Nottinghamshire Healthcare NHS Foundation Trust
Duncan Macmillan House
The Resource
Porchester Road
Mapperley
NG3 6AA

[redacted]

29th November 2024

Private and Confidential
HM Assistant Coroner Sarah Wood

Dear Miss Wood

Regulation 28 Response: Mr. James Southern

I write in response to the inquest which was held 18th and 19th September and concluded on the 2nd October 2024 into the death of Mr James Southern. We accept your findings in relation to the received Regulation 28 and offer sincere apologies to the family of Mr Southern.

Please find below the Trust response and actions taken.

That there remain potential issues of poor record keeping.

We recognise that there were failings in relation to the expected standards of record keeping in the case of Mr James Southern and this fell below the standards expected by Nottinghamshire Healthcare NHS Foundation Trust and regulatory requirements of professional bodies. I would like to assure you that we have taken clear actions in relation to the concerns of individual practice in line with relevant Trust policy including investigating through formal process and referral to professional bodies.

We also appreciate that the systems in place need to protect patients from individual errors or omissions and therefore we have also looked at this in the wider context of services and developed some additional clinical quality standards for all staff in relation to record keeping (Appendix A). This information forms part of the current policy in relation to records management and will support staff awareness and personal responsibility. This document along with other similar documents for differing grades and professional backgrounds have been shared with all Care Units within the Trust.

In reference to this incident and other incidents, individual accountability is a current focus of development and in collaboration with the Royal College of Nursing the trust is developing bespoke

training, for registered and unregistered professionals. Further work that has been completed in relation to ensuring quality and accurate record keeping is the development of specific training for all staff which join the current training programme and compliance overseen for assurance.

To provide a continual flow of assurance we have also changed the process and documentation used within mandatory supervision sessions with all clinical staff to include a specific review of the quality of care being provided evidenced within the patient records. Further work is in progress to change the current content of the quarterly patient records audit to be more specific to patients being cared for in the community alongside increasing the frequency of the audit to monthly. The outcome of the audits will then be reviewed and overseen within the Care Unit's Quality Oversight Group (QOG) and Care Group QOG to ensure senior clinical oversight and assurance.

There are concerns over the level of communication between professionals within the Trust and communication with patients.

It was deeply concerning to hear the experience of Mr Southern and how the pathway for Mr Southern following his contact with the Crisis Team into the Local Mental Health Team (LMHT) was not properly agreed or communicated between teams, this then led to an avoidable delay which is not acceptable. We have reviewed the pathway between Crisis and LMHT services to ensure that clinical quality standards are in place. There are expected standards that Crisis teams have a clinical conversation with respective LMHT services before discharging a patient from the service. This will ensure that both teams are in agreement to the plan of care required and that this is further communicated to the patient. This standard has been added to the Crisis Team Internal Working Instructions (IWI) and will be further discussed within their local QOG meetings from a wider learning perspective to support learning. Further work relating to place-based interface meetings between teams is currently in progress which will oversee the current process of internal transfers of care, ensure compliance and support wider team communications and closer working relationships to ensure patients receive the standard of care expected. In terms of caseload oversight and allocation there is now an improved process which is incorporated within the LMHT Internal Working Instructions that has been shared and discussed with all teams with further oversight of assurance from weekly oversight meetings, supervision and audits to inform any further potential developments required.

I hope that the information contained within this response provides assurance to you and Mr. Southern's family that we have heard and understood the concerns raised and continue in our journey to make improvements subsequent to this process for future patient care.

Yours sincerely

[redacted]

[redacted]
Chief Nurse