NHS
Norfolk and Suffolk
NHS Foundation Trust

Trust Management
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Our Ref:ML/JC

22 January 2018

Private and Confidential
Ms Jacqueline Lake
HM Coroner
Norfolk Coroner's Service
69-75 Thorpe Road
Norwich
Norfolk

Dear Mrs Lake

Regulation 28 report following the inquest of Mr Brian Stannard

I write in response to your report dated 14 November 2017. Under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 you requested the Trust consider issues of service delivery following the conclusion of the inquest into the death of Mr Stannard.

Mental and Physical ill health

Your report identified Mr Stannard had mental and physical ill health. He was placed at the nursing home to respond to his physical health needs as they were the presenting priority at the time of admission. As this improved you note that staff at the home were not adequately equipped to respond to his mental health needs. You further observe there did not appear to be a home available where staff were adequately trained to deal with a person's mental and physical ill health.

You raise an important issue regarding the provision of a range of accommodation services that can support individuals with complex and fluctuating needs. Such provision of accommodation is outside of the direct control of the Trust. The Trust's role is to continually monitor the service user's presentation and to help facilitate changes where these are required. For Mr Stannard, this would have involved working with him, his family, the care home, continuing healthcare services and the GP. The Trust's Root Cause Analysis (RCA) investigation identified there was evidence of inter-agency working noting a routine review meeting was held on 7 November 2016. This meeting observed Mr Stannard's continued physical and mental health presentation, identifying plans to assist with his benefit entitlement and to seek advocacy support to assist with decisions about potential future physical events. It was agreed the placement continued to meet his needs. Tragically, Mr Stannard died a few days later.

Completion of records

Your report confirmed the findings of the RCA report that aspects of Mr Stannard's health record had not been maintained to the expected standard, notably risk assessment and care plans. The Trust are engaged in a programme to improve its performance in this area with active monitoring at all levels of the organisation. The Trust recognises there are many influencing factors affecting this and are working with clinical teams to ensure they have the right number of staff and equipment to ensure work can be allocated in a consistent and balanced way.

Electronic Patient Record system

Your report noted the Lorenzo electronic patient record system was introduced some years ago but that it does not appear to be fully operational and used to its full potential by all staff. The report does not detail the specific areas of concern.

The Lorenzo computer system was implemented across the Trust in May 2015, replacing paper records and, in some areas, consolidating separate electronic systems into one. This has improved clinical safety by providing access to clinical information regardless of location and improving communications between different teams caring for the same patient.

The system is fully operational, however the Trust is aware and is addressing some issues with it. Staff are currently receiving site visits from business change and training specialists to continue to develop their use of the system and the Trust is working with the system suppliers to improve its performance and usability.

Thank you for bringing the matters to the Trust's attention. If I can be of any further assistance please do not hesitate to contact me.

Yours sincerely

Julie Cave
Chief Executive