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NELFT NHS
NHS Foundation Trust

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Mr G Irvine
HM Coroner
East London Coroners Service
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[redacted]
Chief Executive Officer
Trust Head Office
West Wing
CEME Centre
Rainham
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RM13 8GQ
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9th November 2023

[redacted]

[redacted]

Dear Sir,

Re: Inquest touching upon the death of Ms Donna Levy

I refer to your letter dated 31 August 2023 and the Regulation 28 report detailing your concerns about the risk of future deaths in light of the findings of the Inquest.

I should like to extend my sincere condolences to the family of Ms Donna Levy. This must have been an extremely difficult time and I hope that my response provides them, and you, with assurances that the North East London Foundation Trust is taking action to address the issues set out in your report.

At the conclusion of the Hearing into the death of Ms Donna Levy, you expressed the following concerns in respect of the care provided by NELFT:

1. *In the two months prior to her final admission into hospital Ms Levy was being regularly assessed by district nurses, the community matron and her GP. Despite the obvious nature of her deteriorating health, no meaningful steps were taken to escalate the care she received to mitigate the risks of her self-neglect.*

2. *The inquest heard that as Ms. Levy was believed to have capacity throughout this period, and consequently it was determined that there were no practical steps that could have been taken to improve the provision of care to her.*

3. *No formal Mental Capacity Act assessment was ever undertaken or considered.*

4. *No formal referral was made to mental health services regarding Ms Levy's reluctance to take advantage of offered care.*

5. *The Trust responsible for community care did not undertake a Serious Investigation. The decision was justified on the basis that Ms Levy's pressure sore was insufficiently significant to justify further inquiry. The decision was, in the view of the court flawed as evidence heard indicated that the pressure sore was in fact far more serious than appreciated at the time of community treatment. Further, restricting the scope of a serious incident report to the extent of a single pressure sore, neglected to take in the wider physical health problems suffered by Ms Levy that were obvious at that time.*

In respect of the specific concerns, expressed by you at the Hearing and within the Regulation 28 Report, the Trust has put actions in place that aim to address these specific areas for improvement in order to strengthen the safety of our services further. Please note that we have put together a joint Action Plan with London Brough of Redbridge which sets out these actions and I attach a copy of the same with this letter.

In order to improve the services provided by the North East London Foundation Trust it will:

- Engage will the London Borough of Redbridge in weekly Complex Case Discussion meetings involving all 5 Health and Social Services localities and areas of responsibility.
- Introduce two new and full-time senior band 8a nurses.
- Review, revise and disseminate the risk escalation process with health and social care staff.
- Devise a standardised operating procedure relating to how District Nurses conduct their daily handovers.
- Provide Professional Curiosity training for health and social care staff.
- Provide legal training on Court of Protection referrals for health and social care staff.
- Request and encourage GP involvement in discussions of complex cases and professional meetings.
- Provide mental capacity assessment training for all health and social care staff.
- Complete mental capacity assessments in complex cases.
- Undertake risk assessments to identify anxiety / depression scores.
- The Multi-disciplinary Leadership Team will increase the review of cases escalated via High Level Risk Reporting from twice a month to once a week.
- Undertake a review of this case at the Pressure Ulcer Assurance Group to identify any further gaps in care and learning.
- Ensure incident reports include concerns across integrated services.
- Ensure that the new NELFT Pressure Ulcer incidents management approach is embedded.

- Establish staff learning events for health and social care staff.

NELFT did not conduct a Serious Investigation into this matter because, as detailed on the 72-hour Report, it was understood that the incident had occurred within a hospital setting rather than a community setting. It was also understood that whilst Ms Levy was under the care of NELFT community services, the severity of her pressure ulcer had not met the threshold for a serious incident investigation under the previous serious incident framework. Unfortunately, too, we were not engaged in the Serious Incident Investigation that was carried out by the Barking, Havering and Redbridge University Hospitals Trust (BHRUT).

With the introduction of the new Patient Safety Incident Response Framework, this has now changed. This framework includes new processes such as the Patient Safety Incident Report Group Forum (PSIG) that provides for greater and more detailed review of whether an investigation is needed and what form that will take. The PSIG is a NELFT wide meeting headed by the Executive Chief Nursing Officer and attended by, but not limited to, representatives at various levels from the different Directorates, Directors, Assistant Directors, Operational Leads, the Legal Team and the Patient Safety Team.

As part of the new PSIRF governance process it is clear that all pressure ulcers related to sepsis will be investigated via a full Patient Safety Incident Investigation (PSII) by the patient safety incident team. The revised process in place in relation to pressure ulcers also ensures Directorate oversight and expert views of all incident reports for category 2, 3, and 4 pressure ulcers, as well as unstageable and deep tissue injuries. In support of this, we are also establishing multidisciplinary review panels to address key themes in relation to pressure ulcer care, with thematic learning being reviewed through the PSIG and through the the Trust's pressure ulcer assurance group for wider learning.

I hope that I have provided you with some assurance that North East London Foundation Trust is taking steps to address the concerns expressed in your report and that we are continuing to take action to improve patient safety and quality of care.

Thank you for raising this matter with North East London Foundation Trust. If I can be of any further assistance or if you would like a further update on the progress made to address your concerns, I would be happy to provide a further update.

I look forward to hearing from you.

Yours sincerely

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Chief Executive Officer

Enc: Regulation 28 Action Plan