Recommendation 1: Limited commissioning oversight with Trust internal and independent reviews.

Trust engagement with the family during both the internal investigation and the complaints processes was limited. The lack of oversight from the commissioners on the completed internal investigation report compounded this issue. This mirrored our experience. We found engagement with the Trust in this review to be limited at best and this frustrated and delayed our review.

The commissioning body responsible for oversight of the Trust must provide assurance:
• That the Trust Board has a robust process for reporting, identifying, and completing patient safety reviews.
• That the Trust has a process for reporting incidents requiring patient safety reviews to the commissioning body in a timely manner.
• That [redacted] are engaged in the process for investigations and independent reviews effectively, so that their feedback is sought and captured.
• That once a review or investigation is completed, a draft report is shared with patients and/or families before the report is finalised.

- The trust reached out to the Head of Quality and Safety for NEL who responded in November 2024.
  "As part of the implementation of the Patient Safety Incident Response Framework, the ICB undertakes its oversight responsibilities as set out in national guidelines through the following mechanisms:

  As Trusts moved into the new ways of working related to the Patient Safety Incident Response Framework, we collaborated with Trusts in the development of their PSIRF policies which set out their processes for:
  - *reporting, identifying, and completing patient safety reviews*
  - *engaging with those affected by patient safety incidents as part of the review process*

  We gain assurance that these processes, and further national guidance related to the undertaking of patient safety reviews, are adhered to, through ICB attendance at core quality and governance oversight meetings, and review of Trust Board papers.
  We also support the ongoing development of patient safety review processes, having launched and hosting, a Learning Response Peer Review meeting, in which learning response and engagement leads are supported to share their experiences of leading learning responses and provide peer support and learning to tackle challenges they may face when leading learning responses."

- In September 2024 the trust completed a "Patient Safety Incident Review Framework (PSIRF) and Incident Management Policy" (which replaces the "Incident Reporting policy"), along with a PSIRF Plan, which are now live on the Trust's intranet. This marks a key step in our ongoing efforts to improve safety through a more integrated, system-focused approach. The plan sets out how East London NHS Foundation Trust (ELFT) will embed the Patient Safety Incident Framework by: compassionately engaging and involving those affected

by patient safety incidents, applying a range of system-based approaches to patient safety learning, providing considered and proportionate responses, and providing supportive oversight, focused on strengthening response system functioning and improvement.

Recommendation 2: Implementation and application of Trust clinical policies.

Trust policies were in place and in date, but there was a lack of adherence to Trust policies and expected practice.

Trust policies were not applied in key areas:

- Crisis resolution and [redacted] urgent assessment pathway was not followed.
- Contact with [redacted] following [redacted] discharge from hospital did not meet discharge standards, and Section 117 aftercare and discharge planning was not in line with Trust policies.
- Carer assessment, support and engagement was not in line with Trust policy.
- [redacted] care planning was not managed in line with Trust policy.
- Risk assessments and safety plans were not completed in line with Trust policy.
- Incidents were not reported in line with Trust policy, and the internal investigation process was not applied correctly.
- Complaints were not responded to or managed in a timely manner as set out in the complaint handling policy.
- Safeguarding concerns where identified were not followed up in line with expected practice.
- There was no evidence that capacity assessments were completed in line with policy or the Mental Capacity Act (for the key decisions around detention).
- The absence without leave policy was not followed.

The directorate has looked at each of these policy points individually.

2.1 Crisis resolution and [redacted] urgent assessment pathway was not followed.

- The Crisis Assessment Team (CAT), Crisis Line, and [redacted] previously merged into a single service where staff rotated on a roster basis.

  As part of the transformation of the crisis pathway, the service has now been restructured and separated into the [redacted], Crisis Assessment Team (2023) and a Centralized Crisis Line (established in 2024).

  The Crisis Assessment Team now offers a walk-in service for [redacted] who are experiencing a mental health crisis. This service is located at [redacted] and operates from 8 AM to 10 PM, Monday through Sunday. The team also receives referrals from [redacted] making it the best option for mental health assessments when no physical health concerns are identified by the referrer.

  Calls to the crisis line are now handled by a centralized hub, which can arrange assessments directly with local crisis assessment teams or advise service users to visit the local Crisis Assessment Centre for immediate mental health support via a walk-in, ensuring a "no wrong door" approach to accessing immediate assistance during operational hours. As the local team no longer need to manage the Crisis line the service can provide rapid assessments within 4 hours (CAT) and 24 hours (HTT) creating a more streamlined service that allows for quicker assessments and interventions when necessary.

  The team composition has a senior on duty every day to escalate matters and discuss clinical cases. Admin staff keep a live tracker and seek updates on 4hr referrals that are initially logged on the clinical system. They also complete a monthly audit of patients referred, timeliness of assessment with reasons for any breaches.

  All HTT staff are fully inducted over a 4-week process, supported by senior members of the team to ensure understanding of process systems and policies.

2.2 Contact with [redacted] ollowing [redacted] discharge from hospital did not meet discharge standards, and Section 117 aftercare and discharge planning was not in line with Trust policies.

- Since the incident, an inpatient discharge team of social workers, supported by allocated community social workers was set up. They are tasked with making sure care act assessments, as well as needs and plans related to s117 are identified and documented. Due to staffing challenges the implementation of this process has been slower than anticipated.

- In November 2024 we established weekly monitoring of community led discharge plans. The results of this indicate that further improvement is needed. On-going work includes:

    - Social Work Professional Lead and Community Senior Operational Lead confirmed assessment expectations (based on CPA and LBH Statutory assessments) for Community staff and circulated the agreed assessment framework to all community staff in May 2025. This particularly focussed on requirements for inpatient discharge planning including documentation on Section 117 eligibility and plans.

    - External S117 training conducted by EDGE (social care training provider) is to be delivered for all Social Workers at Social Work forum in June 2025.

    - A section 117 Board with representatives from East London Foundation Trust (ELFT), [redacted] and Integrated Care Board (ICB) has been established and is meeting quarterly from April 2025.

    - Recruitment is underway for [redacted] Social Worker to oversee [redacted] legal responsibilities for inpatients. They are expected to start in June 2025.

2.3 Carer assessment, support and engagement was not in line with Trust policy.

- Since May 2024, [redacted] Carer Support workers now screen all new admissions for family, friends and carers. The Carers Hub will provide a call to the family or friend of carer within 48h of admission to offer support and assessment. This happens regardless of how many times someone has been admitted.

- Since January 2025 the ward managers have been responsible for arranging a phone call to the family, friend or carer within 24 hours of a hospital admission. This is a welcome call to provide them with the information they need regarding the person they care for's stay. The ward manager is able to help monitor carer satisfaction with the ward and address any issues which arise, for example carers being unhappy about their treatment whilst on the ward.

- The Carer's lead has conducted training at Away Days for wards throughout April and May 2025. This training gives staff an overview of their responsibilities to family friend and carers, whilst on the ward including, identifying carers, carer's rights, information for carers and being "carer aware" on the wards.

- The Senior Carers Lead provides 1:1 supervision for community Mental Health social workers including in the EQUIP team. This means social worker have a dedicated space to discuss issues, look at their caseload and carers contact and consider their care act duties to identify, assess, involve and support carers in their work.

- To pilot an "introduction to services" drop-in group for carers of EQUIP in-patients. The first group took place on Monday 2nd June 2025 and will then be held fortnightly. The plan is to pilot the carers group (which will be an introduction to EQUIP/information group) for family/friends/carers of EQUIP service-users who are currently on the wards, with a view to use the learnings from this to later run a group for family/friends/carers of service-users in the community.

2.4 [redacted] care planning was not managed in line with Trust policy

- Equip have introduced regular training sessions on 8-week assessment requirements & recording as part of their quarterly Continued Professional Development sessions within the team. Topics covered since June 2024 include
    - RiO Recording
    - 8 Weeks assessments requirements
    - Physical health and psychosis

- Social Work Professional Lead and Community Senior Operational Lead confirmed assessment expectations (based on CPA and LBH Statutory assessments) for Community staff and circulated the agreed assessment framework to all community staff in May 2025. This included completing Dialog assessments on a regular basis as well as safety plan and giving service users a copy of their recovery care plans.

- The Operational Lead for EQUIP has monitored CPA completion (which involves completing Dialog+ as care plan and safety plan). The completion rates have improved as a result of regular reminders, discussion in weekly MDT meeting, as well as individual supervision. The Operation Lead also shares a reminder with the team each week of the CPAs due to expire in the next month, to improve completion rates before they expire. The Operational Lead plans to apply this system to the risk assessments and monitor improvements.

- Completion of documentation, including CPA completion, is reviewed in individual supervision session with staff. There is also a specific review of one CPA each time to support good practice and quality.

2.5 Risk assessments and safety plans were not completed in line with Trust policy.

- Since April 2024 improvements have been made to our inpatient governance oversight process. These ensure managers & matrons have oversight of all governance on their wards and that processes are in line with policy. The Senior nurses meeting now has a focus on a different part of the governance structure each week on a 4-weekly rolling agenda. Each ward presents their current status and progress on these aspects and the quality and completion of risk assessments and safety plans are part of this. There is further oversight of this, including areas of concern and good practice, at the monthly Inpatient Management Meeting and then reported to the monthly Directorate Management Team Quality meeting. There are also regular ward team away days where recurring governance themes are discussed and relevant group training takes place.

- A full case notes audit is now completed weekly by ward managers which ensures not only completion but quality and accuracy of information. Any outstanding tasks are immediately actioned and the findings shared with the local team. The ward matron also does quality spot checks on the weekly audit to ensure standards are being met and in line with policy. This information is then shared weekly as above as part of our governance structure. Improvement is evidenced by the reduction through 2024 of missing risk assessments across the inpatient unit.

- We have ensured all wards have regular Clinical Improvement Groups where full multidisciplinary team and service users are in attendance. These are now occurring more regularly with a clear agenda and minutes taken. These are a monthly co-produced discussion forum discussing and actioning agreed recommendations and decisions to improve the quality and effectiveness of the service. Any concerns or reoccurring themes are shared at team away days and the monthly Inpatient Management meeting.

- Dialog+ and my safety plan training has been given a monthly training space so all RMNs on [redacted] ward are now appropriately trained with many HCAs also having attended. The remaining HCAs have training booked.

2.6 Incidents were not reported in line with Trust policy, and the internal investigation process was not applied correctly.

- As raised in the trust's "factual accuracy response" many of the concerns raised in the report were "not expected to be reported as a patient safety incident as per policy". In this area we disagree with the conclusions of the Niche report.

- Though, in addition to this, there have been some improvements the directorate has already undertaken regarding incident governance.

- In November 2023 the trust moved their incident reporting system from Datix to InPhase, which allows for more flexible monitoring of incidents. This has meant that the [redacted] Directorate Management Team (DMT) have improved their regular oversight of incidents. On a weekly basis a review of the previous week's incidents is undertaken. This covers when teams report high numbers of incidents as well as incidents where physical or psychological harm levels are reported as moderate or above.

- At the monthly DMT Quality meeting the previous month's incidents are further analysed.

- Training around the use of the new trust-wide incident recording system has been promoted to all staff.

- Incidents and the highlighting of potential incidents are discussed at daily ward and inpatient unit-wide safety huddles.

- There is a centralised inpatient staff induction which includes a training session on the use of InPhase and specifically incident reporting.
- In reference to the internal investigation process not being applied correctly, this has been responded to in recommendation 1 response.

2.7 Complaints were not responded to or managed in a timely manner as set out in the complaint handling policy.

- In November 2023 the trust moved their governance system from Datix to InPhase, which allows for more robust monitoring of complaints. This has meant that the [redacted] DMT have improved their regular oversight of complaints.

- We have set up a fortnightly Complaints Forum with the Complaints Team. Complaint investigators attend this to help improve the timeliness and quality of complaint responses.

- Escalation of cases takes place at weekly DMT huddles on Fridays and further analysis of complaints reported in the previous month are reviewed at the monthly DMT Quality meeting.

- Complaints training was conducted for Ward matrons and Managers by the Complaints team manager in August 2024.

2.8 Safeguarding concerns where identified were not followed up in line with expected practice.

- A directorate Safeguarding Sub-group was established in August 2024, to strengthen directorate safeguarding governance. This reviews and monitors safeguarding activities, performance, and outcomes, ensuring compliance with relevant legislation and policies. The group meets monthly and is co-chaired by t [redacted] with the following objectives:
  - To review and update on progress and actions on Safeguarding Adults Reviews (SARs), Domestic Homicide Reviews (DHRs), Rapid Reviews (RRs) and Child Safeguarding Practice Review (CSPRs).
  - To analyse and monitor Section 42 (S.42) enquiry performance data. This is to include concern and enquiries numbers, conversion rate to S.42, delayed enquiries, and outcomes achieved.
  - To review and evaluate incidents of inpatient violence and aggression and to identify safeguarding implications and themes;
  - To review safeguarding training compliance levels. This is to include level 2, 3, and WRAP training.

- To review any PSII/72 hour reports that may have safeguarding implications.
- To review safeguarding supervision compliance levels and themes.
- To discuss ad-hoc advice numbers and themes.
- To monitor and review progress against the safeguarding action plan, proposing additional and corrective action as required.

2.9 There was no evidence that capacity assessments were completed in line with policy or the Mental Capacity Act (for the key decisions around detention).

- The Trust Mental Health Law manager presents quarterly data to the DMT showing the training compliance for Mental Health Act (MHA) and Mental Capacity Act (MCA). They also present data on Patient's rights being read, Community Treatment Orders and overall detention figures.

- The MHA and MCA training compliance are reviewed monthly in the Senior Nurses meeting and at the Inpatient Management meeting as part of our governance structure. Any concerns highlighted are then raised in a monthly report to the Quality DMT meeting.

- Wards hold Rights Clinics on a weekly basis to reread patient's rights.

- The records keeping audit (clinical documentation audit) is reviewed weekly in the Senior Nurse meeting and this audit includes patient's rights and the quality of these conversations. This audit follows the same governance process, being reviewed at the monthly Inpatient Management meeting and then issues raised to the DMT.

- Power BI (the trusts data and performance dashboard system) is used daily by ward MDTs to ascertain which patients have had rights read and capacity and consent completed.

2.10 The absence without leave policy was not followed

- Since this incident a new Pan London Joint AWOL policy, in line with recent Right Care Right Person programme, has been agreed in conjunction with the Police. This new Pan London policy was raised as an agenda item with discussion in the Senior Nurses away day held on the 17th September 2024 to raise awareness and to be taken back to their clinical teams for further dissemination.

- Th [redacted] conducted an audit of AWOL cases in 2024, which was repeated quarterly. This was reviewed and the findings were positive. We have continued to develop the robustness of our approach to this process. As a result, in line with the Trust policy, we are following the AWOL policy guidance for each patient who is AWOL. There will be oversight of this by the ward matrons and daily unit-wide senior nurse safety huddle. We are going to continue to audit this on a quarterly basis on all wards and will be overseen by the Directorate's Quality DMT meeting.

- We had a [redacted] task and finish group to address adherence to Trust and Pan London AWOL Policy/ Guidance and strengthen inpatient leave planning. There has been a training program developed which is being taken to all ward away days from 30th April 2025. This will be done on a yearly basis.

Recommendation 3: Effective listening and joint working [redacted] as partners in risk management [redacted]

Concerns raised [redacted] were not effectively listened to.
The Trust must ensure that staff are aware of the steps they can take to ensure that concerns raised by families, partners, nearest relatives, and key relationships are still heard, captured, and given fair weight. The Trust must provide staff with tools and training to facilitate this.
The Trust must provide assurance of efforts made to promote the importance of listening to and working with families and carers. The Trust must provide assurance that the lessons from this review are shared widely across the Trust.

- An annual audit including review of feedback from patients, families and carers involved in safety reviews was completed in December 2024. The audit included identifying how engaged, supported and listened to families/carers felt during the safety review. The outcomes of this audit were shared at DMT.

- There was a Trust-wide Learning Lessons seminar held on 30th October 2024. This was a thematic analysis of the concerns identified in completed investigations from 2020 to July 2024. One key theme addressed was the breakdown of communication involving service users, family and relatives. In February 2025 the Learning seminar focussed on carer involvement in care planning and risk management and there is another session on this planned later in the year.

- People Participation Services are working with service users and carers to identify practical ways of engaging with families and patients currently in receipt of care.

- Over the past 12 months the Trust have made progress in how we proactively identify, recognise and support the family, friends and carers of our service users.

- In May 2024 the Centre for Mental Health opened a Family, Friends and Carers Hub. The hub is staffed by the [redacted] Carers Service, who work closely with the Voluntary Care Sector to bring resources together around informal carers, young carers and young adult carers.

  The hub works by screening the file of every service user who is admitted to one of our MH wards, has a MHA Assessment but is not admitted, or is involved in a safeguarding for a family, friend or carer. Once identified, a trained carer support

worker contacts the carer within 48h where there are no confidentiality issues. If there are confidentiality issues, the hub will contact the Ward, Approved Mental Health Professional (AMHP) or Safeguarding Adults Manager (SAM) to try and resolve issues.

- Since January 2025 the ward managers have been responsible for arranging a phone call to the family, friend or carer within 24 hours of a hospital admission. This is a welcome call to provide them with the information they need regarding the person they care for's stay. The [redacted]s able to help monitor carer satisfaction with the ward and address any issues which arise, for example carers being unhappy about their treatment whilst on the ward.

- The Trust started a Hospital Discharge pilot on the 11th November 2024 in order to strengthen the relationship between the hospital wards and community mental health teams. As part of this pilot the carers service bases a carer support worker within the hospital discharge team. This ensures that all carers of an adult being discharged are offered 1:1 support from the worker, along with a carers assessment and support plan. The offer to carers includes peer support (1:1 and group) and psychoeducation. The worker's relationship with the carer can continue for as long as is needed because it is both a hospital and community service.

- The Trust have now set up a Carers Hub Website that includes a great deal of information about mental health, its services and how to support someone with a mental health condition. There are videos available on the site that focus on various issues effecting carers of adults with mental health.
- The Trusts Family, Friends and Carers Strategy implementation group are currently reviewing the Triangle of Care Toolkit. In [redacted] we are confident that the actions we have taken, as set out above, are in line with the principles and spirit of the toolkit.

Recommendation 4: Effective risk management planning

[redacted]

The Trust must review risk management training and guidance to support staff in developing risk formulation and risk management plans for individuals who mask symptoms. This training should emphasise the importance of triangulation and seeking and listening to the views of those who know the patient best.

- The Trust has undergone a detailed and careful process of review of the risk assessment form in use. A new form is now in a final testing phase with relevant stakeholders, to ensure that it is user friendly and comprehensive when rolled out. This degree of change to practice needs to be done carefully and with a high degree of planning. Roll out of the form to clinical practice will take place later in 2025.

  o The form has been developed in line with NICE guidance and best practice, with a focus on risk formulation instead of risk stratification and tick boxes.
  o The wording includes specific prompts relating to masking of symptoms:
  - The wording is: 'Are there any concerns of the service user not disclosing relevant information or potentially masking symptoms?' Where the answer is yes, there is a free text box for details to be provided.
  o The new form also has a reworded section on Information from Family and Carers:
  - The wording is: 'Have family or carers expressed any safety/risk concerns?' Where the answer is yes there is a free text box for details to be provided.
  o As part of the roll out, it is planned that a link to a short video will be available, guiding people in formulation-based risk assessment. That video will include the importance of considering that people may mask symptoms and of including information from carers.

- Trust-wide communication has been sent reminding staff that service users can be guarded about symptoms, and that information from carers can be helpful in identifying this.

- By being linked to the practicalities of the risk assessment form, we anticipate that the above video format will have good reach and relatively quick uptake. Additional future work around [redacted] will remain on the Trust's agenda, including at its Quality Committee. This will be a continuous and evolving piece of work to enhance the training offer, including team-based training.

Recommendation 5: Managing significant changes in care and treatment plans when clinical management changes unexpectedly.

[redacted]

The Trust must provide assurance that when a consultant is unexpectedly away from clinical duties, continuity and oversight for care is provided. This should be through the allocation of a named individual.

The Trust must also provide assurance that if the new consultant proposes a significant change to a person's diagnosis or care and treatment plan, these changes are shared within a multidisciplinary forum, with the patient and family/carer involved.
Where there are any differences of opinion or challenges to this change, the patient (and/or family/carer) should have the right to seek a second opinion.

- A discussion with [redacted] Inpatient consultants took place on the 11th November 2024 and as a result an email regarding recommendations for covering Consultant sick leave was sent on the 20th November 2024. This included expectations that the named covering consultant must make contact with the resident doctors and ward or community manager for the covering team at the start of the covering day to inform them that they are covering. They will also let them know how they can be contacted and if there is a best time for any discussions or patient reviews. The named covering consultant must handover any follow up tasks or concerns about patients and risks that they have dealt with to the returning consultant or the next consultant covering RC duties. This plan will also go into the resident's handbook for induction, so resident doctors are aware.

- A discussion was held at the Clinical Service Development Group (Consultant meeting) on 26th February 2025 regarding the need for any covering consultant to discuss a proposed significant change to a person's diagnosis or care and treatment plan, within a multidisciplinary forum, and with the patient and family/carer involved. Where there are any differences of opinion or challenges to this change, the patient (and/or family/carer) has the right to seek a second opinion.

- There has been an increase of advocacy support available on the wards, which can offer support to service users who disagree with any aspects of their care and treatment. The advocate on Ruth Seifert ward attends the ward weekly. Efforts have been made by ward staff to increase service user's awareness of advocacy presence on the wards. There are advocacy posters and leaflets available on the wards. The new welcome pack that has been developed also has details on advocacy.

Recommendation 6: Improve the experience of [redacted]

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Recommendation 7: Effective use of leave of absence [redacted]

[redacted]

The Trust must provide assurance that when leave of absence is authorised, the patient's (and, where appropriate, family or carer's) experience of this leave is discussed properly and recorded in clinical records. This should be used to inform the effectiveness and purpose of the continued use of leave of absence and risk assessment.
Practice should be in line with the guidance set out in the [redacted]

- The [redacted] conducted an audit of leave standards and documentation relating to cases throughout 2024. The results are largely positive with some areas where further improvement will be monitored. It is intended that this audit will be completed on a quarterly basis to provide assurance of ongoing improvement.

- We had a [redacted] task and finish group to address adherence to Trust and Pan London AWOL Policy/ Guidance and strengthen inpatient leave planning. There has been a training program developed which is being taken to all ward away days from 30th April 2025. This will be done on a yearly basis.

- The Trust AWOL/Missing Persons Policy was ratified in January 2025. This includes a new Leave Monitoring Form and Pre-Leave Risk Assessment Checklist which is being used on all wards.

Recommendation 8: Immediate action when a detained patient goes missing (or is absent without leave)

[redacted]

The Trust must provide assurance that for all [redacted] patients who go missing or who become absent without leave (AWOL), immediate alerts are raised, and immediate action is taken in line with Trust policy and national guidance.
This must be evidenced through the development, implementation, and use of a robust assurance process.

- Since this incident a new Pan London Joint AWOL policy, in line with recent Right Care Right Person programme, has been agreed in conjunction with the Police. This new Pan London policy was raised as an agenda item with discussion in the Senior Nurses away day held on the 17th September 2024 to raise awareness and to be taken back to their clinical teams for further dissemination.

- The [redacted] conducted an audit of AWOL cases in 2024, which was repeated quarterly. This was reviewed and the findings were positive. We have continued to develop the robustness of our approach to this process. As a result, in line with the Trust policy, we are following the AWOL policy guidance for each patient who is AWOL. There will be oversight of this by the ward matrons and daily unit-wide senior nurse safety huddle. We are going to continue to audit this on a quarterly basis on all wards and will be overseen by the Directorate's Quality DMT meeting.

- We had a [redacted] task and finish group to address adherence to Trust and Pan London AWOL Policy/ Guidance and strengthen inpatient leave planning. There has been a training program developed which is being taken to all ward away days from 30th April 2025. This will be done on a yearly basis.

- The Trust AWOL/Missing Persons Policy was ratified in January 2025. This includes a new Leave Monitoring Form and Pre-Leave Risk Assessment Checklist which is being used on all wards.

Recommendation 9: Access to and amendment of records [redacted]

[redacted]

The Trust, as a matter of urgency, must ensure all staff are aware of the need to identify where records have been added to or amended and which is therefore not contemporaneous. This should be communicated to all staff as a matter of urgency and reinforced through regular training and audits. The Trust must also demonstrate assurance that any records accessed or amended following [redacted] can be readily identified.
The Trust should now determine if any altered records were outside professional standards expected and take appropriate action.

- Trust-wide guidance was sent to all staff on behalf of [redacted] on the 21st October 2024 outlining the importance of record keeping and more specifically around retrospective records.