Essex Partnership University
NHS Foundation Trust

11 March 2024

Chief Executive Office
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Private and Confidential
Ms Rebecca Mundy
Assistant Coroner for Essex
Coroner's Office
Seax House
Victoria Road South
Chelmsford
CM1 1QH

Dear Ms Mundy,

Ms Nadia Wyatt (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 15th January 2024 in respect of the above, which was issued following the inquest into the death of Ms Wyatt .

I would like to begin by extending my deepest condolences to Ms Wyatt'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 Ms Wyatt's family with comprehensive assurance of changes that have been made at the Trust to address the concerns you have raised, which I will address in turn:

Concern 1:
Failure to update Nadia's records with the outcomes of referrals that were made and whether such referrals were accepted or declined, either for Nadia or her carer.

Response:
The Trust has revised line management supervision forms to include quality of record keeping, their professional responsibilities, Trust policy and values, and NMC accountability frameworks in respect of record keeping. In addition to discussions during supervision the Crisis Response and Home Treatment Service has been reminded of this in their team meetings.

Bespoke training on the importance of documentation is being arranged for all staff working in the urgent care pathway in April 2024.

In order to ensure the assessments undertaken by the Home Treatment Team are comprehensive and the findings (including the rationale for the decisions made) are clearly documented, regular audits on Home Treatment Team assessments will be undertaken and the findings shared with the team to continuously improve practice.

Concern 2:

Failure to include within her records considerations and professional opinions reached on the prospect, or not, of readmission for in-patient treatment together with the final decision and rationale.

Response:
As noted in response to Concern 1 bespoke training on the importance of documentation is being arranged for all staff working in the urgent care pathway in April 2024.

The Home Treatment Team complete gate keeping assessments which provide professional opinions and rationale, including the 'purpose of admission', or a home treatment care plan as an alternative to admission. All admission requests have oversight from the Purposeful Admission Clinical Lead.

The Trust is currently commissioning a unified Electronic Patient Records System. This system will permit access to all of the required clinical systems and will also embed a new mechanism to ensure robust clinical information sharing.

Concern 3:
Lack of bespoke care plans tailored to Nadia's needs. Notwithstanding the fact Nadia had begun to disengage and declined to be involved in her care planning, more personalised plans could have been drafted taking into account her personal characteristics, needs and past medical history.

Response:
The Trust's Urgent Care and Inpatient Care Unit is implementing a new initiative 'International Fundamentals of Care Framework', which is a nursing framework that supports transition and care planning based on trusting therapeutic relationship, integration of care and context of care. The Home Treatment Team in Mid and South have added the framework principles to the Newman's form that is given to patients to develop and assist with their view and planning of their care and treatment needs. The Newman's form is based on the Newman's model of care, which encourages individuals to be involved and interact with their health needs.

This initiative also provides for in-put from family members where consent is given and is appropriate.

The Admission Checklist in place will also support staff to plan care, escalate required support and referrals in a timely way, and reduces risk levels in respect of avoidance of actions being missed.

Concern 4:
Evidence of "cutting and pasting" into Nadia's care plan from another patient's care plan.

Response:
In order to ensure that clinical notes are individualised, and copy and pasting is not part of the team culture, regular audits on Home Treatment Team record keeping will be undertaken and the findings shared with the team to continuously improve practice. The Home Treatment weekly multi-disciplinary meeting where patients care is reviewed, also provides opportunity for notes to be reviewed and any action required to be taken forward.

Concern 5:
Failing to undertake risk assessments at all relevant and appropriate stages and/or failure to record that such an assessment had in fact taken place and what the outcome was.

Response:
Assessments and clinical notes are reviewed with individuals during their one to one supervision to focus on the quality of their record keeping including risk assessment. Storm training has commenced with Teams to enhance risk assessment skills.

Concern 6:
Failing to provide a "RAG" rating to risk assessments and/or to indicate where required that a risk exists.

Response:
The Teams discuss all patients including their 'RAG' rating during their daily multi-disciplinary meeting case reviews and safety huddles to ensure accuracy of records.

The Trust also randomly audits patients' records on a monthly basis to identify any concerns with RAG rating of risk assessments in order for actions to be taken where discrepancies are found.

Concern 7:
Failure to include risk management and contingency planning within Nadia's care plans as well as key elements of her condition at that time, including her recent inpatient admission.

Response:
Assessments and clinical notes are reviewed with individuals during their one to one supervision to focus on the quality of their record keeping including risk management and contingency planning.

The Teams discuss all patients during their daily multi-disciplinary meeting case reviews and safety huddles to ensure accuracy of records including good team risk management and contingency planning in adherence to Trust policy.

Concern 8:
The potential for over-reliance on Nadia's husband, albeit he was only too willing to support her and care for her, and the need to balance maintaining Nadia's care and treatment in the community with the need to support her carer as well.

Response:

All staff have been reminded via Team meetings to ensure case discussion in the multi-disciplinary team meetings document carer's views and carer's needs. The Team Carer's Leads have been reminded to offer referrals for carers support, and refer on where consent given by carer and the importance of documenting carer's views clearly.

I hope that I have provided 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.

Yours sincerely,

[redacted]

Chief Executive