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Private & Confidential

HMC Melanie Lee
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24 September 2024

Dear Madam

RE: REGULATION 28 REPORT

1. This is a formal response to your Regulation 28 report issued on 18 July 2024 where you set out concerns relating to the care of late Ms Anna Elliott under the East London NHS Foundation Trust's **(the 'Trust's')** care.

2. I understand that at the inquest into Ms Elliott's death, you heard evidence from the Trust's Borough Lead Nurse ('BLN') for Tower Hamlets outlining the learning that has taken place because of her death. I understand that you remained concerned about the risk of future deaths in relation to the following areas:

    Concern 1 – Record Keeping
    Concern 2 – Quality of Observation Records
    Concern 3 – Missed Observations
    Concern 4 – Falsified Observations
    Concern 5 – Safety Plans

3. I am writing to assure you and the family of Ms Elliott that the Trust has carefully reviewed the issues highlighted within the Regulation 28 Report and has planned the actions outlined below.

RESPONSE

Concern 1: Record Keeping

4. I was concerned to hear evidence that there were several areas with record keeping issues. I will address these in turn.

Phone calls to Home Treatment Team regarding patients

5. The Tower Hamlets Crisis Services acknowledge that on 23 November 2021 the calls made by Ms Elliott's mother to the Home Treatment Team (HTT) were not recorded in the RiO medical records or passed on.

6. Steps are now in place to ensure calls are not missed: the administrators' office will now be covered with admin staff during the team handover from 14:00 to 16:00 to ensure calls are not missed.

7. In addition, HTT staff will be offering carers and significant others a check-in/follow up call for support as needed. An escalation process has been put in place to improve communication within and outside of the team.

8. It is now the case that the shift co-ordinator has the patient/carer phone at all times or allocates it to a named staff member whose identity is then documented on a log for reference.

Patient progress notes

9. There will inevitably be cases of human error where entries may be recorded incorrectly. Currently, the Management of Incorrect Entries Policy sets out how to remove an incorrect entry. Members of staff detecting an incorrect entry should take steps to correct it as per the policy.

10. The Trust has a robust Clinical Record Keeping Policy in place. The auditing functions behind a RiO progress note entry contain detailed information on who made a note, on behalf of whom, when they made it as well as the same details for any update to that note. This effectively serves as an electronic signature on that note.

Smartcards

11. I was concerned to learn that some staff members were not following data protection guidelines through sharing log in details with other staff members and leaving smartcards unattended. When joining the Trust, staff are issued a smartcard and they will receive information on how to keep their smartcard safe; this includes never allowing anyone else to use it. This message is further reiterated in RiO training sessions.

12. Data Security Awareness training also covers managing devices. As of 3 September 2024, Tower Hamlets training compliance with this training is currently 94.27%. The Directorate has since reminded staff on how to keep smartcards safe (via email on 2nd September 2024) with a plan for Matrons to reiterate this message at Away Days (team meetings) by the 30th of November 2024.

Handover documentation

13. Tower Hamlets is currently working on creating a standardised handover template. This project is being led by the Deputy Borough Lead Nurse. The aim is to have a running document over a 24-hour period. The handover template has been tested on some of the wards and is currently being rolled out to the remaining wards. Roll out should be completed by the end of September 2024. The Matron responsible for ward will be responsible for the initial audit daily, this will be audited by the Lead Nurses quarterly.

14. In addition, the Trust will continue to use Safety Huddles as a way of discussion and decision making during a shift. Safety Huddle discussions will be documented on the handover template. This will ensure vital information during a shift is captured in the handover documentation.

Concern 2: Quality of Observation Records

15. The expectations of recording entries in safe and supportive observation charts has been brought up at the Directorate's safety discussions.

16. The issues with the quality of observations have also been discussed with Ward Matrons in governance meetings.

17. The Directorate has now adjusted spot check data to be specific around quality of observations. It will begin collecting data from September 2024.

18. It is mandatory for inpatient nursing staff to attend online training on intermittent observations on ELA (ELFT Learning Academy). It is part of a suite of essential training and also includes Honesty in Documentation training. Compliance is monitored via individual staff ELA records or monthly training reports.

19. The Trust is currently developing a new E-observations (e-obs) platform which has in-built prompts to ensure staff capture the location of a patient, what they observe and their interactions with a patient. Daily spot checks will be undertaken by the clinical nurse manager or the most senior nurse on shift out of hours. It is hoped that this will be in place in the coming six months.

Concerns 3 and 4: Missed and falsified Observations

20. I apologise that the most up to date data was not provided during the inquest hearing in relation to missed observations. It has come to my attention that the data from an old presentation was used. Going forward we are using power BI (a Microsoft data application) to capture up-to-date information in a consistent and easily accessible fashion.

21. The Trust has undertaken (and continues to undertake) a significant amount of work in relation to both missed and falsified observations. Tables setting this out are provided below.

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 Cavendish Square community of practice attended by Chief Nurses and are applying to enrol 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 MDT 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.
Electronic Observations	The e-obs platform being developed will support with improving completion of observations as the system will record any delayed observations records that are entered, reducing the risk of falsification. All entries will be time stamped. It will alert staff on the shift once prescribed observations are overdue by 5 or more minutes; reducing the risk of missed observations. Each staff member will have their own log in for the app and any observations they complete will reflect this- staff should not be able to use other people's log in to falsely record observations completed. On the app each patient's observation care plan will be linked to their record of observation. This ensures continuity of care. Any reviews in level of observations will require an entry to be made verifying the escalation and decision-making process.

Concern 5: Safety Plans

25. In Tower Hamlets the Trust has introduced Dialog+ Plus and Safety Planning training facilitated by Trust Matrons. We have a monthly schedule where inpatient staff in Tower Hamlets must attend Training covering Dialog+ care planning, safety plans and risk formulations. Staff have an opportunity to practice using scenarios in groups.

Conclusion

26. I hope this response provides sufficient reassurances to you and to the family of Ms Elliott about the additional learning that has taken place at the Trust because of her sad death.

27. I would like to offer my sincere and heart-felt condolences to her family at this difficult time.

Yours sincerely

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Chief Medical Officer