NHS
East London
NHS Foundation Trust

Office of the Chief Medical Officer
Trust Headquarters
5th Floor
9 Alie Street
London E1 8DE

Private & Confidential

Coroner ME Hassell
Senior Coroner for Inner North London
St Pancras Coroners Court
Camley Street
London
NlC 4PP

14 December 2021

Dear Madam,

Re: Ms Freeda Glausiusz

This is a formal response to your Regulation 28 report (**the Report**) dated 20th October 2021 where you set out your concerns relating to:

1) The care that Ms Freeda Glausiusz received from East London NHS Foundation Trust (**the Trust**); and

2) Unacceptable delays in document disclosure from the Trust to the Court.

I wish to assure you and the family of Ms Glausiusz that the Trust takes these issues very seriously. I outline the steps that have been taken to address your concerns below.

PART 1: ISSUES RELATING TO MS GLAUSCIUZ'S CARE

I understand from the Report that whilst you were reassured by the findings and actions outlined in the Serious Incident (**SI**) investigation, you remain concerned about the following issues surrounding the phone call between Ms Glausiusz's father and the Crisis Line call handler. You noted your concern that:

1) This is not the first time that you have made a PFD Report to ELFT in relation to its Crisis Line.

2) Not only did the clinician in question not make a note of the call in the medical record, he told you in court that, after Freeda Glausiusz's death his manager had told him not to make an appropriately dated retrospective note in the record. He said that he had made a note on a piece of paper, but he did not now have that piece of paper.

We care We respect We are inclusive

3) When you asked the lead SI reviewer if the Trust is confident that it has taken all appropriate actions in respect of that clinician, she was not able to give you that assurance.

1. Changes to the ELFT Crisis Line

To address your concern about the PFDs issued to the City and Hackney Crisis Line (the Crisis Line), I requested the Legal Affairs Team compile all Regulation 28 reports issued by HM Coroner to the Crisis Line and all the responses provided for five years. After reviewing the relevant reports, it appears that past actions put into place by the Trust (please see **Appendix 1**) have not consistently resolved the issues you have raised in relation to: 1) the quality of the Crisis Line call handlers' risk assessments; and 2) how calls of relatives and friends who call the Crisis Line are dealt with and incorporated into risk assessments.

The Trust commenced an overhaul of the Crisis Line starting mid-2021 (prior to Ms Glausiusz's inquest) as consequence of an increased number of serious incidents within the service (including Ms Glausiusz's sad death), high staff turnover, and difficult team dynamic. The immediate actions include provision of additional staff training, increased staff oversight and improved recruitment. In the longer term, the structure of the Crisis Line is being re-shaped to improve patient care. After considering your Report, I requested that the Medical Director for London, revisit the past Regulation 28 reports to ensure that all changes will incorporate the concerns raised over the last five years.

IMMEDIATE ACTIONS TAKEN

Increased Oversight

In May 2020, immediately, after Ms Glausiusz's death, the Deputy Borough Director listened to calls by each staff member to assess the quality of the care being provided. The results showed improvement was required.

Now, senior staff supervisors (registered mental health nurses, social workers or occupational therapists at a Band 7 level) listen to a sample of each Crisis Line clinician's calls (with them) on a monthly basis to assess the quality of their care.

In July 2021, the Deputy Borough Director listened to recorded calls from each staff member working on the Crisis Line. The standard was overall good. However, the outcome was that the contract of an Agency Nurse was terminated and another nurse was commenced on a performance management process.

Between 20 November 2021 – 28 November 2021, the CCG conducted a 'mystery shopping' audit of the Crisis line to measure responsiveness to calls. 70% of calls were answered in one minute or less, with 20% less than two minutes. The qualitative feedback was that staff were pleasant and polite.

From January 2022, a larger Trust-wide Crisis Line call quality audit will take place. The audit tool has already been devised.
Finally, there is a plan for the Crisis Line to change its crisis line provider to a service which allows staff supervisors in-call listening so that supervision can occur in real-time.

Recruitment

Two significant changes have been made to the Crisis Line recruitment process. Since August 2021, all interviews for new staff include telephone call role playing as selection criteria.
As of October 2021, a Crisis Line specific induction checklist was introduced and all staff (whether bank or permanent) need to undertake a minimum of 6 supervised calls before they can work independently. Importantly, all supervisors will be senior Band 7 qualified mental health clinicians.

Training

The Crisis Line is highly stressful environment. There is a high number of calls involving difficult topics. Therefore, training that takes in consideration staff wellbeing and resilience should lead to better quality calls.

With this in mind, the Crisis Line call handlers will be attending specialised training provided by the Samaritans. Training sessions are taking place between 29 November and 16 December 2021. Further, a Quality Improvement Project addressing issues of Crisis Line Staff well-being was commenced in October. It will focus on increasing staff resilience with a focus on skills, process, workload and stress management and supervision.

Policy Changes

The City and Hackney Crisis Line Operational Policy has been updated to include a section on how call handlers should deal with concerned relatives and family members. This will be ratified on 17th December at the ELFT London Crisis Strategy Group and the updated content will be discussed with staff members at their team business meeting on 6 January 2022.

LONG TERM CHANGES

By the end of 2022, the City and Hackney Crisis Pathway will undergo a complete transformation. Currently, the Home Treatment Team, Crisis Assessment Team and Crisis Line are managed as one team with staff working between all three. The new service envisions a separately managed Home Treatment and Crisis Assessment Team. The latter will comprise the Crisis Line and Urgent Assessment Team. It is envisaged that smaller, focused teams this will enable better management and supervision, more focussed training and development.

Part of the transformation involves reviewing all job descriptions, operational policies and introducing a training programme tailored specifically to the needs of Crisis Practitioners. Standardised assessment and care planning tools will be introduced across the pathway, including the Psychiatric Liaison Team in the Emergency Department and the Crisis Café. A crisis hub will be established as an alternative to the Emergency Department. It is hoped staff will be able to work flexibly across the pathway in order to increase staffing in a specific area in the immediate demand becomes high. The Crisis Pathway services will work more closely with our voluntary sector colleagues to improve access to crisis services and care which is better focussed around the needs of specific communities.

I am hopeful that the extensive changes being made to the Crisis Line will address the issues of care quality raised by HM Coroner over the last five years.

2. Medical Records Concerns

I share your concern that not only was a record of [redacted] call not recorded in Ms Glausiusz's medical record but also that senior managers told the relevant clinician not to write a dated retrospective note in the record.

To address this matter, medical records training for all senior nurses was provided on 24 November 2021 to all senior nurses and managers at the Trust. The focus of the training was good record keeping, observations and retrospective record keeping.

The Crisis Line managers that attended this training will be highlighting the learning to all staff at the next away day on 6th January 2022**.**

3. Actions in relation to call handler

For reasons of confidentiality, I am unable to detail specific actions that have been taken under the Trust's Human Resource policy. However, I can assure HM Coroner that the Deputy Borough Director for City and Hackney, with the support of the Director of Nursing for London have thoroughly investigated the content of the crisis line call and taken appropriate actions to ensure patient safety.

PART 2: ISSUES RELATING TO DOCUMENT DISCLOSURE

In your Report, you outlined a chronology of unacceptable delays in the disclosure to the Court. In particular,

1) You received a copy of the recording of the call (without a transcript) the day before the inquest.

2) You received a statement from the clinician who took the call the day before the inquest.

3) You received statements from other ELFT clinicians in dribs and drabs earlier this month.

4) You received a copy of the SI report the day before the inquest.

5) You never received a copy of the 48 hour hot de-brief.

I share your concern that such delays impede your investigation, is disrespectful to bereaved family and does not evidence the open, learning culture that we foster at the Trust. To this end, immediately conducted my own investigation into the reason for these delays and sent you a letter on 23 November 2021 explaining what the Trust is doing immediately to rectify this matter. (Please see **Appendix 2**). For convenience, I outline these actions again here with important updates.

Serious Incident Report Delays

The Trust has hired four new SI investigators. They start work beginning in November and are tasked with clearing the current backlog of SI reports that have accumulated throughout the pandemic. It is estimated that this will be completed by the end of 2021.

I have sought assurance from the Associate Director of Governance and Risk that until that time, SI investigations with inquest dates will be prioritised and that HM Coroner is provided with realistic due dates if SI reports are going to be submitted to the Coroner's Court late.

Additionally, in the instance that SI reports are late, HM Coroner will be provided with the 48 Hour report.

Witness Evidence Delays

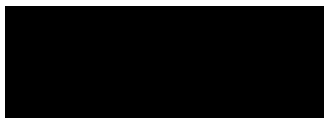
The Trust has also agreed to hire an additional solicitor in order to increase the Legal Affairs Team's capacity which has been affected by long term sickness absence and the increase in inquests. A new solicitor will join the team by late March.

In the interim, the Interim Associate Director of Legal Affairs has assured me the Legal Affairs Team will be tasked with diligently chasing up witness statements and evidence such as recordings in a timely manner and provide realistic deadlines to the Coroner's Officers if issues such as clinician sick leave hinder progress.

I note, the Trust has not previously been requested to provide transcripts of recordings of calls. Going forward, the Interim Associate Director of Legal Affairs will liaise with your Coroner's Officer's to discuss how the Trust will provide such a transcript to you.

I hope this response assures you and the family of Ms Glausiusz that the Trust has taken significant steps to address your concerns and improve patient safety at the Crisis Line as well as further

Yours sincerely



Chief Medical Officer