HEALTH SCRUTINY COMMITTEE

24 March 2019

Title: North East London Foundation Trust's Response to Regulation 28 Reports	
Report of the Interim Chief Executive of North East London Foundation Trust (NELFT)	
Open Report	**For Information**
Wards Affected: None.	**Key Decision:** No
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Summary

Under the Coroner's and Justice Act 2009 coroners have a legal duty to issue a report where the coroner believes that shortcomings in care identified during the inquest may reoccur and cause or contribute to the deaths of the patients in the future. These are known as Regulation 28 Reports or Reports to Prevent Future Deaths (PFD).

In the last 5 years NELFT has been invited to contribute to 296 inquests and has been issued with 10 PFDs. NELFT has a robust process in place to ensure appropriate actions are taken and learning is embedded following the issue of a PFD.

As part of this year's internal audit cycle NELFT have commissioned a BDO audit of coroner's inquest and PFD processes, to provide independent assurance. The audit has been completed and we are awaiting the final report.

Recommendation

The Committee is recommended to note the contents of this report and ask questions of NELFT's representatives to obtain assurance that the Trust's response to PFDs is robust.

Reason

This report is for noting and allows the Committee to put questions to the officer presenting the report.

1. Introduction and Background

1.1 The Committee has asked for assurance from NELFT around the actions it is taking in response to recent Regulation 28 reports. The Committee has requested that the Chief Executive of NELFT attend so this can be discussed.

1.2 Under the Coroner's and Justice Act 2009 coroners have a legal duty to issue a report to a person, organisation, local authority or government department/ agency where the coroner believe that shortcomings in care identified during the inquest may reoccur and cause or contribute to the deaths of the patients in the future. These are known as Regulation 28 Reports or Reports to Prevent Future Deaths (PFD).

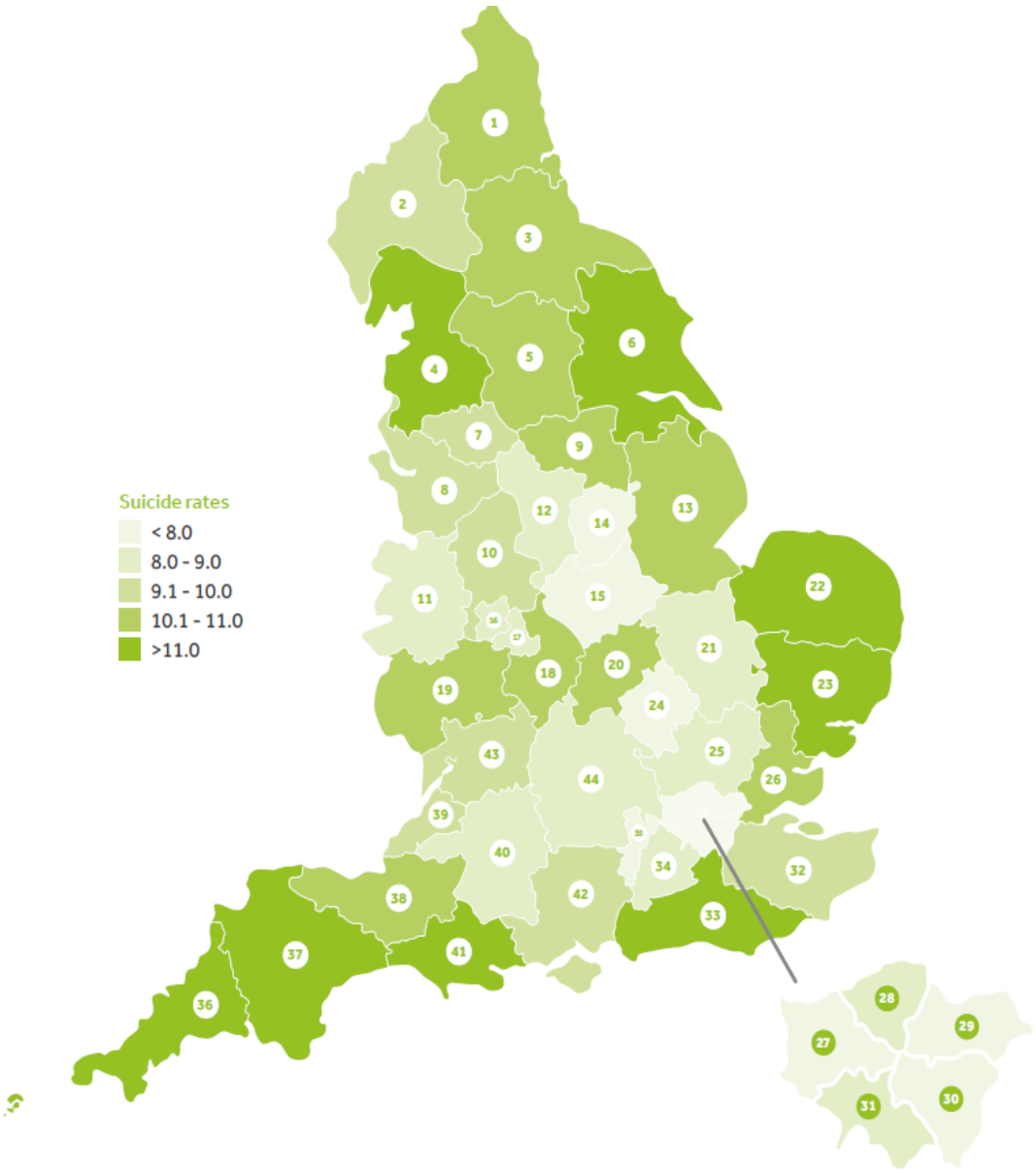
1.3 The organisation receiving the PFD has a duty to provide a response to the coroner detailing action taken/ proposed to be taken and a timetable for this, within 56 days of the PFD being issued.

2. Benchmarking and Reporting Culture

2.1 NELFT provides mental health and community health services for a population of around 4.3 million. During the month of January 2020 we provided mental health care to 20,243 individuals and community health care to 39,754 individuals. Many of these people received multiple episodes of care from the treating service.

2.2 The most recent National Confidential Enquiry into Suicides and Safety (2019) demonstrated that the East London Sustainability and Transformation Partnership (STP) footprint had one of the lowest rates of suicide per 100,000 population in England at 7.5 per 100,000.

Figure 1
Rates of suicide per 100,000 population by STP 'footprint' area of residence



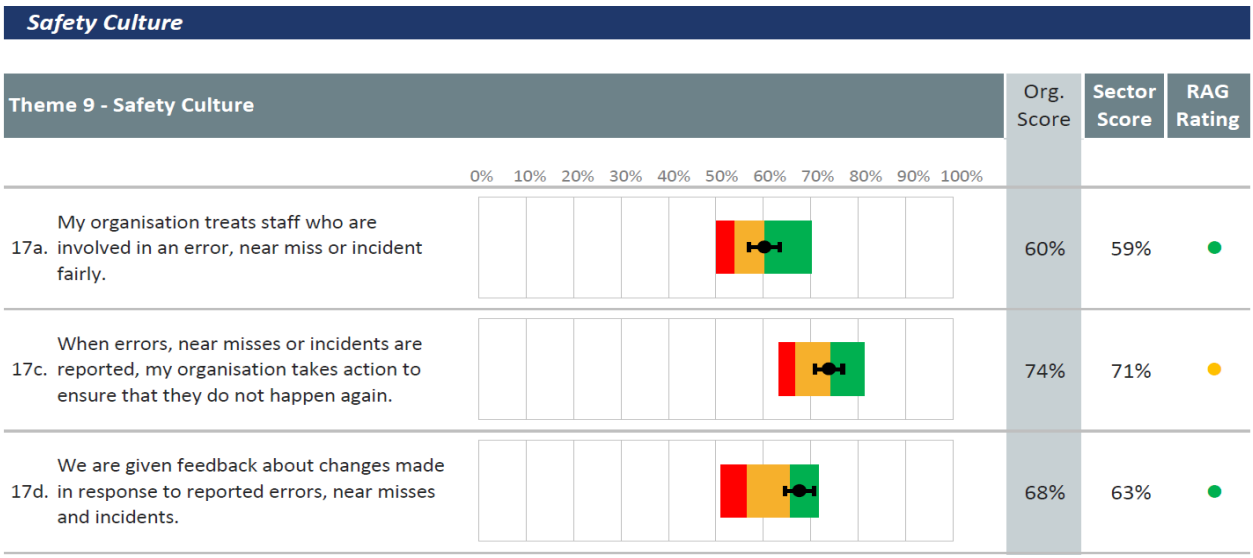
2.3 The National Reporting and Learning System benchmarking report (September 2019) publishes comparative data to help organisations identify under-reporting of patient safety incidents. The figure below indicates that NELFT continues to be a high reporter, which is considered as having a positive patient safety culture.

Figure 2 Reporting Culture

2.4 The Care Quality Commission (CQC) inspection report published in September 2019 stated: “The trust managed patient safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave patients honest information and suitable support. Incidents were investigated in a timely manner and the reports were completed to a high standard”.

2.5 The annual CQC staff survey also provides comparative data relating to staff experience, including staff confidence in the safety culture of the organisation. In the Red Amber Green (RAG) charts below, the red segment represents the range of scores achieved by the lowest scoring 20% of organisations within the sector, the amber segment represents the middle 60% and the green segment represents the top 20%. The latest survey results released in February 2020 are presented below. 3,500 staff responded, equating to a 59% response rate.

Figure 3 Staff Perception of Safety Culture



2.6 Between January 2015 and December 2019, NELFT was invited to contribute to 296 inquests in relation to unexpected deaths, which equates to around five inquests a month. These related to patients who were, or had historically, received mental health or physical health care from NELFT. During this five year period, ten PFDs were received from Coroners. One related to mental health care provided in Barking and Dagenham. A further two related to Barking and Dagenham residents receiving care in the Acute and Rehabilitation Directorate - one in the 136 Suite and the other in our intermediate care wards for physical health.

2.7 The Patient Safety Lead for Mental Health NHS England and NHS Improvement (NHSE/I) was approached for benchmarking data in relation to PFDs across other London Trusts; however, they do not collect this data as they do not believe it is meaningful, due to differences in Trust size/ portfolio and different individual Coroner's approaches to issuing PFDs.

3. Actions and Learning

3.1 The following process is undertaken within NELFT following the issue of a PFD, to ensure appropriate actions are taken and learning is embedded:

Regulation 28 PFD received from Coroner
Operational Director provides response and develops action plan
Chief Executive Office approves response and sends to Coroner, CQC, Commissioners
Action plan implemented, evidence of completed actions monitored at Divisional Business Meeting **Exceptions reported to Quality Leadership Team Meeting and escalated to Quality Senior Leadership Team Meeting**
Local learning event held at service level for immediate learning. Representation from equivalent services in other Directorates for shared learning.
Learning from inquests report disseminated by Legal Team through governance meeting structures to support wider learning
Specific Trust wide learning disseminated in a learning cascade by Serious Incident Team- also available to all staff via a 'shared learning' desk top icon
Learning shared at NHSE/I Provider Mental Health Patient Safety Forum to support London wide learning
Action plan includes audit to ensure learning is embedded in practice
Completed PFD action plan and evidence submitted to Quality Leadership Team Meeting to approve closure
Current inquests and outcomes reported to Executive Management Team bi-weekly
Quarterly Learning from Inquests report to Board – combined with Learning from Serious Incidents, Complaints and Patient Experience to ensure data is triangulated

3.2 A thematic review was undertaken of the ten PFDs received by NELFT between January 2015 and December 2019. Eight of these related to patients receiving different care, from different services and different concerns were raised for learning. There were two PFDs (2016 and 2019) which related to the Section 136 Suite and

the handover and recording of information between London Ambulance Service / Police and the mental health crisis team.

3.3 The action plan in relation to the Section 136 Suite was completed and approved for closure in November 2019. This included:

- Evidence of service and Directorate level learning events
- An ongoing training package for London Ambulance Service staff
- Police handover and escalation of concerns added as standing agenda item for Police Liaison Group
- Audit showed full compliance that handover information had been uploaded, documented and shared with the assessing team

3.4 In addition to the Section 136 Suite PFD, there were two further PFD's in 2019. One related to our intermediate care wards for physical health and the ordering of emergency pendant alarm telecare equipment. The action plan was completed and approved for closure in October 2019. This included:

- Trust wide patient safety learning cascade for all Occupational Therapists (OTs)
- Telecare training for inpatient and community OTs including Borough specific processes and phone system requirements
- Equipment ordering processes and telecare added to the local induction process for new starters
- Trust wide pendant alarm working group established.

3.5 The remaining PFD related to Barking and Dagenham Mental Health Access and Assessment / Specialist Psychological Services. The response and action plan were submitted to the Coroner on 29 January 2020. A local learning event has been held, including representation from the equivalent services in other NELFT Directorates and 5 of the 20 actions have already been completed. The anticipated closure of this action plan is due in September 2020 – i.e. all 20 actions to be completed and evidence of completion finalised. Actions include:

- Strengthening of recording of key worker details
- Care planning and review of length of stay within a brief intervention team
- Restructuring of the specialist psychological services to embed them within the core services, thus facilitating improved working arrangements between services and specialists.

3.6 The Senior Coroner for the area of East London and the Patient Safety Lead for Mental Health NHSE/I have been invited to speak at NELFTs annual learning event this month.

4. Risk Management

4.1 As part of this year's internal audit cycle, NELFT have commissioned an independent audit of coroner's inquest and PFD processes, which will be completed by the approved auditors, BDO, to provide independent assurance.

The BDO Public Sector Internal Audit team are experts in delivering internal audit services to NHS, central government and local government organisations. Internal audit minimises operational risk and promotes good governance through the scrutiny of the effectiveness of systems and processes.

The audit has been completed and the final report is due in April 2020, which will present findings and recommendations for NELFT.

Public Background Papers Used in the Preparation of the Report: None.

List of Appendices: None.