North Bristol
NHS Trust
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Bristol BS10 5NB
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The Coroner's Court
Old Weston Road
Flax Bourton
BS48 1UL

[redacted]

Dear Mr Sowersby,

Re: Regulation 28 following the Inquest into the Death of Mr George Elliot

I write further to the Regulation 28, dated 04th October 2022, issued as a result of the inquest into the death of Mr Elliot.

Quality of the Patient Safety Investigation:

The Regulation 28 raised concerns about the quality of the investigation report and supporting process following Mr Elliot's fall in hospital. Furthermore, it raised concerns that if this report were representative of the wider quality of such reports it may indicate that North Bristol NHS Trust may miss opportunities to learn, which may contribute to further deaths.

We recognise the investigation in the case of Mr George Elliott missed key elements and that the process of approval did not identify these. Accuracy in our investigations is very important to us to provide insights for learning. A key driver for North Bristol NHS Trust is being open and honest with patients and families following an incident. To achieve this, it is essential that we understand the facts of what has happened. Therefore, we take this Regulation 28 report very seriously as it tells us that on this occasion, we have not achieved the degree of understanding that we strive for. The Patient Safety Incident Investigation relating to Mr Elliott was commissioned early under the new PSIRF framework and was completed at during a period in which North Bristol NHS Trust was experiencing extreme pressures relating to the covid pandemic. This was a particularly challenging time for both clinical and nursing staff. It is likely to be due to the pressures at this challenging time that this investigation missed key elements.

[redacted]

We would like to assure you that this is not reflective of the standard and quality of patient safety investigations at the Trust and of the rigour placed on conducting such investigations, as well as the process for approving and learning from them.

The Trust has extensive governance relating to Patient Safety Incident Investigations. When a Patient Safety Incident Investigation is commissioned, the responsible Clinical Division allocate an investigation team/panel. The process of investigation is supported by the Clinical Division, with oversight through the Patient Safety Group and then ultimately being received and approved through the Patient Safety Committee. The Patient Safety Committee in February 2022 that approved this report was chaired by the Director of Nursing and Quality.

As further assurance, the Trust recently had an audit into its PSIRF conducted by KPMG. This audit looked at the processes and controls over learning from incidents that are part of PSIRF. This audit returned a finding of significant assurance in relation to the PSIRF policy and procedure framework, the Patient Safety Incident Response Plan (PSIRP), the supporting investigation templates as well as the key guidance documents and educational materials available. The audit identified minor improvements; however, these did not relate to the investigation process. Prior to rolling out PSIRF at the Trust in June 2021, key staff involved in undertaking investigations received training on this new investigation process from Baby Lifeline/Cranfield University as well as ongoing coaching and training provided through the Trust's Patient Safety Team.

<u>Key national changes – Patient Safety Incident Response Framework (PSIRF):</u>

North Bristol NHS Trust has been one of the national early adopters for the Patient Safety Incident Response Framework (PSIRF) which we have previously written to the Coroner about to update about changes that are likely to be seen in inquests. I have attached a copy of this letter for ease of reference.

PSIRF replaces the Serious Incident Framework and represents comprehensive changes to the way in which NHS organisations respond to patient safety incidents, including what and how to investigate.

In August this year, the final PSIRF documentation was published by NHS England, with all NHS Trusts now transitioning to PSIRF. We in NBT are using the newly published documentation to conduct a gap analysis about the end-state framework documentation. The core reason for the gap analysis is to ensure that, as an early adopter, we are now working in full alignment with the final guidelines that other (non-early adopter) organisations are starting to transition to. This is a process being adopted by all other early adopters.

There are key points during the pathway of investigation that we have and continue to strengthen. For clarity, we have set out the key points below:-

Identification and commissioning of an investigation:

Patient safety incidents are routinely reviewed, with automatic flagging in our electronic system set for types of incidents and harm levels. A Patient Safety Incident Investigation will be commissioned for any incident in which we believe that a death was more likely than not due to a problem with care (as per the Learning from Deaths processes). This was the case for Mr Elliot, with the incident report for his fall triggering a PSII. The investigation was assigned an investigation team.

Investigation process and support:

Supporting high quality investigations is a key objective for North Bristol NHS Trust. PSIRF continues to change the way that the NHS should consider and support patient safety investigations, with a key principle of moving away from the Serious Incident Framework to PSIRF, being to do fewer investigations but to do them better, focussing on Patient Safety Incident Investigations requiring expert, professional investigation knowledge and skills, supported by the required time to conduct them. This represents a significant change for the NHS, and North Bristol NHS Trust as part thereof, as many NHS organisations rely on investigations being carried out by staff members, often clinicians, that already have a fulltime role – therefore doing the investigation in addition to their existing role.

Over the past 4 years, the governance teams within our divisions have undergone significant investment, part of which has been to ensure governance teams are better resourced to support and undertake investigations in relation to patient safety incidents. To continue to strengthen our approach, we are also reassessing our approach to how we support detailed, high-quality investigations, and considering establishing new posts that focus entirely on investigations. This is in line with the recently published national PSIRF guidelines.

Oversight:

Oversight of investigations is a key area that we have and continue to focus on. With PSIRF, the way this works will be significantly different, both at organisational and system levels.

The new national PSIRF "Oversight roles and responsibilities specification" published in August 2022 states "Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control".

At NBT we have developed and are implementing a process in which the central Patient Safety Team routinely review the progress of investigations. This process focuses on the timeliness, but also the rigour being applied to the actual investigation process. Any concerns and feedback will be communicated with the respective Division and, where necessary, escalated to the Chief

Medical and Nursing Officers through the established weekly meetings that oversee patient safety learning and investigations.

Falls Policy:

Whereas the Regulation 28 does not note the Falls Policy as the reason for the Regulation 28, it raised specific points about it that I would like to take this opportunity to address. The Falls Policy referenced is no longer in place, it was replaced with an updated policy in December 2021 that maps to the NICE Guidelines relating to falls. A routine review of this policy is due to be presented to the Patient Safety Committee in December 2022.

Next Steps

Carrying out robust patient safety incident investigations is a key tenet in our learning systems and culture.

As noted above, we accept that the George Elliott investigation missed some key elements, but do not consider this is reflective of the standard of our Patient Safety Incident Investigations at the Trust. We are presently conducting a gap analysis using the recently published PSIRF national guidance. As part of this, we are re-focusing on how we support expert investigations being conducted by scoping the structure and capacity within our central and divisional teams.

The findings of the gap analysis, as well as any associated improvements to strengthen our systems and processes will report through our Patient Safety Committee and Quality Committee, with oversight from our Chief Nursing Officer and Chief Medical Officer.

I hope you will take some assurance from this letter setting out our response in relation to the concerning points you made in your Regulation 28 report.

Yours sincerely,

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Chief Executive

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