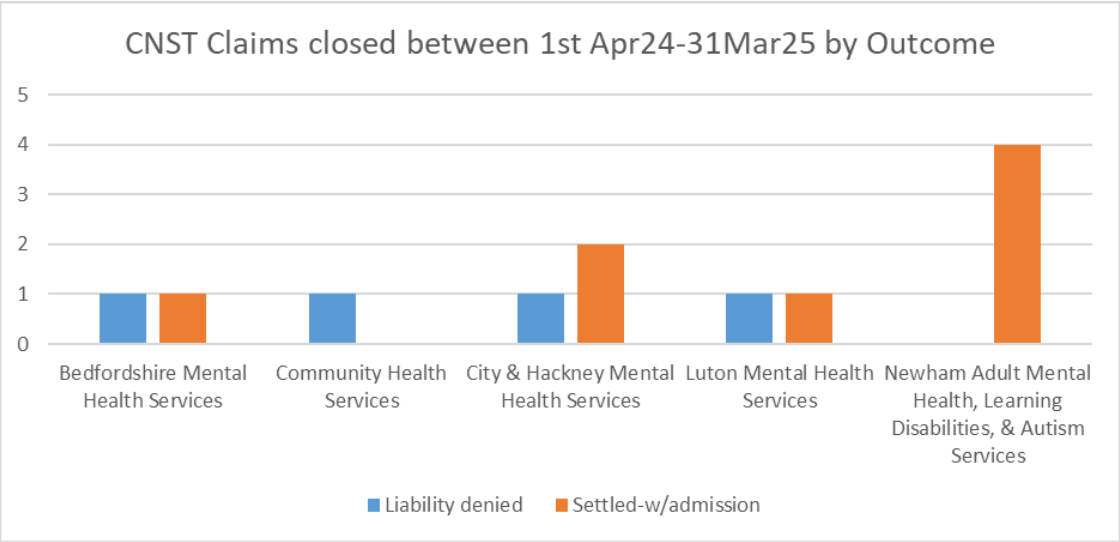
3.4. The pie chart below shows the new claims received during this period broken down by incident category (where an incident category has been recorded). Adult service user deaths account for the highest proportion of new CNST claims. This is consistent with previous years.



3.5. **Closed CNST Claims**

3.6. Between 1 April 2024 and 31 March 2025, 12 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. 8 were settled with an admission of liability, whereas the Trust denied liability in 4 claims.



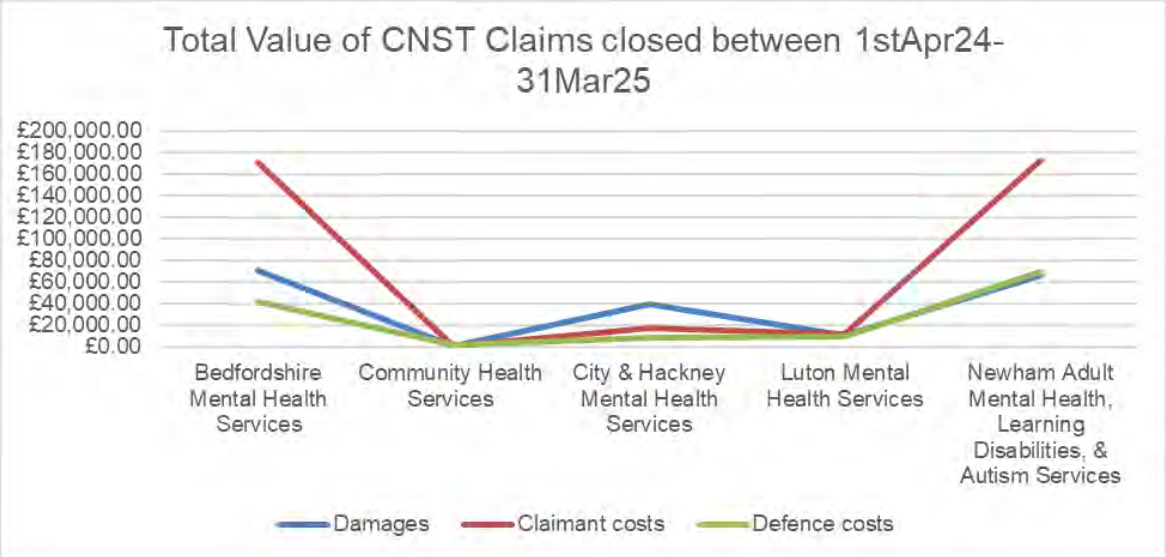
3.8. **Value of CNST claims closed between 1 April 2024 and 31 March 2025**

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 2024 and 31 March 2025 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 £184,957 (2023/24 £448,890.00)

3.13. Claimant legal costs £371,726 (2023/24 £766,500.00)

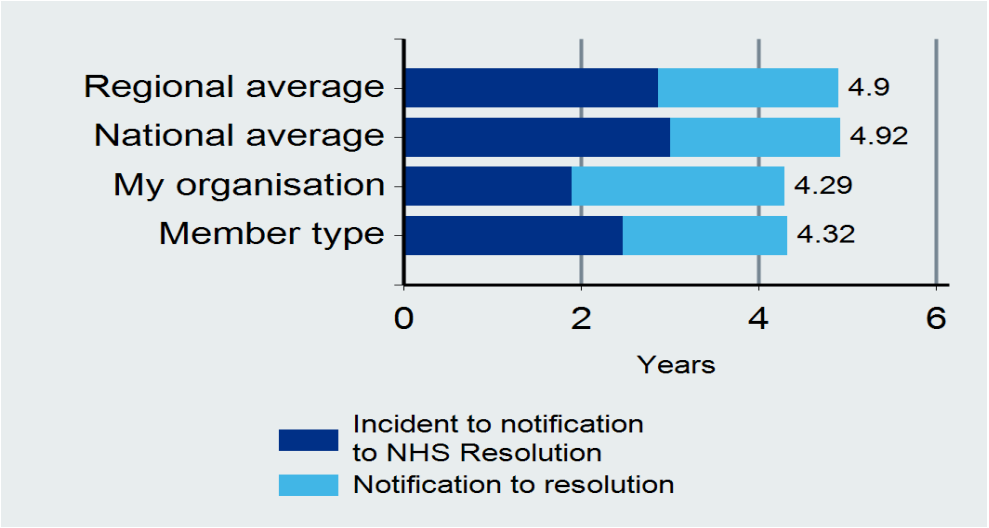
3.14. ELFT legal costs £129,024 (2022/23 £174,093.00)

3.15. Total £685,707 (2023/24 £1,389,483)

3.16. **CNST Claims Benchmarking**

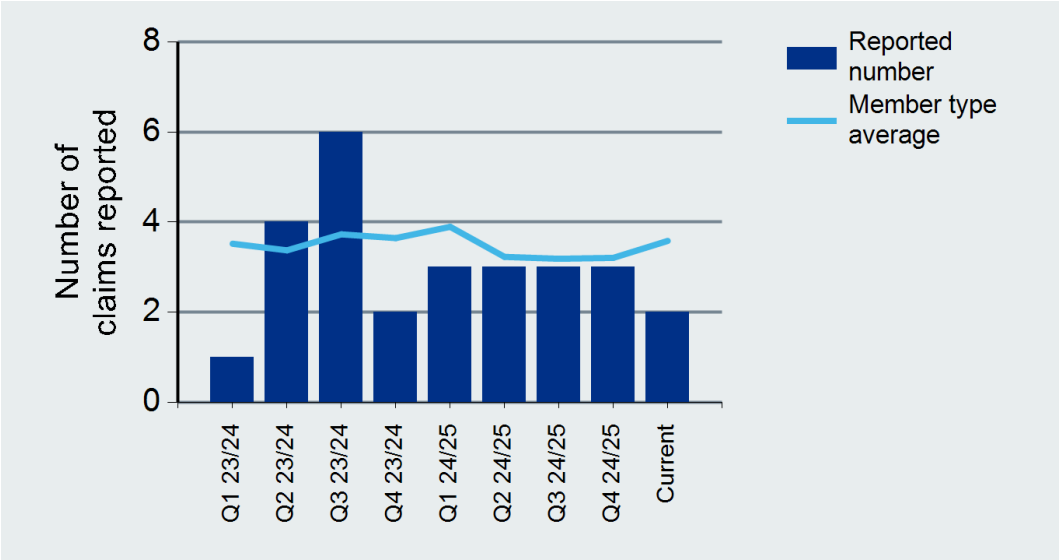
3.17. An exercise was undertaken to benchmark the Trust's CNST claims. In particular, the data provided information as to how long the Trust resolves claims in comparison to other Trusts across the country and the number of claims received by ELFT in comparison to both other London Trusts and other Mental Health Trusts.

3.18. **Time to Resolution**
The graph below shows the Trust's CNST claims activity from incident notification to notifying the NHSR and then from notification to resolution. You will see that this has been measured against the regional average, national average and member type.

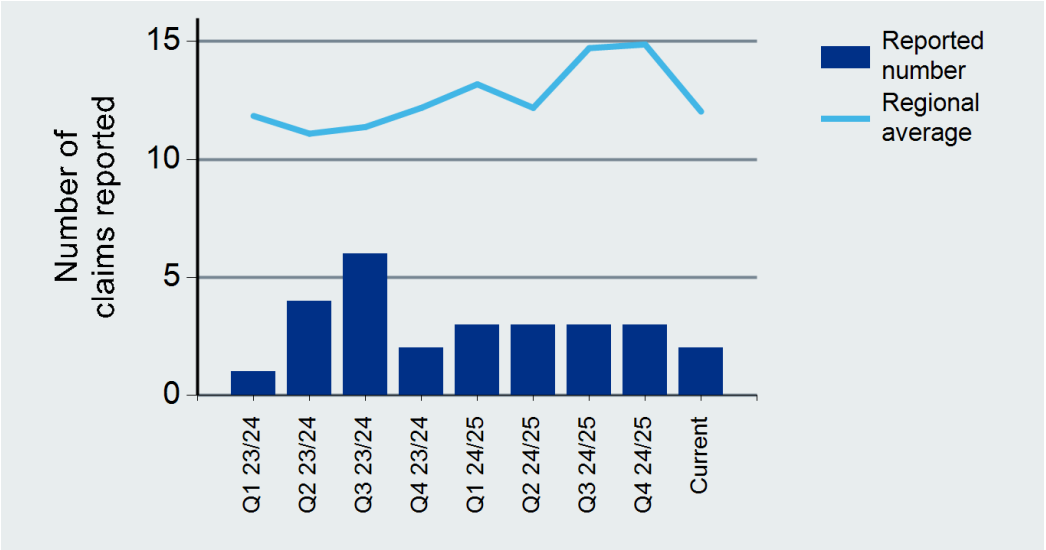


3.19 Number of CNST Claims

3.20 This graph shows the number of the claims the Trust has received from Q1 23/24 to date in comparison to the average number of claims received by other Mental Health Trusts. For the purposes of this report, our focus is on Q1 24/25- Q4 24/25.



3.21 The graph below shows the average number of the claims the Trust has received from Q1 23/24 to date in comparison to the average number of claims received regionally. For the purposes of this report, our focus is on Q1 24/25- Q4 24/25.



3.22 CNST Trends

3.23 Of the 36 open CNST claims, 12 have arisen as a consequence of negative inquest conclusion. 9 of these were settled with admission while 2 have been paused until the inquests have taken place. Please note, settled does not mean the case is cl;osed yet. It simply means that an agreement as to damages has been made.

3.24 Forged observations have 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, NHSR have requested confirmation that the Trust has highlighted all observation related incidents to the CQC.

3.25 The Team has been keeping abreast of the Trust's observation work and continues to feed into the work being done as requested.

3.26 There has been a rise in service users bringing claims against the Trust as Litigants-in-Person. A litigant-in-person is an individual who represents themselves in legal proceedings instead of instructing a barrister or solicitor. There are currently 7 claims. Liability is denied in 2 claims and the remainder are under investigation. The common theme that runs through all these claims ranges from the service user's being unhappy with care and treatment, attitude of staff, delay in accessing services following a referral, belief of incorrect diagnosis to belief that incorrect and false information has been recorded in medical records. Notably, of the 7 claims, 4 commenced due to the dissatisfaction with their complaint's response.

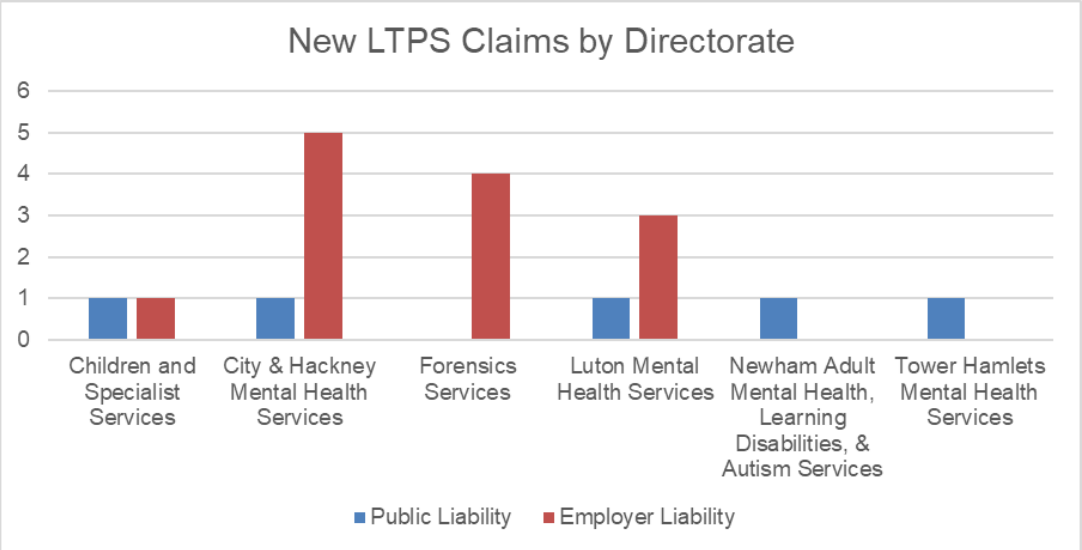
3.27 The Team has started to meet with the Complaints team regularly in order to identify complaints that are likely to turn into claims from litigants in persons to see if they can be resolved at the complaints level. The Teams are working well together and believe there are further programmes of work that can be undertaken jointly to stem some of the increase in these types of complaints and claims.

3.28 Overall, the Trust's benchmarking exercise shows that the Trust does not have excessive CNST claims in comparison to other London and other mental health Trusts. It is anticipated that this is because, the Trust's incident reporting system catches most incidents that go onto to be claims and they are well investigated in advance of proceedings. This assists in preventing claims, early resolution (through means other then the courts) as well as shortening procedures.

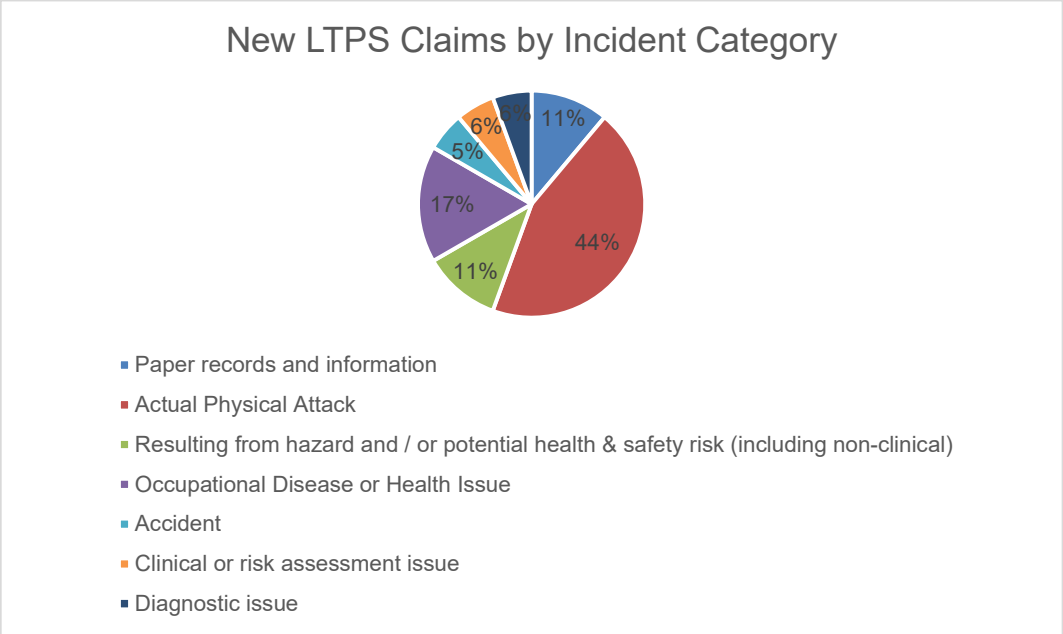
4. EMPLOYER LIABILITY AND LIABILITY TO THIRD PARTIES (LTPS)

4.1 New LTPS Claims

4.2 Between 1 April 2024 and 31 March 2025, 18 claims were received under the LTPS scheme. Last year 24 claims were received. The graph below shows these broken down by Directorate.



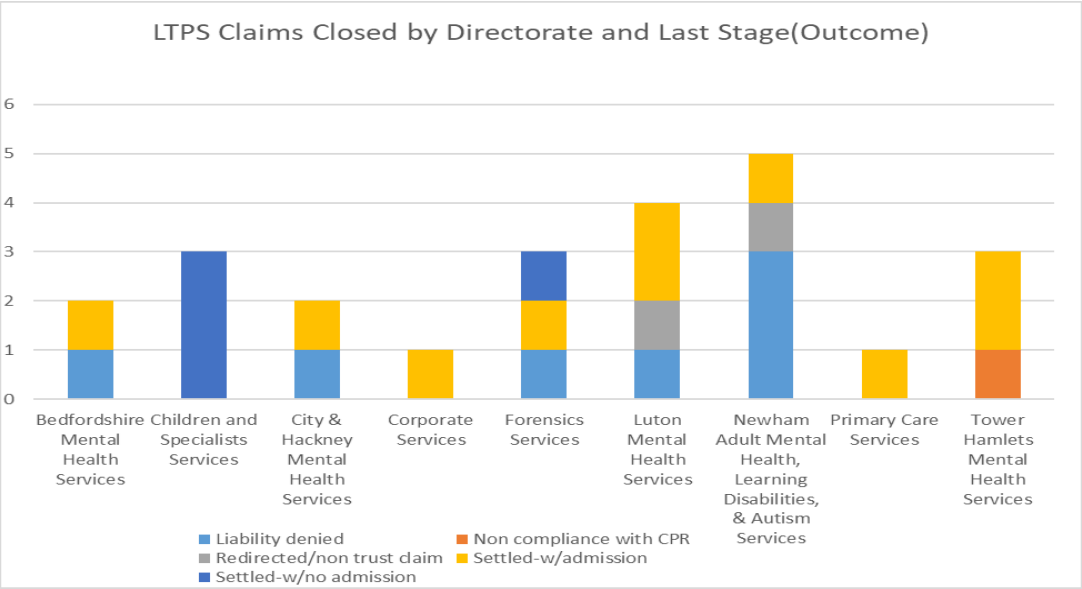
4.3 The graph below shows number of claims received during this period broken down by type. The highest number of claims received during this period were for violence and aggression. This is consistent with the last and previous years.



4.4 Closed LTPS claim

4.5 Between 1 April 2024 and 31 March 2025, 24 claims were closed under the LTPS scheme.

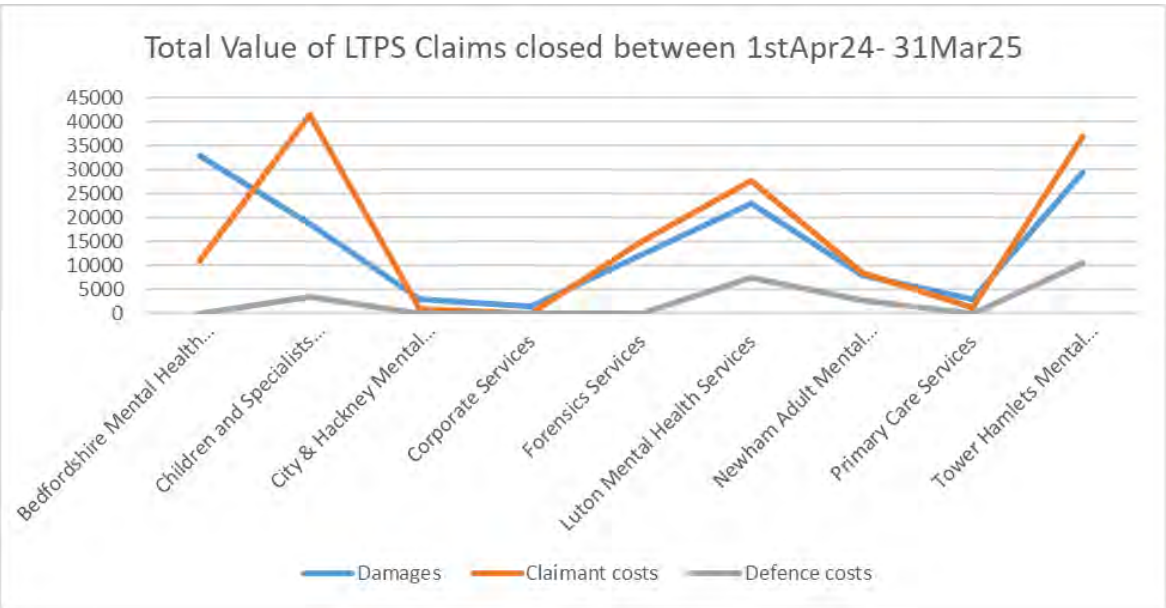
4.6 The graph below shows the number of claims closed during this period split by outcome and Directorate. Last year the Trust denied liability in a large portion of claims. This year 60% of closed claims were settled.



4.7 Total value of LTPS claims closed between 1st April 2023 and 31st March 2024

4.8 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.

4.9 The graph below shows the total value of the claims closed between 1st April 2024 and 31st March 2025.



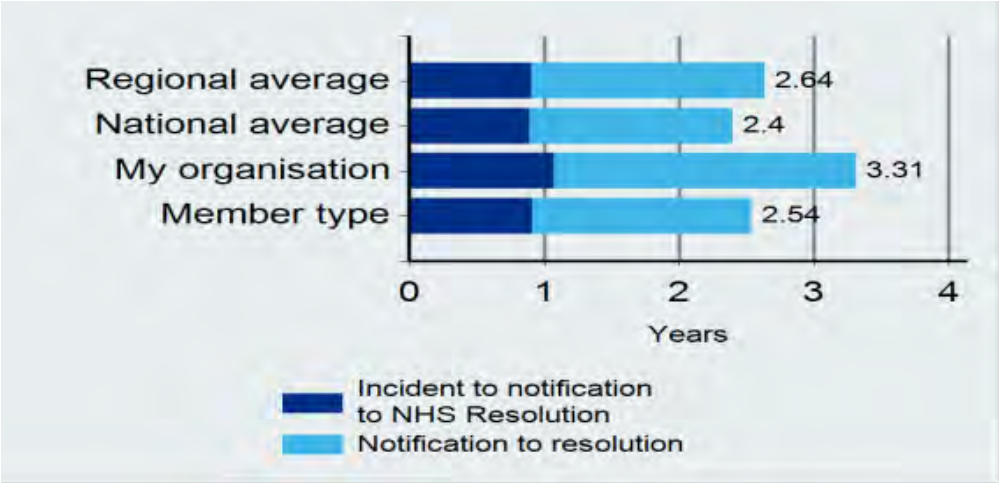
4.10 Damages - £131,873 (2023/24 £52,443)
4.11 Claimant legal costs – £109,209 (2023/24 £72,061)
4.12 ELFT legal costs – £24165 (2023/24 £23,626)
4.13 Total - £265,247 (2023/24 £148,130)

5. LTPS Claims Benchmarking

5.1 An exercise was undertaken to benchmark the Trust's LTPS claims. It was measured how long the Trust resolves claims in comparison to other Trusts across the country and the number of claims received by ELFT in comparison to both other London Trusts and other Mental Health Trusts.

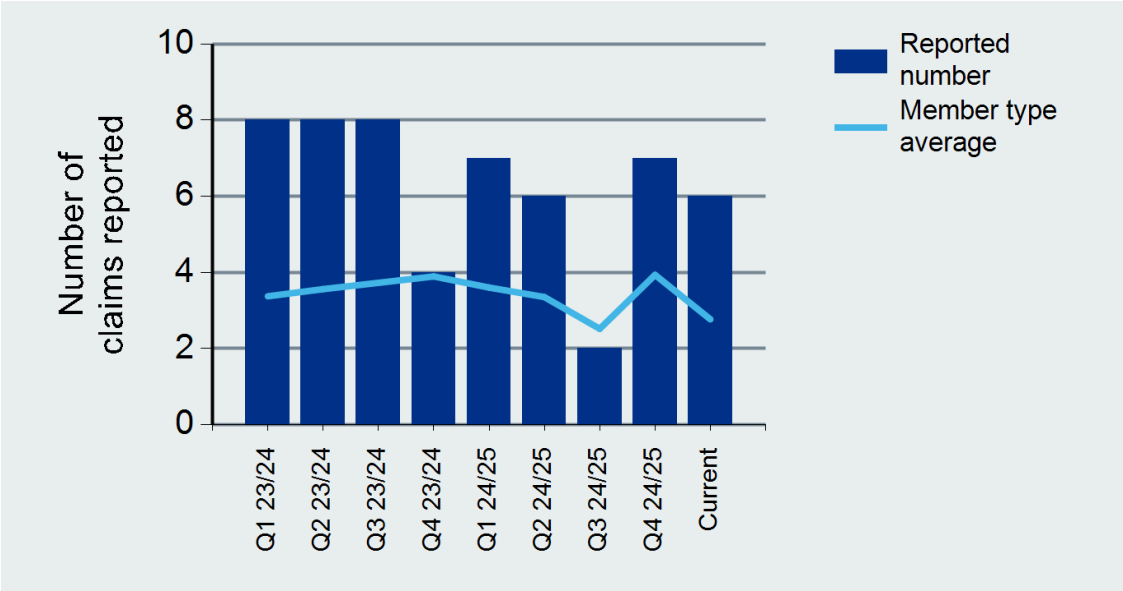
5.2 Time to Resolution

5.3 The graph below shows the number of claims the Trust has received from Q1 23/24 to date in comparison to the average number of claims received by other Mental Health Trusts. For the purposes of this report, our focus is on Q1 24/25- Q4 24/25.

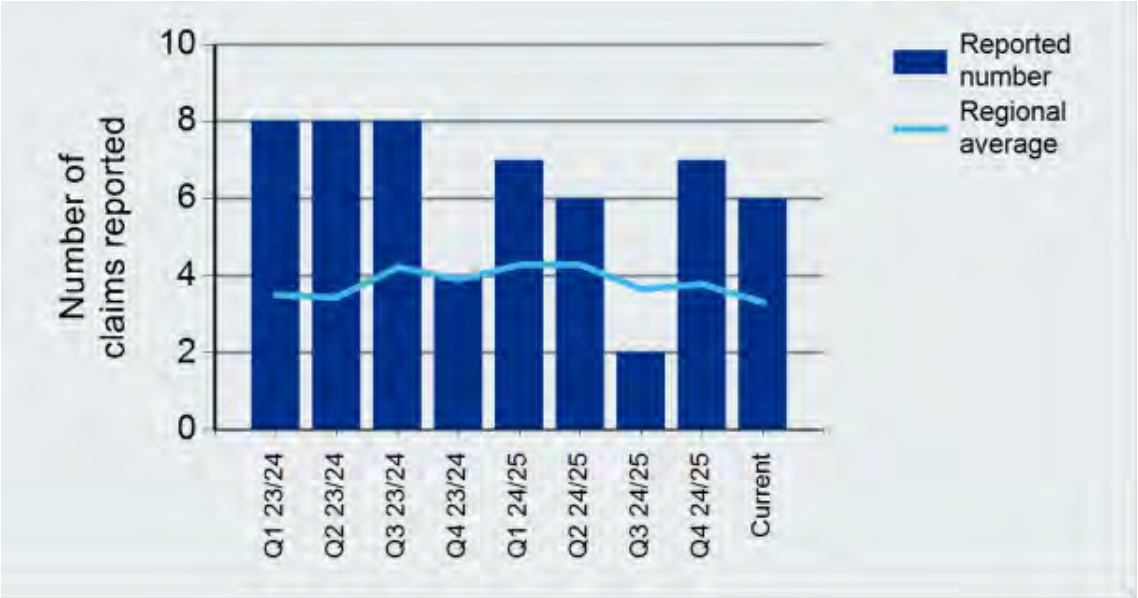


5.4 Number of LTPS Claims

5.5 The graph below shows the number of the claims the Trust has received from Q1 23/24 to date in comparison to the average number of claims received by other Mental Health Trusts. For the purposes of this report, our focus is on Q1 24/25- Q4 24/25.



5.6 The graph below shows the average number of claims the Trust has received from Q1 23/24 to date in comparison to the average number of claims received regionally. For the purposes of this report, our focus is on Q1 24/25- Q4 24/25



6. LTPS Trends

6.1 Of the 40 open claims, violence and aggression claims remain high making up 57.5% of the LTPS claims. We have admitted or currently settling over 50% of these claims as the Trust failed to defend these due to lack of updated care plans and risk assessments, insufficient staffing levels, lack of Safety and Intervention training for Bank staff and lack of security at reception.

6.2 ELFT is one of the defendant Trusts in the Covid class action claim. The claimants in the ELFT claim are 2 doctors who are alleging to have caught COVID whilst working on the Wards at the height of the pandemic. All defendant Trusts are being represented by 2 Court appointment firms and all claimants are being represented by 2 specific firms. Management of this class action is currently “in closed court” between the legal teams and the Judge. Trusts are currently in the middle of information and document collating which (in order to mount a successful defense) should show that all government guidelines at the time were followed, disseminated to every staff member in a reasonable manner, enough and appropriate PPE was provided to all staff, all health and safety regulations were followed and all relevant risk assessments undertaken etc.

6.3 We have recently received an asbestosis claim where the claimant’s employment dates back to the 60s. It is reported that following the completion of his apprenticeship with his employer at the time (Pinching & Walton), the claimant spent 7-8 weeks at St Clements Hospital where he worked in a loft that was lined with asbestosis insulation sheeting. This sheeting was subsequently removed where a great amount of dust was generated and it is reported that the claimant was not provided with any mask and as a consequence it is alleged that he was exposed to a major risk of fatal injury by inhalation

of asbestos dust. Having reported this claim to our Insurer, we have been advised that the Department of Health will be the main defendant in this matter. However ELFT will need to provide any available information that could assist with this case. To that end- our Insurer has instructed a solicitor to assist ELFT in collating any information from the Trust that may assist in this matter.

6.4 As mentioned at para 4.3, there has been a rise of litigants in persons. 5 claims have been brought under the LTPS scheme where the allegations range from continuing acts of discrimination, breaches of statutory laws to a flooded bathroom that led to a slip. Two of the claims follow on from dissatisfaction of the complaint process.

6.5 The benchmarking shows that ELFT does not perform well compared to other NHSR London or Mental Health Trusts. The Trust and the QAC are aware (through this yearly report) that assaults account for the highest number of LTPS claims. There are concerns as to how these incidents are recorded across the Trust. There is scope for improvement which would help manage the resolution more promptly.

6.6 NHSR has a new rating system for types of claims. Currently, the Trust is scores RED for violence and aggression claims. This means that NHSR recommends that ELFT take immediate action to reduce the number of violence and aggression claims as it has significantly more than other like Trusts across the county. We suspect the number of violence and aggression claims account for ELFTS increased number of LTPS claims. The Team's analysis is that a focus on updating Risk assessments and ensuring that Bank Staff are included in safety huddles and receive safety intervention training would significantly reduce numbers.

6.7 We do note that there is a great deal of work across the Trust to improve risk assessments. We will be exploring whether lack of updated care plans and risk assessments, insufficient staffing levels, lack of Safety and Intervention training for Bank staff and lack of security at reception at the non-pay work stream meeting with oversight form the Chief Nurse. Understanding these problems and prioritising solutions This could assist in both reducing claims and improving staff and service user safety on words. We have already experienced the effectiveness of this approach in managing the Trust's Ex Gratia claims.

7. Action Being Requested

7.1 The Board/Committee is asked to:

RECEIVE and **DISCUSS** the findings of the report

NHS East London NHS Foundation Trust

MEDICAL EDUCATION ANNUAL REPORT TO THE QUALITY ASSURANCE COMMITTEE

07 JULY 2025

Title	
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

To set out progress against the workplan for the past financial year, and to set out proposed workplan for the coming financial year.

Committees/meetings where this item has been considered

Date	Committee/Meeting

Key messages

This report highlights our key achievements, challenges and quality interventions that have taken place in the last year. Progress continues to be made with Faculty Development initiatives, led by our Faculty Development Lead, IMG Lead and Faculty Development Coordinator roles, to enable Medical Education 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, and further collaboration opportunities with negotiations with the University of Anglia taking place for the hosting of a number of additional international medical students, which will also bring in extra funding.

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, along with on-going work to support our 'future plan' for improving the trainee experience of psychotherapy training in-Trust etc.

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.

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 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 and expect for the 2025-26 academic year that UNiC placements will be increased to 15 students based on discussions held and agreements made in the 2024-25 academic year.

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:

Place of Excellence in Psychiatric Teaching and Practice

- *Med Ed @ELFT Facts:*
  - At the heart of Medicine and the people we serve; strong links into diverse communities
  - QI and Research driven
  - Experiential Learning Centre
  - Clinical Leadership model
  - Centre of excellence for innovative Arts/-nonverbal therapy services
- *Med Ed @ELFT **P**rinciples*
  - **P**eople **P**articipation (co-production) focused; emphasis on subjectively defined recovery goals
  - **P**assionate about **P**atient care
  - **P**opulation Health targeted
  - **P**romoting staff wellbeing support
  - **P**rioritising outcome related support systems (subjective quality of life)

We care We respect We are inclusive

2 Progress against work-plan during last financial year

2.1 Key achievements

Postgraduate

Medical Education Faculty Away day: In November 2024, the Medical Education Faculty regrouped to review progress against our current Medical Education 5 year plan (2024-2029), and reflects key components of quality in all clinical learning environments for all learner groups and our commitment to developing a sustainable workforce. This is mapped against the HEE Quality Framework 2021 as well as the NHS People Plan, aligning to ELFT's primary driver of improved experience of staff. The 2024 Away Day was well attended, with a number of trainee reps also present. Positive feedback was received and engaging conversations held regarding progress made to date eg. through developing and supporting supervisors and SAS / IMG doctors (Faculty/SAS/IMG development), curriculum matching to deliver a high quality MRCPsych teaching programme for our trainees and SAS doctors, improved trainee feedback channels that lead to change, and continuing to develop and deliver our simulation agenda. Conversations also highlighted where some challenges remain, which will be covered in the relevant section below.

Faculty / IMG / SAS development: We continue to develop and deliver our Faculty Development agenda with the help of our 2023 appointed Faculty Development Lead and Faculty Development Coordinator - our Educational and Clinical supervisor courses remain very popular, and we have run extra (supervisor) Coaching and Mentoring courses because of high demand. In January 2025 we also ran a very successful course on supporting Resident Doctors with workplace aggression, which involved the NHSE appointed Training Programme Director for London who leads on this work-stream. Feedback for all courses remains positive and our approach remains focused and targeted, ensuring that all training aligns with the seven core domains mandated by Health Education England (HEE). This alignment supports not only the development of our doctors but also complements the appraisal process of Educational Supervisors, fostering continuous professional growth and excellence in clinical education.

Led by our 2023 appointed Trust IMG Lead and two IMG Peer Advisors, we also continue to progress and develop our support offer for IMG (International Medical Graduates) doctors in

the Trust - in 2024, we were successful in obtaining approval from the General Medical Council to recruit Advanced International Fellows and we now have the first AIF in post. We have made improvements throughout 2024/25 in offering support for IMGs and were at 63.85% compared to overall NHS benchmark of 58.78% (MWRES audit). We have worked extensively with IT to have a bespoke IMG induction resource now freely available online on the ELFT website, linked to the International Recruitment page, and we plan to further develop the website with discussion around collaboration with the internal ELFT Learning Academy as well as inter-organisational initiatives. In 2024, we co-produced and delivered, with IMG involvement (IMG Peer Advisors), an initial Communication Skills Workshop for IMGs, which received excellent reviews. We have also recently linked in with the cross-disciplinary IMG support network across London and the Capital Doctor project.

As part of SAS Week, an SAS Wellbeing Away Day was held in October 2024. The day offered a varied programme and concluded with a session centred on wellbeing and coaching, providing attendees with valuable tools and reflections to support their professional and personal resilience, and was one of our best-attended events to date. The event reflects the Trust's ongoing commitment to the development, wellbeing, and recognition of SAS doctors within ELFT. Our SAS Continuing Professional Development (CPD) programme continued to be delivered successfully throughout 2024-25, with positive feedback received, led by Medical Education appointed SAS Advocate, SAS Tutor and Faculty Development roles. We have also supported the development for SAS doctors to become educational / clinical supervisors and appraisers in ELFT, with SAS doctors encouraged to complete training now available through SAS CPD opportunities. The Leadership Programme for SAS doctors successfully completed two cohorts across 2024-25, receiving positive feedback and strong engagement. These sessions enhanced leadership skills and contributed to professional development within this group. An example of the development of our SAS doctor cohorts being enabled to take on more leadership roles in ELFT can be seen with the appointment in November 2024 of an SAS doctor to co-lead with a substantive Consultant the post of Undergraduate Lead for City & Hackney.

Simulation: Led by our Trust Simulation Lead, progress continues to be made with our simulation agenda - we obtained a grant from the London Simulation Network (via NHSE) for peer review of our simulation courses and to offer peer review to other centres. This was completed in March 2025 with very good feedback from CNWL, a lead simulation Trust in our region, regarding our simulation courses. We have also embedded simulation training in the resident doctor induction, for Core trainees new to psychiatry and new ST4 higher trainees joining the rotation. For the ST4 trainees this is jointly delivered with NELFT. We continue creating a Simulation Faculty and we now have 10 people joining meetings regularly representing other staff groups. To support this we have joined with 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. This was piloted in February 2025, with positive feedback received. Service user involvement in the co-production and delivery of simulation programmes continues and they are an active part of the debrief. In Luton & Beds we also have a Quality Improvement project underway to expand the delivery of Simulation Facilitator training to resident doctors, to improve engagement in teaching, as well as experience of learning via simulation within their own training.

Redistribution of training posts/trainee expansion posts: The NHSE led redistribution of training posts programme (2022-32) aimed to impact health inequalities by reviewing and aligning tariff-funded specialty training placements to the areas of greatest healthcare need across England. In turn this was anticipated to support a fairly distributed overall medical workforce to provide current and future patient needs. Psychiatry was part of a later implementation phase and there were a number of difficult conversations held through 2023-24 regarding the need to highlight a number of our training posts to be lost to other training regions as part of the programme. In December 2024, however, we received notification from the National (redistribution) Team that the programme wouldn't be continuing and no psychiatry training posts would be lost. At the start of 2025 we received notification from

NHSE of the opportunity for a number of trainee expansion posts across London and East of England. We were ultimately able to successfully bid for 6 new 50% NHSE funded training posts in total (4 for London and 2 for Luton & Beds), which turned a number of previous 100% Trust funded posts into 50% NHSE tariff funded or utilised current budgeted wte available to enable additional wte, with the additional NHSE funding and overall Trust savings these posts would support. The 6 new posts cover specialty areas such as CAMHS and Old Age that have been highlighted by NHSE as areas requiring particular focus to support our changing local population needs.

Undergraduate

International Medical students: We continue to successfully support an ongoing rotation of medical students from the University of Nicosia. Academic placements continue to go well, with positive feedback consistently received (our placements generally receive the highest feedback scores across the placement scheme) and we are currently planning for the 2025/26 cohort of UNiC students, with an agreement in place to increase our student numbers and the additional funding this will provide. In December 2024, with the help of our ELFT Contracts team colleagues, we also negotiated and agreed a higher per student, per week rate which came into effect in the Spring 2025 semester continuing, We are also currently in negotiation with the University of Anglia regarding another international collaboration, with final details and agreements to be confirmed for hosting a number of medical students, which will also bring in additional funding, with a planned placement start date of January 2026.

QMUL (London) and University of Cambridge (Luton & Beds) medical students: We continue to support a significant number (500+) Year 1 (Physician Associate), Year 2 and Year 4 medical students across London and Luton & Beds:

i) Our second Quality Assurance site visit in Luton & Beds was held in November 2024, involving the UoC Clinical Dean and other senior UoC alongside ELFT Medical Education and senior Trust representatives. Student feedback remains very positive overall and thanks were received from the Clinical Dean - 'This is a placement that works well and thanks were conveyed to the Trust for providing such a good placement' - a mid-Quality Assurance cycle meeting has also taken place in May 2025 to review action points from the November 2024 meeting and once again no issues or points of concern were highlighted or raised.

ii) In Luton & Beds we agreed an increase in our student numbers for 2024/25, to a maximum of 48. After trialling a ‘what to expect in psych’ session with an FY doctor leading, we will continue with this session at induction. Student feedback has been positive and they appreciate this informal Q&A session. To support this, posters have been designed and distributed to wards and Drs offices so they are aware of student learning expectations and the placement curriculum.

iii) Our 2025 London Quality Assurance site visit by QMUL was held in-person in March with positive feedback again received from the QMUL visiting team; moving forwards this will now be a biennial occurrence. The conversations were based around direct feedback given by medical students in advance of the Trust meeting and a number of action points were discussed and agreed eg. induction changes and a move to having in-person inductions compared to on-line. We will be regularly engaging with and feeding back to QMUL the impact of these changes requested, considering our concerns this may have on the attendance and engagement of medical students in key induction information provision in advance of placements starting.

iv) Formal teaching sessions of QMUL Y4 students, delivered by our Medical Education Fellows, have been transformed with all sessions during the five-week clinical placement-teaching block now being Team Based Learning (TBL) in place of traditional lectures piloted. These sessions cover all of our Psychiatric Specialties. The feedback has been exceptional for these sessions and attendance has vastly

improved. The development and delivery of these new sessions has again benefitted from the collaboration and involvement of colleagues from the Academy of Lived Experience.

v) We are currently hosting the final cohort of the 2024/25 Y4 QMUL medical students for their psychiatry placements. Our five clinical placement localities continue to receive overall positive feedback from students. Themes that emerge from informal feedback are that students feel welcomed, included and valued more so than on many of their previous placements.

2.2 Challenges & Related Actions

GMC trainee survey / formal quality interventions: Following the 2024 GMC trainee survey results highlighted concerns by Core and GP trainees on rotation in Tower Hamlets locality eg. regarding workload, handover and supervision, Medical Education in liaison with NHSE, local service leads and trainees methodically worked through related NHSE Trust actions towards resolutions. To enable this we first completed and submitted a Trust self-report, which confirmed what action we'd be taking to resolve the issues raised – this included adding additional agenda items to be covered in local trainee led resident/senior meetings, trainee rep led local trainee only forums with specific questions set by Medical Education asked of trainees, there was significant investment from the directorate management team into capacity and flow work, resulting in reduced bed occupancy on the wards, and effective clinical supervision was discussed in local senior Consultant meetings, with supervisors reminded to go through clinical competencies with their trainees at the start of their placement.

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 (Resident Doctors Forum, local Resident/Senior meetings etc), we also continue with the monthly meeting between Medical Education and trainees reps, to provide an open forum for trainees to feedback to us, along with the on-going monitoring 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.

Physician Associates / Medical Apprenticeships: NHSE withdrawal of central funding for Physician Associates (PA) work-streams in the last financial year and moving forwards continues to create a challenge for this previous Medical Education priority – further to financial implications highlighted in last years' report, NHSE funding to support additional programmed activity payments for our Medical Education Associate DME, to lead on PA work-streams, ceased at the end of 2024. Funding sourced to enable our former PA Ambassador to work with us for a small number of hours on an ad-hoc Bank basis, to continue with our PA work-stream and to support PA development, ceased at the end of March 2025. Our Luton & Beds fixed-term Band 4 Administrator, initially recruited on a 12 month fixed-term contract in September 2023 with NHSE funding to support the PA work-stream but role expanded to provide wider Medical Education key administrative support for Postgraduate and Undergraduate activities in L&B, was extended using short-term Medical Education funding highlighted but this ceased at the beginning of April 2025; a business case to make the role substantive was submitted in January 2025 but no outcome has been received to-date, which links to the significant financial pressures and restrictions currently

faced by the Trust, alongside of the withdrawal of central funding for this particular work-stream.

Physician Associate numbers are also currently reduced in-Trust, impacted through the UK-wide conversation regarding use of Physician Associates within the NHS. We do, however, continue to support our current PAs eg. through on-going conversations regarding formal GMC recognition of their clinical status and related internal clinical revalidation processes being considered for implementation. Progress regarding the new Medical Apprenticeship model is also currently on hold, awaiting news from NHSE regarding this being rolled out considering recent government changes, with both elements being outside of Trust control.

Medical Education Cost Pressures: The department continues to operate under cost pressures and whilst we have undertaken a number of internal reviews, to ensure we're both maximising our external income streams and also following Trust financial restrictions and protocols, conversations continue with internal Finance regarding these cost pressures and the need to review NHSE Trust funding received, to support historic Medical Education faculty appointments and our educational activities and work-streams.

Psychotherapy: One of our priorities for the year ahead in our 2024 report was to implement 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 following the 2022 GMC Survey results. Some positive progress has been made eg. through review of our CBT introduction course offer for Core Trainees, in collaboration with NELFT colleagues, to ensure equal opportunities for trainees on rotation in both Trusts to complete this course, which supports them completing psychotherapy short case training requirements. We have, however, recently been made aware of concerns fed back by a number of (London focused) psychological services who support trainee supervision opportunities for short and long case completion, around the impact service re-configuration and Trust Financial Viability (FV) measures are having on supervision opportunities for trainees on rotation in ELFT. An initial meeting, led by Medical Education, between Clinical Directors and Trust and Local Psychotherapy Leads took place in May 2025 and further information around this and related actions will be covered in the key priorities section below. We have also reached out to trainees on rotation, to ask they feedback directly to Medical Education, any concerns or issues they are having regarding meeting their psychotherapy training competencies.

For the Lead Psychotherapy Tutor role for ELFT, this post is currently appointed to, however, this is still job planned in SPA time and in the current climate of FV no progress has been made to support this role through paid additional programmed activity.

SAS/Faculty development: While overall engagement was encouraging in 2024/25, a small number of courses have encountered challenges with attendee attendance and participation. In response, active follow-up with non-attendees is underway. This issue will be reviewed in collaboration with our doctor cohorts and related faculty leads, with further consideration given to the management of persistent non-attendance should this remain a concern. We are also currently reviewing our 2025/26 offer to ensure it's targeted and there's no saturation or repetition/over-delivery of development courses that are no longer supported as needed considering course sign up or attendance data.

General: 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. There are currently plans in place to review and enhance clinician job planning, which we expect will help address this issue moving forwards.

3 Work-plan for the coming financial year

3.1 Key priorities

SAS/IMG/Faculty: Whilst we continue to achieve and deliver in this area, SAS/IMG/Faculty development will remain an important priority for us moving forwards - informed by feedback from last years' participants, to ensure the programme is both comprehensive and responsive to the evolving professional development needs of our medical cohorts, a refreshed and diverse CPD programme is planned for 2025/26, designed to reflect the identified needs and interests of our workforce. The upcoming offer will include a broader range of topics such as career development, support for doctors in difficulty, and other areas prioritised through participant feedback. We will also continue to explore and support recently linked in areas with the cross-disciplinary IMG support network across London and the Capital Doctor project. Linked to the above and 'challenges' previously highlighted, we employ a constant review process, closely monitor course delivery and will make any adjustments needed through direct engagement with medical cohorts, feedback received and through regular meeting forums already in place where any issues, impact and related actions can be discussed and agreed as needed.

Simulation: Whilst initial support for simulation development within MDTs is very positive, and some progress has been made in expanding our Simulation Faculty, our aim is to further develop ELFT's definition of Simulation and how we can incorporate it further in MDT settings – we will continue to work with NELFT colleagues to deliver the bespoke train the trainer package to do in-house simulation based training for staff who want to join the Simulation Faculty, and will monitor progress based on engagement and evidenced by further expansion of our Simulation Faculty and wider engagement by MDTs and other staff groups. Based on previous trainee feedback received we are creating two more simulation courses for resident trainees, to improve their human factors skills and confidence during their training**,** a bid was submitted and approved for SuppoRTT (Supported Return to Training) in Luton & Beds to fund simulation sessions for Core and Higher trainees and we will continue to engage with and adjust our offer based on feedback received which is discussed in regular meeting forums already in place. Considering we were unsuccessful in highlighting funding to continue with and appoint to a 12 month Medical Education (Simulation) Fellow for 2025/26 academic year, we are also currently actively following up a Trust Deputy Simulation Lead appointment attached to a substantive Luton & Beds medical role, to assist with supporting our simulation agenda.

Psychotherapy: Considering the update confirmed in the previous 'challenges and related actions' section, implementing our 'future plan' for improving trainee experience of psychotherapy training competency delivery in ELFT will continue for the foreseeable. At the meeting held in May 2025 to discuss recent service feedback received, it was agreed a more thorough and widespread review of and conversation with services that can support trainee psychotherapy training requirements was needed. This is currently underway and a follow up meeting has been set up to discuss and review the findings. This will again involve Medical Education, Clinical Directors and

Psychotherapy and Psychological service leads. Our plan will be adapted as needed dependent on future conversations to come, and we will again be utilising our trainee feedback forums and tools highlighted within this report across the year to gauge experience through direct feedback received, and to ensure trainees continue to feel supported in meeting their psychotherapy training competencies.

Knowledge and Library Service provision: One of our key priorities for the upcoming year relates to knowledge and library service provision for all staff within ELFT, which Medical Education is intrinsically linked to considering the annual cost of the library service contract with the current provider, Homerton (Newcomb) library, has historically been covered by Medical Education - library service costs have increased for 2025/26, on the basis of payment for services actually delivered, and related to this the Trust is also assessed by NHSE against 16 key standard indicators, considering ELFT receives funding from NHSE to deliver knowledge and library services to all of our staff. There is currently a Trust wide review taking place, involving all relevant ELFT professional leads (Medical, Nursing, AHP, Pharmacy etc) which comprises a number of related meeting forums - the focus of these meetings and conversations are based around defining a Trust strategy for knowledge and library service provision for all ELFT staff, better understanding NHSE funding and internal finances towards a wider contribution from other professional groups beyond medical for knowledge and library service provision, along with greater understanding and wider promotion of services both currently available and additionally those that will form part of our Trust strategy to support this service provision moving forwards.

GMC 2025 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 2025 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 2025 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. Local leaders, as needed, will be engaged with via monthly Med Ed led Postgraduate Lead meetings, monthly Medical Managers meeting forum and further ad-hoc meetings as/if needed to discuss progress and any on-going actions.

4 Action Being Requested

4.1 The committee is asked to: **RECEIVE** and **NOTE** the report

NHS East London NHS Foundation Trust

ANNUAL REPORT
TO THE QUALITY ASSURANCE COMMITTEE
7 July 2025

Title	Annual Report on Research and Innovation
Author	Karin Albani, Associate Director of Research
Accountable Executive Director	David Bridle, Chief Medical Officer

Purpose of the report

To present the Research & Innovation (R&I) activities which took place in the Trust over the last year and set out the objectives for the coming financial year.

Committees/meetings where this item has been considered

Date	Committee/Meeting
	Research Committee (circulated to membership for comment)

Key messages

Innovation and research are key aspects 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. The R&I team aims to broaden ELFT's research portfolio with a view to engage with commercial studies, initially focusing on Dementia research.

In a letter to all NHS trusts / boards from 30th May 2025, NHSE stipulated the following:

- establish board-level reporting of research activity and income, with scrutiny of the UK Clinical Research Delivery (UKCRD) programme site level performance metrics for study set-up

Strategic priorities this paper supports

Improved population health outcomes	☒	Evidence shows that clinician and healthcare organisation engagement in research is linked to improved healthcare performance[1]. Patients treated in UK trusts with strong research activity experience better health outcomes[2].
Improved experience of care	☒	Patients consistently report highly positive experiences of participating in research, often highlighting feelings of empowerment and strengthened relationships with their clinical teams. The National Institute for Health Research (NIHR)[3] annual surveys consistently shows that over 90% would be willing to take part in research again.[4]

[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.

[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)

Improved staff experience	☒	Healthcare staff involved in research also report positive personal and professional outcomes. This involvement can support the recruitment and retention of skilled, committed staff and foster a culture of enthusiasm, innovation, and continuous improvement. Reflecting this, the Royal College of Physicians now emphasizes research as an integral part of direct clinical care.[5]
Improved value	☒	Research is recognised in the NHS Constitution[6] and is a core objective in NHS England's Long Term Plan[7]. Reflecting its importance, the NIHR presented supporting evidence to the Care Quality Commission (CQC), which now includes research-related questions in the "well-led" domain of its assessments of NHS 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. Background/Introduction

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. The R&I function – as part of a broad innovation portfolio, encompassing Quality Improvement, service evaluations, trainees' degree projects, right up to externally funded research grant programmes – is driven by the improvement needs of the Trust's Places and Clinical areas.

Every day in the UK, someone receives a diagnosis for a disease or health condition. The treatment, care and support they receive will be shaped by research, ensuring that NHS patients continue to benefit from improved and modern services, and helping to deliver better outcomes to patients across the country. There is a significant body of evidence to show that research active trusts have better patient outcomes. The benefits of research apply at all levels from the individual patient to the entire population.

Research is fundamental in providing the evidence we need to transform services and improve outcomes, it is essential to find out which treatments work better for patients and plays an important role in discovering new treatments, making sure that we use existing treatments in the best possible way and improving the quality of life for people living with illness. Research can find answers to things that are unknown, filling gaps in knowledge and changing the way that healthcare professionals work. Patients who participate in research have the opportunity to access cutting-edge treatments.

[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)

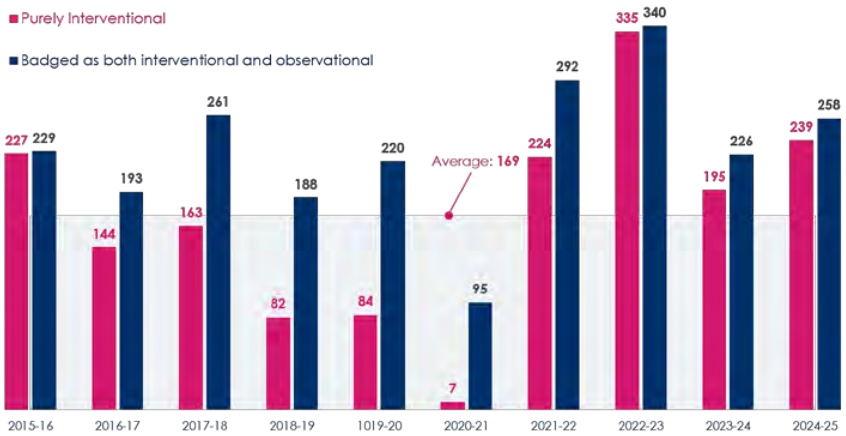
[8] Care Quality Commission (2018) *CQC Inspection framework: NHS trusts and foundation trusts: Trust Wide Well Led* (W8)

2. Key achievements during last financial year

The team pursued a deliberate strategy to prioritise enrolment into interventional studies, where patients are offered treatment options they would not otherwise receive outside of research – although recruitment into such studies is much more resource-intensive than for a simple survey. Our focus proved successful, and enrolment in interventional studies this year was more than 50 percent above our own average and a third above the average for community and mental health trusts across London.

As a result of that strategy, overall recruitment into research studies in 2024/25 decreased from our previous year's high and we enrolled just under 700 participants enrolled into 27 studies from the Department of Health and Social Care's (DHSC) National Institute for Health Research (NIHR) research Portfolio.

Figure 1: Recruitment to Interventional Studies



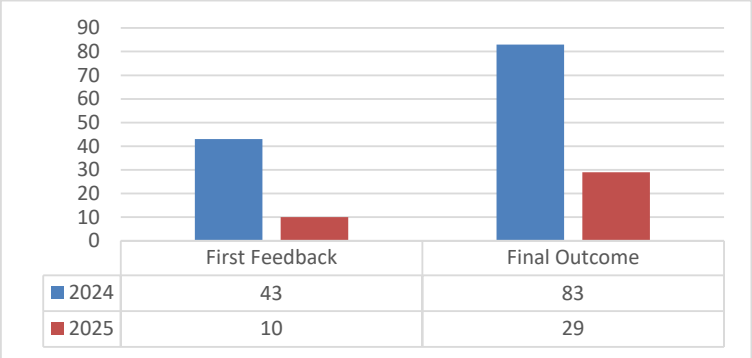
Support for evaluation projects

A key objective of our 5-year plan was to position the R&I function as part of a broader innovation portfolio, encompassing Quality Improvement, service evaluations, trainees' degree projects, right up to externally funded research grant programmes.

Established in 2018, the Trust's Governance and Ethics Committee for Studies and Evaluations (GECSE) has a two-fold role a) to ensure that studies taking place at ELFT comply with regulatory and ethical standards; and b) to provide recommendations to support the delivery of the best science possible so that the organization can confidently rely on study outcomes.

With the creation of a new Research Operations Coordinator, who plays a key role facilitating the work of the GECSE, we have reduced the time required for applicants to receive an outcome by two-thirds, even as the volume of applications is on track to increase by 30% over the previous year (17 applications in first 5 months 2025, versus 31 in full year 2024).

Figure 2: Working Days to First Feedback and Final Outcome



Focus on Equality, Diversity and Inclusion

A significant objective for 2024/25,[9] was to pilot a specific EDI Lead for Research at ELFT. In this role, Rahul Bhattacharya has attended the national UKRD Inclusion symposium in July 2024 linkin gup with other members of the EDI research community, and has since been appointed to the *UKRD Inclusion Working Group* (December 2024).

Within ELFT he has regularly shared findings of recent research linked to EDI at appropriate platforms to ensure latest learnings from these influence service delivery, trust strategy and policy, presenting to the trust EDI board (early 2024) and PCREF (Patient and Carer Race Equality Framework) working group (Jan 2025). His full report on first year's activities is Appendix A.

The North London Regional Research Delivery Network (RRDN) viewed this pilot as a success, continuing to fund the post in 2025/26 and Rahul has been appointed to lead their EDI working group.

A research hub in Bedfordshire and Luton

This year, facilitated through the academic partnership between ELFT and the University of Cambridge, we successfully re-launched the Bedfordshire and Luton (B&L) Research Hub to increase research capacity, embed a culture of collaborative research, and improve representation. During its first year, the hub has successfully brought together research-enthusiastic staff across the region with some notable successes including: research activities. The hub intends to foster integrated research across the traditional boundaries of physical and mental health care.

- Co-designed a research engagement plan with established CYP social prescriber link workers and piloted 'Research Champions', who underwent bespoke CYP mental health training to engage with the diverse communities in Luton in CYP health.
- Menopause and Mental Health pilot service funded by the Bedfordshire, Luton and Milton Keynes (BLMK) ICS to raise awareness among both the workforce and service users, while improving clinical services for women in the premenopausal and menopausal stages of life.
- B&L memory team has now embarked on their first commercial trial Five-lives that is exploring the use of an app to boost brain health and improve cognition.
- Raised the research profile at ELFT and collaboration in Bedfordshire including constructing our own local priorities which have informed the development of the BLMK ICS research strategy "pillars"

2.1 Challenges

Divestiture of primary care

The partnership with the Primary Care Unit at Cambridge University will be inevitably impacted by the decision to largely exit from primary care in Luton/Bedfordshire, not least since the appointed Assistant Professor of Primary and Community Care is a GP by background. As seen above, the momentum in 2024/25 was very positive in Bedfordshire and Luton. We will need to carefully consider in 2025/26 which services in ELFT can most benefit from collaborating with the university.

Structural reorganisation in the wider context

During 2024/25, the NIHR replaced the Clinical Research Network (CRN) with a new Research Delivery Network (RDN) and have spent the past 18 months reviewing the support and funding the new network provides to partner NHS providers. Unfortunately, this resulted in uncertainty when staff turnover resulted in vacancies in the network-funded posts and, as a result, the team was under-resourced for much of the year.

Impact of financial reviews

Given the challenging financial position, the plan for ELFT's Forensic Service to establish a research unit[10]—funded through the North London NHS Forensic Collaborative—was delayed in

[9] Objective ¶3.1.2 from 2024 Annual Report from R&I
[10] Objective ¶3.1.4 from 2024 Annual Report from R&I

2024. However, plans remain in place to set up the unit, albeit with a reduced staffing model, in the 2025/2026 financial year.

The unit will promote research to improve the quality of forensic services by providing dedicated capacity for clinicians to engage in research activities. The proposed Forensic Research Unit (FRU) will fund several dedicated research posts and offer protected, funded time for clinicians to conduct research. It will also include training opportunities for post-holders in research skills such as thematic analysis, Delphi interviews, statistical software, and research ethics.

The FRU is expected to involve a multidisciplinary team, including qualified psychologists, trainee psychologists, master's students, and allied health professionals (AHPs).

Similarly, the University of Lancashire's bid to develop a Mental Health Research Group (MHRG) in which ELFT would be a designated mentor institution[11] has had to be significantly reworked and resubmitted to reduce costs.

3 Objectives for the coming financial year

Innovative mental health care service delivery

In 2023 a delegation of ELFT started to explore the Trieste community care service model with a visit to local services. Subsequently, ELFT decided to pilot corresponding 24/7 community services and successfully applied to NHSE to become one of six national pilot sites, achieving one of our 2024/25 objectives.[12]

In the coming year, working with the World Health Organisation (WHO) Collaborating Centre for Research and Training in Trieste, and the Italian National Research Council, ELFT is conducting a comprehensive evaluation of service outcomes with a focus on coproduction, continuity of care and a reduction in the use of coercion in acute crisis care. This groundbreaking research will dovetail with the national evaluation programme and it is envisaged that the findings will inform service development and policy across the UK.

Commercial research delivery

The DHSC has identified the delivery of commercial research as a priority;[13] however, implementation in mental health and community settings remains challenging. This year, we successfully participated in two commercial research studies, marking an important step forward.

Key challenges we've encountered include:

- the need to rapidly assess study feasibility within the Trust; and
- establishing a clear process for allocating income generated—across the service, the Principal Investigator, and the research department (for capacity building).

In response, we are developing a dedicated commercial study assessment pathway and working with finance to design a streamlined process for the appropriate distribution of commercial research funds. We have started to partner with Cambridge & Peterborough Foundation Trust for the purpose of receiving mentoring support from their R&D team, given the trust's broad commercial study portfolio.

We anticipate that these developments will strengthen our infrastructure and enable ELFT to engage more confidently and consistently in commercial research moving forward.

Putting the service user at the heart of research

ELFT's unique service user and carer research group (PoPuLar) successfully completed another co-produced research study project. A corresponding paper with the title "Advance Directives as a

[11] Objective ¶3.1.3 from 2024 Annual Report from R&I
[12] Objective ¶3.1.1 from 2024 Annual Report from R&I
[13] Letter from NHSE to all trusts: "boards should have visibility of their research delivery and income. It is also important research is not impacted by recruitment freezes being applied to Research and Development (R&D) posts that are funded from external sources such as grants, awards and allocations through contracts to deliver priority infrastructure, such as Commercial Research Delivery Centres

care planning tool for service users with complex mental health needs - a service evaluation“ has been submitted for peer-reviewed publication to the British Journal of Psychiatry Bulletin.

Building on the existing model developed at ELFT, PoPuLaR+ will expand these activities across the Northeast London Integrated Care System (ICS) and will promote lived-experience informed and initiated research, support service users and carers to become active members of this group. Members will design, conduct, analyse and disseminate research that is led by service users and carers that suits their strengths and present this work to others. The aim to create a dynamic and inclusive environment for mental health research that reflects the diverse experiences and needs of service users / carers and contributes to improving health and social inclusion / wellbeing outcomes across the region.

Ensuring the future

Karin Albani, the current Associate Director of Research (ADR) at ELFT will be retiring at the end of 2025 after more than twenty years working in the department at this Trust. This represents a risk of lost capacity and expertise to the organisation which we are working to mitigate. At the same time, this offers us an opportunity to explore more radical options to maximize the effectiveness of the department, such as merging with QI, with NELFT,[14] or increasing regional cooperation through the Noclor partnerships.

4 Action Being Requested

The committee is asked to RECEIVE and NOTE the report for information.

[14] Although linking our future with a Trust outside the region could undermine to our efforts to increase research activity in our Beds & Luton geography.

Report on impact of EDI Research Lead

Having an EDI research lead with active links with academia as well as experience of frontline clinical work, medical education and medical management provides the opportunity to develop and embed learning from research and systematic analyses into practices and policies which have maximum influence across systems without delay.

Policy and Strategy

Following strategic developments in EDI research from NIHR in 2023 (reviewed in 2024; and earlier FDA guidance on clinical trial diversity), the initial pilot of EDI research Lead for East London NHS trust (ELFT) was funded in 2024.

I attended the national UKRD Inclusion symposium in July 2024, network with the EDI research community and have since been successful in joining the *UKRD Inclusion Working Group* (December 2024).

Within ELFT I have regularly shared findings of recent research linked to EDI at appropriate platforms to ensure latest learnings from these influence service delivery, trust strategy and policy. I have presented to the trust EDI board (early 2024) and PCREF (Patient and Carer Race Equality Framework) working group (Jan 2025).

Research Studies and Outputs

Studies undertaken at ELFT with a specific EDI aspect, particularly promoting access and participation.

- I am co-applicant for Culturally Competent Mental Health Advocacy (ongoing NIHR-funded research related to recommendations of MH Bill from 2022). The work is currently in recruitment phase (Part of Research Strategy Group- shared learning from recruitment sites to ELFT). I am also involved with the study group and LEAP (lived experience advisory panel).
- I was Co Applicant for NIHR funded co-produced research into variability of access across communities for the pandemic (ARIADNE). I was part of a successful bid in further review of the impact of the study from Warwick University and organised further co-production workshops to review finding and had a national dissemination event with expert by experience involvement in June 2024.
- UK-REACH I-CARE – Increasing retention of healthcare staff from ethnic minority groups (NIHR funded) – set up ELFT as site in October 2024 – currently recruiting and trying to set up associate PI
- COPACT (2021- current): successful NIHR-PRP application that will inform DHSC directly of how the MHA is working and co-design local options for reducing use of the MHA and considering ethnic disparities. I am PI for CoPACT study (NIHR funded) and helped recruit for this study in minoritised groups and arranged co-production workshops. Currently post data gathering phase. (also set up Associate PI, see Workforce:)
- ART-CARMA (2023- current): ADHD Remote Technology study of cardiometabolic risk factors and medication adherence 'ART-CARMA' – completed recruitment in October 2024 (set up associate PI)

Peer Reviewed Papers published in the last year:

- Gillard S, Foster R, City, White S, Bhattacharya R, et al. Implementing peer support into practice in mental health services: a qualitative comparative case study BMC Health Services Research 2024 (Accepted for publication)
- Winsper C, Bhattacharya R, Bhui K, et al. The impact of reduced routine community mental healthcare on people from minority ethnic groups during the COVID-19 pandemic: qualitative study of stakeholder perspectives. The British Journal of Psychiatry. 2024;224(5):150-156. doi:10.1192/bjp.2024.11
- Kumar V, Pavitra KS, Bhattacharya R. Creative pursuits for mental health and well-being. Indian Journal of Psychiatry 66 (Suppl 2): p S283-S303, 2024; DOI: 10.4103/indianjpsychiatry.indianjpsychiatry_781_23

Funding applications over the last year:

- Lateef project looking into Muslim counselling – collaborating for funding: protocol writing stage
- Collaborated with Unit for Social & Community Psychiatry at QMUL. I hope this finds you both well. proposal for the Barts charity which focusses on preventative community-based support – submitted: awaiting outcome
- I also collaborated with QMUL for Pegasus related project and another project with Newham council for funding applications though these were not successful

Developing further research Partnerships:

- I have been in early conversation with Warwick Medical School for the AdSoLve (Addressing Socio-technical Limitations ov LLMs for Medical and Social Computing aimed at unifying Expertise, Transforming Research: AI, Law, Medicine) to set up EL FT as a clinical partner site
- HELPS qualitative study on Mental Capacity Assessment- conversation with setting up EL FT as partner site

Workforce

I have supervised 2 Associate PI in NIHR funded project (CoPACT – higher trainee; ART CARMA – ACP / Pharmacist). I am awaiting approval for the UK REACH I-CARE research to obtain approval for Associate PI scheme to recruit an IMG as Associate PI. I have also supported a social worker apply and design a small qualitative project looking into patient experience (SMI population). I have been actively involved in research capacity building with the new initiative with BLMK ICB to build a research hub and ensure EDI research is on the agenda.

I have regularly offered mentoring and supervised trainees and recently had advanced training in coaching and mentoring. I currently supervise 6 trainees, 1 non-medical prescriber, mentor 1 SAS doctor and 1 member of DMT (QA team). These also help build capacity in diverse and research competent staff. I also co-chaired an EDI themed research afternoon at Barts on 6.11.24.

Equity of Research design

I am aware and advice on equity of research design and the NIHR framework. In my role as EDI Lead I have had regular meetings with Research Delivery Manager for ELFT looking into proposal submitted to ELFT through an equity lens and offered suggestions on having a more equitable protocol (e.g. disaggregation of data, costing of in-reach interpreter etc.)

Diversity data

Data Analysis

I am currently leading on disaggregation and analysis of large data set collated by Plymouth University after being commissioned by the trust to investigate impact of Community MH transformation. I am looking into the data set and interrogate this through the equity lens.

Data Reporting and Engagement:

I am currently advising in two projects looking into adherence and stigma with patients with HIV, one with Mildmay Mission Hospital and other with Chelsea Westminster Hospital (2024-5); Both projects have been registered with respective organisation as audit / service evaluation. I presented a review and expert opinion on adherence in HIV at a seminar.

Review and EDI quality assurance

I have regularly carried out peer and expert review and editorial work and am familiar with research methodology and ensured quality assurance around EDI. I have had training in unconscious bias and diversity. I am mindful of cultural diversity from professional and personal life experience. I am the handling editor for training and education related submissions for the BJPsych Bulletin (RCPsych publication with impact factor of 2.6)

Rahul Bhattacharya, ELFT EDI Lead for Research
February 2025