Norfolk Community Health and Care NHS Trust

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Ref: [redacted]
Kenneth George Willard KING - Regulation 28 Report

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23 January 2025

Dear Senior Coroner,

I am writing to you in response to the Regulation 28: Report to Prevent Future Deaths, relating to the death of Mr Kenneth George Willard King, dated 27th November 2024. Please find set out below the summary of actions taken, and those planned to be taken, in relation to your concerns. I have also enclosed a copy of the full Trust action plan including timelines for implementation. We would like to apologise if information previously provided and presented during the inquest has not provided yourself or Mr King's family with the necessary assurances that Norfolk Community Health and Care (NCH&C) are committed to the delivery of safe, effective and evidence-based care. We would also like to apologise for any additional distress this may have caused Mr King's family and offer our sincere condolences for their loss once again.

Following receipt of the report, a working group consisting of senior quality leaders, senior operational leaders and subject matter experts was commenced on 11th December 2024. The concerns raised within the report were reviewed and further areas for learning, improvement and development have been identified. These have been detailed in the attached action plan which is being regularly monitored by trust governance processes including risk group and quality committee. The action themes and focus areas include:

- Monitoring and Recognising the Deteriorating Patient in the Community
- Quality Assurance in Community Services
- Clinical Skills and Competencies
- Community Demand and Capacity Issues Impacting on Quality of Care and Patient Safety
- Temporary Worker Service

In relation to your specific concerns (in bold), please find responses below. Full details and timelines can be found on the enclosed action plan.

Concern 1: Evidence was heard that there is no formal structure in place as to when or with regard to the frequency of carrying out physiological observations on patients in the community. Observations are required to be taken if the attending clinician has any concerns about the patient's wellbeing or a deterioration in their condition, or at the request of a senior clinician or GP.

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No specific questions are asked of the patient, such as if they are feeling unwell, have pain or localised heat, the attending practitioner relies on general conversation carried out at their attendance to help form a view as to whether observations are required to be taken.
It was accepted in evidence that the decision to perform observations relies on the clinical judgment of the relevant clinician, which is a subjective decision which may be exercised incorrectly and at variance with other clinicians.

In this case, evidence was heard that Mr King presented as feeling well but had high inflammatory markers, which may mask when observations are required to be carried out. Some patients may not be forthcoming about any symptoms unless specifically asked.
Trust guidance was updated and disseminated to all clinical staff to mandate the completion of physiological observations on every initial patient visit with immediate effect. A community patient escalation plan has been published and cascaded to support staff in identifying patients at risk of deterioration and the escalation actions that are required which includes the completion of physiological observations.

A community patient assessment guide is being created which will provide exploratory questions that community staff can use to ascertain any changes in the patient's condition and identify if any further action is required. Both of these documents and how to use them will be included in the Deteriorating Patient training.

Different clinicians carry out visits in the community and so have no overall view of a patient's presentation and any deterioration. Written records are available but evidence was heard that in this case, on the last visit, the record of the previous attendance was looked at and no history prior to that.
Due to operational pressures and the need to work flexibly with staff allocation to ensure patients with priority and complex needs are seen in a timely manner, it continues to be very difficult to provide consistent staff allocation to individual patients. Whilst this would be best practice for continuity of care, escalation actions such as the movement of staff are sometimes required to minimise risk to our patients. Whenever possible continuity of care is maintained and patients most at risk or at end of life would be prioritised. Handovers are completed to share learning and patient updates and clinical leads are available to support with complex patient discussions and escalation of conditions. As a trust we recognise the importance of continuity of care and are currently piloting a named clinician and geographical area caseload approach which is being analysed and will inform the development of our future community nursing model.

All community clinicians are given thirty minutes protected time each day for visit preparation, which includes reviewing of patient records prior to visits. We acknowledge that the record review can be variable across clinicians practice and that is an area of focus to understand why. It is also recognised that clinicians responding to urgent care visits may not have the ability to review the record at all prior to the visit. We are looking at ways to ensure more consistency with the senior operational and quality leadership team.

Evidence was heard that Health Care Practitioners may have limited clinical training and rely on instructions and advice from trained nurses.
The trust holds a clinical training programme that is open to registered and non-registered clinicians as per the competency matrix. Additional sessions are held, such as the Deteriorating Patient Training, which is open to all staff. From review of the attendance logs, it is acknowledged that there is lower uptake of this training by community staff, particularly podiatrists and non-registered clinicians including phlebotomists. The training sessions will have a targeted focus on those staff groups, and we are currently gathering information to understand the barriers and challenges to good attendance levels. It is also recognised that different staff groups will need different levels of training.

The current competency matrix has been under review and a newly developed community competency matrix has been out to consultation and is in the final stages of ratification. To support the competency management and sign off process, we have also developed competency passports aligned to each role. Each Place area will be completing a gap analysis of competency and training needs to ensure that our current clinical training programme is accessible and offers appropriate availability.

Our non-registered clinicians do work under the delegation of registered staff who provide ongoing advice, support and review. Shadow and observational review shifts are completed to ensure competency of individuals in both practical skill and theoretical knowledge. This is an ongoing review process and will be supported with the competency passports. In addition to this monitoring and overview, there is an expectation that staff work within their limitations and escalate where further support and development is required.

Concern 2: Mr King died a year ago and although there is a training programme which is being devised and rolled out it is not expected to be in place for a further eighteen months.
We would like to apologise if information previously presented has not been clear or has caused yourself or Mr King's family any confusion. NCH&C has a full clinical training programme and currently is and will continue to be delivered on a rolling basis across various locations. Whilst most of the clinical training is provided by our clinical education team, additional or enhanced sessions are provided by subject matter experts. One example of this is the wound care and tissue viability training package that is provided by the Tissue Viability Specialist Nurse. I have included the 2025 wound care and tissue viability training plan for information. As part of the action plan, we are currently scoping all clinical training to understand previous attendance levels and accessibility of sessions, so we can understand barriers or challenges to accessing the training. The tissue viability and wound care pathway has been a priority workstream within our community transformation programme, 'Better for All'. The workstream has a number of quality improvement initiatives and focus areas such as the implementation of the National Wound Care Strategy guidance and the use of digital technology in wound care, which have different timeframes for completion. For clarity, the eighteen-month timeframe stated at the inquest was relating to the Better for all transformation programme duration and some of the individual initiatives, rather than the training programme which is on a rolling agenda.

The policy to prevent bank staff applying for roles when they have not undergone the required training is not yet in place.
We acknowledge that there is inconsistent and variable levels of clinical supervision and monitoring/ management of clinical competencies for this staff group. The majority of our bank staff are well known to the substantive teams and are supported with training and clinical supervision. The competency passports and matrix will provide a robust process for competency management moving forward. As part of the interim plan, restrictions are in place so that only temporary worker staff known to the local team and where competencies are signed off will be able to book community shifts.

We hope that the information provided offers you full assurance that immediate learning and actions have been taken and further actions are planned to prevent recurrence. If you wish to discuss anything further following receipt of this letter and action plan, I would be very happy to meet you. Please do not hesitate to contact the Clinical Governance and Quality Team on the details at the top of this letter.

Yours Sincerely

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Executive Director of Nursing and Quality

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