East London
NHS Foundation Trust

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

Tel: [redacted]

E mail: [redacted]
Website: www.elft.nhs.uk

Private & Confidential

Ms Saba Naqshbandi KC
HM Assistant Coroner
By email only:
[redacted]

4 September 2024

Dear Madam

RE: Regulation 28 Response – Mahamoud Ali

I am writing on behalf of East London NHS Foundation Trust ('the Trust') to provide a formal response to the Regulation 28 Notice that you issued following the inquest touching the death of Mr Mahamoud Ali, who died in August 2020.

The Trust extends its most sincere condolences to Mr Ali's family.

As you will recall, you heard evidence at the inquest that a member of staff had falsified three observations of Mr Ali. You also heard evidence from a senior doctor about the steps that the Trust has taken in recent years to reduce the incidence of falsified observations.

The inquest jury concluded that Mr Ali's death was an accident following falls (which took place before his admission to ELFT). Although the jury did not conclude that any falsified observations contributed to Mr Ali's death, the Trust acknowledges that you have the legal power to issue a Regulation 28 Notice if you have ongoing concerns. In your Notice, you highlighted a concern that the action undertaken thus far by the Trust has not been sufficient to ensure that observations are being conducted and/or recorded as required.

You also noted that the Trust had identified 11 other fatal incidents since August 2020 where observations may have been falsified. The Trust identified these incidents following your request for information about incidents which had taken place after Mr Ali's death in August 2020. In the interests of transparency, I can confirm that a further incident has since been identified in this time period, occurring on Loxford Ward (Wolfson House) in July 2022, where an observation took place but was documented in another staff member's name.

In the interests of context, the Trust would like to point out that in some of the identified cases the incorrect information that was documented may have been through error rather than deliberate falsification, and in some cases it was difficult to establish if falsification had taken place at all (such incidents were however included out of an abundance of caution when providing data to you and with the intent to extract all possible learning from when observations are not undertaken as designed). Notably, even including this extra case, the majority of the identified incidents predate the majority of the Trust's extensive work to improve practice around observations.

Again, in the interests of context, the Trust notes it is unclear if it is disproportionately prone to observation records being falsified, or if its investigation processes mean that it is better at detecting when this has occurred.

The Trust has considered your Notice extremely carefully. As well as setting out the steps that the Trust has already taken in this area (for the benefit of those who did not attend the inquest but have an interest in this matter), this response will also set out the further steps that the Trust has taken since 2023 and are looking to enact. Some are 'direct' measures (for example Honesty in Documentation training) and some are 'indirect' measures (such as escalation protocols where there are insufficient staffing resources); in the Trust's view both are vital in reducing the incidence of falsified observations.

Improvement work already undertaken at the time of writing

Overarching theme	**Therapeutic engagement and observation improvement work undertaken**
Staffing/ resource availability	Staff establishment reviews were undertaken in 22/23 and 23/24. Correct and agreed investments have gone into teams, increasing staff on each shift by one unregistered Band 3. Additional investment has been made for a Band 4 Life Skills Recovery Worker on Mondays to Fridays 9am to 5pm to increase the delivery of activities and opportunities for meaningful engagement.

	A proactive recruitment campaign has been ongoing with services moving to zero registered vacancies and a review of the unregistered workforce (correct band and skill). Staffing rotas for the wards have been reviewed and updated to reflect safer staffing requirements; senior approval of rotas is required six weeks in advance of the current period and quarterly rota monitoring meetings are in place. Escalation protocols have been developed for use to guide staff when there are not sufficient resources in place to meet care needs.
Staff competency	The Inpatient Safety Suite of training is now 'live' and classed as essential for all inpatient nursing staff. This gives the ability to have oversight of compliance via Trust-wide training reporting. This suite includes training on observations and honesty in documentation. Honesty in Documentation training was developed in Dec 2023 and rolled out face to face across all inpatient services over the period from December 2023 to April 2024. A pilot of Trust-wide clinical induction started in August 2024. Prior to this, comprehensive clinical inductions were being done in directorates. This Trust-wide approach supports consistency of material and ensures core learning on commencement of clinical roles. Non substantive staff (bank staff) are booked to attend and have access to protected study time to achieve the same competencies as substantive staff. Trust-wide learning lessons seminars open to all staff focus on areas of learning and improvement from incidents or identified areas of good practice. Safety discussion sessions are facilitated weekly in directorates for all inpatient staff to review observation data, reflect on gaps in practice and disseminate learning. Time to Think forums in directorates are well established. These are held monthly in directorates, led by lead nurses and are open to all staff within the inpatient service. They are a protected resource for teams to reflect on their practice, understand work as it happens using data and clinical examples, and generate discussions to inform learning and next steps.

Quality improvement	A Trust-wide Quality Improvement programme which involved all 54 wards, their staff teams and service users across the Trust, and ran over a period of 18 months, was undertaken from September 2022 and led to three agreed interventions. The aim was to improve consistency of completed observations and shift the culture of observation practice. The three change ideas agreed to move into standard practice were: • Board relay- this idea is based on the concept of a baton relay – you never let go of the baton until you pass it onto the next person. The board relay is related to general observations and intermittent observations only and aims to reduce the risk of observations being missed and improve handover of clinical information between staff undertaking the observations • Twilight shifts- this shift pattern adds an extra member of staff to requirements for a shift. The hours reflect periods where there is reduced structured activity (after 5PM) and covers the early part of a night shift. Staff undertaking these shifts lead on offering therapeutic interventions in the form of activities to service users on the ward. • Zonal observations- zonal observations allows an alternative method of observation, which involves designating the ward into different zones where allocated staff observe and engage with patients individually and as groups for set periods of time. This is to allow for continuous engagement with patients and monitor environment and patient dynamics over a 12hour shift. Zonal observations can be plotted against certain times or functions dependent on the ward layout and key tasks relevant to the service user group A digital application to document observations (using Microsoft PowerApps) has been developed and is in the testing phase. It is planned that this will be piloted from October 2024 on four wards and then scaled across all inpatient units.
Standards of professional practice	Expected standards of practice have been communicated to staff, with frequent updates on improvement work since 2021 to date. In 2023, this specifically addressed accountability and responsibility for accurately documenting observations. It included the importance of honesty in documentation and gave guidelines for staff to follow for occasions when observations were missed. The Trust-wide Quality Improvement programme described above has introduced the observation relay board to reduce incidents of observations being left or not handed over.

Audit and monitoring	The Standard Observation Measurement (SOM) Tool was developed for oversight of rates of completion of all observations. Individual ward teams and directorates can access and use their data to drive continued improvement. Local governance systems exist to ensure changes to practice are embedded. Night visits are undertaken by senior staff in directorates to monitor practice through spot check audits and observing work as it happens.
Inpatient Ward Safety Culture Improvement Work	Since 2023 a new safety culture self-assessment process has been incorporated into the Quality Assurance annual review process for each in-patient team across ELFT. Annually, staff complete an anonymous survey based on each component safety culture element. A bespoke team report on the safety culture results is then shared back to directorates and teams (where enough responses are received) with advice/signposting to where steps can be taken to strengthen safety culture. The survey tool results are then discussed in team away-days and meetings with teams, enabling local leaders to focus on areas where improvements need to be made. All of our mental health inpatient wards have been participating in this process, with good engagement and over 800 responses have been collected from across all directorates and wards. Next steps are to seek service user perspectives to triangulate and strengthen the safety culture intelligence available to the teams. The Trust is involved in the London-wide Cavendish Square community of practice attended by Chief Nurses (Observation practice is one of its yearly objectives) and have applied to enroll in a new NHS England 90-day collaborative around Enhanced Therapeutic observations.

Further planned improvement work

Areas for further development	Recommended improvement work
Staffing/ resource availability	Continue to review escalation protocols to senior staff on site in response to changes in acuity or demand or if there are staff shortages on a shift. This is to include: • Task prioritisation and allocation; • A mechanism for swift deployment of resources to meet demand and robust reporting where care delivery is compromised.
Staff knowledge and capability	To improve the robustness and governance of systems for the temporary/bank nursing workforce. This would include better oversight of training compliance and support offered (supervision and reflective practice). Continued work on honesty in documentation.
Professional practice	Review and relaunch use of SOM tool and outputs to impact on practice. Further explore possible tools for assurance against falsification of observation that does not rely on CCTV, although this may be difficult to design. This should include a review of national improvement workstreams. A review of night-shift culture engaging staff and service users and observing work as done. Design standards for night shift practice and a mechanism for assurance including senior night visits. A review of findings from the service user experience of observations qualitative audit tool. The introduction of the Loop App will ensure that only staff with the required competencies for each clinical area are able to book onto bank shifts. Building on the Quality Improvement work around therapeutic engagement and observations, in June 2024 ELFT commissioned an external Human Factors and Patient Safety Consultant to undertake an analysis of observations practice on our mental health In-Patient Wards to better understand observations practice from a human factors/systems approach, and to provide redesign ideas to address any gaps, pain points and workarounds that exist. Once the work has been completed,

	senior leadership review of the findings and suggested improvements of the Human Factors Analysis work.
Communication	To continue the Trust-wide campaign and consistent program of communications to staff discouraging the falsification of observations, encouraging honest reporting and improving staff awareness of reporting requirements for missed observations.
Observation practice	To maintain involvement in the Cavendish Square community of practice attended by Chief Nurses to develop new approaches and adopt learning Developing the second phase of quality improvement work to include collaborative work with the whole Multi-Disciplinary Team to identify alternatives to observations during working hours. This would require a significant cultural shift away from observations, which will require a significant project to be undertaken Trust-wide.
Learning system	To develop a learning system that includes learning from incidents and improvement work internally, but that also links in with national work in relation to observations practice. To design an internal governance process for the review of reported cases of missed observations and learning that arises from this, that will report into the Patient Safety and Quality Assurance committees. An Executive-led improvement board will monitor actions and agreed plans.
Standardised processes	To develop a consistent approach to supporting staff to learn from incidents involving poor observations practice through reflection, personal accountability and if indicated onward referral to regulatory body. This will be followed in parallel to the Trust Disciplinary process.

I hope that the above descriptions of work both done and to be done provide you and Mr Ali's family with reassurance that the Trust takes this issue extremely seriously and is determined to ensure that observations are being conducted and recorded as required.

Yours sincerely,

[redacted]
Chief Medical Officer

[redacted]