Essex Partnership University
NHS Foundation Trust

21st September 2023

Chief Executive Office
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

Private and Confidential
Mr Sean Horstead
HM Area Coroner for Essex
Coroner's Office
Seax House
Victoria Road South
Chelmsford
CM1 1QH

[redacted]

[redacted]

Dear Mr Horstead,

Mrs Johanne Blackwood (RIP)

I write to set out the Trust's formal response to the report made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, dated 27th July 2023 in respect of the above, which was issued following the inquest into the death of Mrs Blackwood.

I would like to begin by extending my deepest condolences to Mrs Blackwood's family. The Trust sympathises with their sad loss.

The matters of concern as noted within the Regulation 28 Report have been carefully reviewed and noted. I will now respond in full to these concerns in the hope that this provides both yourself and Mrs Blackwood's family with comprehensive assurance of changes that have been made at the Trust to address the concerns you have raised.

1. Lack of a formal handover between care coordinators

As part of the Inquest hearing, it was recommended by yourself, as the presiding Coroner, that the operational management at Essex Partnership University Foundation Trust (EPUT) consider establishing a mechanism and process for a formal structured handover between care coordinators. The service manager took this recommendation on board and has been working with colleagues and departments to produce a purposeful template that will form part of the Patient Electronic Record specific to the care coordinators' handover. This document has been approved, for implementation Trust wide, following a process of consultation and with comments gathered from all community services.

This process is being used to capture vital information around patients, their care, risk, care plan and areas that are under review. The approved template will also be used as a handover tool by any care coordinator who moves on from their role. This will allow the team and relevant managers to look at the required steps/process in order to ensure oversight while a new care coordinator is appointed, ensuring continuity of patient care. For example, from the handover, the former care coordinator might suggest that a weekly contact is maintained with the patient and this can be facilitated by the team leads/manager.

In addition, where notice has been given by any care coordinator (of their departure from the Trust) the team will promptly make an attempt to recruit another member of staff with an aim of ensuring an overlap of at least two weeks, to allow for effective handover and continuity of care, again Trust wide.

This provides an opportunity to introduce the new care coordinator to all their patients face to face and also get to know the patients' care and needs in more detail. On a positive note, the team has recently been able to recruit more substantive staff which will reduce the reliance on temporary/agency staff.

By way of an update, the Team at Grays Hall have extra care coordinators in post to respond to the service demands and currently there are no vacant posts that have not been covered either by agency and permanent staff.

2. **Lack of a policy or procedure requiring that a formal handover is documented in the medical records.**

   As highlighted in Care Programme Approach Policy and Procedure, there is a clear expectation of the need to ensure that a tailored review is undertaken when a new care coordinator is allocated. This is to establish rapport with the patient, meet family and carers, review care plan, undertake risk assessments and maintain contingency planning i.e. the actions that are required for events like relapse symptoms, crisis etc. by the patients or those involved in their care.

   As highlighted above, the introduction of a new template as part of handover will enable this type of vital information to be captured, updated and reviewed in a timely way which will take into account all the necessary information within the patient's clinical records. The handover template *(Care Coordinator to Care Coordinator Transfer of Care Document)* will form part of the patient's electronic record and will be easily accessible to anybody working with the patient.

3. **Lack of clarity over who has oversight and is responsible for the care of patients in the community when no care coordinator is allocated/a new care coordinator is awaited. This third concern was previously raised as part of the PFDR issued in the case of SM (RIP).**

   The Community Mental Health Team (CMHT) based at Grays Hall, as well as CMHT teams across the Trust have access to the Team caseloads via the Trust Intranet system "Client Information Website" which provides a breakdown of all patients open to the team. The feature provides further information on the full team case list which denotes allocated care coordinators and those who have not assigned a care coordinator yet. The team manager and team leads, are able to utilise this tool to have an oversight of team caseloads alongside the Management and Supervision Tool (MaST). This system allows for Trust wide access and scrutiny on case load requirements.

   The Grays Hall / Trust wide CMHT's teams have a process in place where all patients under their caseload are RAG rated according to their level of needs. This document is used as part of the Multi-Disciplinary Team (MDT) discussion in order to establish any change required or review for the patients, when these are brought to the attention of the MDT. Where there is indication that a new care coordinator is required, this patient will be 'Red' rag rated which will act as a highlight and prompt an overview to members of the MDT. The team leads and manager will determine early actions, including any capacity considerations, to facilitate allocation of a new care coordinator.

In the event that a new care coordinator is not available, the team ensure that those patients without an allocated care coordinator have direct contact from clinicians within the team. This is done through a clinical MDT approach; patients are prioritised according to their presenting need and contact is through the use of creating from the Duty Person and Buddy worker System. In addition the staff have opportunities to work additional safe hours, by way of overtime which includes weekends and evenings so that all patients have a timely review by a practitioner avoiding any extended gaps in care whilst a care coordinator is appointed.

Grays Hall staffing establishment has significantly improved over the last year with the recruitment of two Band 6 and one Band 7 permanent staff and the use of regular agency staff. There are two more permanent care coordinators starting in October 2023.

In addition, the team are using the *Care Coordinator to Care Coordinator Transfer of Care Document* which is completed by the ***outgoing*** care coordinator and will conduct a handover with the team leads and managers. This document is part of the patient electronic record so any subsequent care coordinators will be able to see vital information readily.

The document itself has been created from the Thurrock locality, however has been shared across all EPUT Community Mental Health Services which use both Mobius and Paris (Electronic Patient Record systems). The clinical change managers who support new templates and reviews of documents for Mobius and Paris have both been involved in the development of the 'Care Co-ordinator to Care Co-ordinator' transfer document.

This concern has been previously raised within the matter of SM (RIP) within the Regulation 28 report dated 25th February 2022, it is noted that in both cases, there was a period of time before death when the patient did not have a care coordinator. In Mrs Blackwood's care, this was a regrettable error and was due to a lack of staff and a delay in the new allocation. In SM's case, there was a view that a care coordinator was not needed. However, both cases raised the question of what oversight should be in place to ensure someone remains stable and they are given safety netting advice when they do not have an appointed care coordinator. I hope that the assurances and changes to practice set out within this response satisfactorily addresses this concern.

4. A failure to update the risk assessment, care plan and security plan

The team manager and team leads now receive monthly performance updates with regards to the various care standards compliance which include care plan and risk assessment which are then shared with the care coordinators for action. In addition, during supervision sessions with care coordinators, the supervisor will conduct a highlight review from MaST which provide clear options for care coordinators caseload for that particular supervisee.

MaST uses information from patients' clinical care records to provide a clear visual display of individual or team's caseloads with an ability to filter by risk of crisis, level of complexity or frequency of contacts. MaST is used to identify patients that are high risk or those who are in need of enhanced support. MaST is able to pick up the cohort of patients that are not engaging or are in need of increased care requirements and shows when care standards such as risk assessments or care plans need to be reviewed.

Training in the use of MaST has been rolled out already with the Community Mental Teams on the Mid and South Essex locality, and will be extended across all EPUT Community Mental Health Teams as a phased implementation. There have been further bespoke sessions undertaken for the use of MaST in the MDT in the Community Teams at Grays Hall. MaST

will also provide each clinician, team leader, Manager or Consultant the opportunity to see whether any documentation require updates or escalation. For example, this could be in relations to care plan, risk assessment or annual reviews for physical health.

In order to improve capacity and patient contact, the team has recently increased the number of support workers to work with care coordinators in care provision. This is in return providing care coordinators with more opportunity and time to ensure that their patient documentation is kept up to date.

The support workers from Grays Hall / CMHT's, conduct a daily handover where their workload is discussed. The importance of clear, structured handovers is being cascaded via learning and awareness sessions and newsletters.

The allocated caseloads and any issues of concern are promptly brought to the attention of the team Leads/manager or allocated care co-ordinator for further actions including any required escalation.

During staff team meetings there are various agenda items that are discussed which include arising issues, productivity, information sharing etc. The leads and managers again, emphasise the need for clinicians to ensure that their care records are up to date. If they need protected time to ensure this task is completed this is facilitated by the team Leads and manager.

In summary, the Trust acknowledges that Mrs Blackwood did not have an updated community risk assessment and care plan. These documents should have been updated following discharge from the inpatient ward and when there were changes to presentation, risk and the plan in which they were working towards. Evidence within the clinical records suggest that care coordinator had been making plans to update the care plan and risk assessment, however this was not completed prior to Mrs Blackwood's sad death.

Whilst being mindful of not repeating the evidence provided to your Court during this Inquest, we re-iterate our regret at the fact that Mrs Blackwood's husband was not offered a carers' assessment, although this was considered at intervals in his wife's care, more should have been done to support him. We sincerely apologise for the distress this would have caused.

I hope that I have provided some reassurances around the steps that we have taken to address the issues of concern contained within your report. We know there is an acute need to embed and effect change, hence we will monitor the above provisions to ensure these are contributing to our overall aim of keeping patents safe and delivering therapeutic care.

Please do let me know if you require any further information at this stage, including copies of any of the documents referred to above.

We will await your direction before sharing a copy of this reply with the family and the CQC (the latter having requested a copy of the same).

Yours sincerely,

Chief Executive