Tees, Esk and Wear Valleys
NHS Foundation Trust

Office of the Chief Executive
West Park Hospital
Edward Pease Way
Darlington
Co Durham
DL2 2TS

31 July 2024

Ms J Richards
HM Assistant Coroner
For County Durham and Darlington

By Email: [redacted]

Dear Ms Richards

Re: Response to Report to Prevent Future Deaths issued on 04.06.2024 in relation to the Andrew Naylor Inquest

I am writing to you in response to the Prevention of Future Death (PFD) Report issued to Tees, Esk and Wear Valleys NHS Foundation Trust ("TEWV", or "the Trust") on 04.06.2024 following the inquest touching the death of Andrew Naylor. I note that the PFD Report issued has been directed to both TEWV and County Durham and Darlington NHS Foundation Trust (CDDFT), on the basis you have concerns in respect of both organisations. I have not responded to point 5(1) as this issue relating to Chlordiazepoxide, appears to be for CDDFT to respond to and I am assured that they have responded.

I have provided a response below in respect of concerns 5(2) and 5(3) of your PFD Report as it appears those are the matters where your concerns are directed to TEWV (with the second of those also being a matter for CDDFT to respond to). Point 5(4) is noted. I set out below your concerns, as well as the response from TEWV in respect of each matter:

> ***5.2. There appears to be a lack of a joined up process between acute clinicians, alcohol and drug treatment teams, and mental health teams, to consider the safety of a discharge, and to ensure that crucial information relevant to risk is shared appropriately (which may also be, to an extent, hampered by a continuing inability to see each other's records), and whether discharge should be delayed or care stepped down, until a place of safety is identified, and to ensure that a robust safety plan is in place upon discharge.***

I will reiterate the Trust's position which we explained at the inquest, that it is recognised that communication between the liaison staff and acute staff could have been improved in Andrew's case. As I understand HM Assistant Coroner heard during the evidence at the inquest, the following measures have been put in place to address this concern:

1. **TEWV access to CDDFT Electronic Patient Record:**

When liaison staff attend and assess a patient within the acute Trust, the expectation is that a verbal handover is given of the contact, along with a written entry on the acute Trust's Electronic Patient Record (EPR) system (as well as TEWV's EPR system, Cito). This system allows all involved in a patient's care to see discussions and plans from all involved. As

advised, the EPR team within CDDFT attended the liaison team office on Wednesday 27 March 2024 to take steps to begin the process of putting the acute Trust's EPR on to the TEWV clinician's laptops. The EPR team have assisted, a data protection impact assessment was completed however we then experienced issues with organisational firewalls. The two IT teams have been working together to resolve this and we are now testing the platform. The testing concludes 06/08/24 and if it has been successful, it will be rolled out further from 12/08/24.

The significant benefit of this is that TEWV liaison clinicians will be able to copy full details of their assessment from TEWV's EPR (Cito) on to the acute Trust EPR. Prior to this, liaison staff were reliant on being able to locate an available CDDFT computer on the ward/ department, which are understandably in high demand. It can be difficult to capture the full detail of an assessment with such constraints, but the new process of having CDDFT's EPR on TEWV laptops, will enable the full assessment to be detailed much more efficiently.

For reassurance, TEWV were very recently inspected by the CQC. We had 24 hours notice of the inspection which focussed on the Crisis Care pathway which included Liaison services. The CQC read the EPR entries of a sample of patients in ED reviewing both the acute hospital entry and the TEWV entry to ensure there was joined up information. We are awaiting the final report however we have received good feedback and there were no actions for immediate follow up or statutory warning notices.

2. **Team meeting discussions:**

As you are aware, it was not possible to conclude Andrew's inquest in the one day initially allocated on 14 March 2024, and therefore it was adjourned and later concluded on 3 June 2024. Following the first day of Andrew's inquest, the initial learning identified during day one was picked up, and discussions took place within the team meeting, on 15 March 2024. Those discussions have continued within daily MDT meetings, to remind liaison staff of the importance of documenting, and verbally handing over if a patient reports themselves to be homeless. Conversations continue with regard to ensuring the important information relevant to a patient's risk, is handed over.

3. **Audits:**

I can reiterate that in order to provide a check that improvements are being made in respect of communicating with acute Trust staff, a further check has been added when completing the team's monthly audit to ensure it is documented that a verbal handover has been completed. This check is completed alongside the Trust Quality Assurance Schedule audit (a Trust standard) and the Advanced Nurse Practitioners (ANPs) completing the Quality Assurance Schedule have been asked to carry out a deep dive to check documentation around communication with other Trusts/ services. As part of this, we now check that it is documented that a verbal handover has been given. If any issues are identified, this is picked up with the team as part of team meetings/ supervision to ensure it is addressed as soon as possible. Verbal assurance has been given by the Advanced Nurse Practitioners carrying out the audit/ deep dive into assessments, that they are assured it is now more consistently documented that verbal handovers have been completed.

4. **Discharge arrangements.**

As we described to HMAC, the experience of the Liaison team working within CDDFT is that discharge would not usually be delayed for a homeless patient, in circumstances where the patient (1) has capacity, (2) is medically optimised and deemed fit for discharge, (3) is considered fit for discharge following review by the mental health liaison team, (4) has been appropriately signposted to the Local Authority regarding homelessness, and (5) has support in place in the community from the Community Mental Health Team as well as Drug and Alcohol services. Clearly, it is imperative that capacitous, homeless patients who are fit for discharge, are given the correct advice, signposting and support around homelessness, but in our experience, this does not mean remaining as an inpatient until accommodation arrangements have been secured. Health providers are not commissioned to carry out the role of the Local Authority in supporting and accommodating homeless people whilst their housing needs are addressed.

> ***5.3 There was no consideration given by either the acute or mental health teams to contacting the deceased's family or friends, which may have provided an essential safety net in the absence of accessible professional support. The TEWV Trust are candid that work in relation to this issue is a work in progress and remains incomplete.***
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> ***5.4 Although both Trusts indicated that they are in the process of addressing the concerns raised in this Inquest, I consider that at the time of the conclusion of this Inquest that there remains a risk that future deaths could arise.***

By way of context, it is relevant to note that there was reference in the medical records to Andrew indicating that he was going to contact his brother. Although Andrew himself did not have access to his own mobile telephone, liaison staff were aware he had been making calls on the morning of his discharge, presumably utilising the hospital telephone. At that time, Andrew was considered to have capacity and was not presenting with any acute mental health difficulties and therefore it would not have been unreasonable for staff to accept that Andrew would be making contact with family himself in these circumstances.

More broadly, and as previously advised, staff are expected to ask all patients if we can speak with family/careers/friends about their care – if they accept then we do this and document it within our records. If a patient refuses, then we have to consider whether the patient has capacity to make that decision, consider the level of risk, and take a sensible approach to this, balancing confidentiality. Staff have to be mindful our patients are adults and sometimes don't want their family to know or be involved.

A number of initiatives are ongoing across the Trust in promoting the importance of contact with family and carers. It is a significant piece of work to develop a culture across the organisation and although we consider we have made huge strides towards achieving this, it

will never be 'complete', as the Trust will always be striving to improve communication with carers, and we will continually reflect, learn and improve, as well as continuing training and processes of induction for those joining the organisation. This will not have an end date but as previously advised, the current initiatives to improve Trust processes are:

1. **Open letter to all staff:**

On 13 May 2024, I personally reissued a letter (initially sent in June 2021) to all Trust staff members about the support the Trust will offer when making decisions about the difficult balance between patient confidentiality and appropriate sharing of information. In particular, the letter provides *"We want to emphasise however to you all, that we would rather support you for saving a person's life by breaching their confidentiality than have to explain why we held onto information that could have made a difference."* I understand that you have already received a copy of this open letter.

2. **Common sense confidentiality guidance:**

The Associate Directors and Associate Nursing Directors have met to discuss and review the Trust's current common sense confidentiality guidance leaflet, it will be consistent with the open letter to staff. This has included a review of the guidance issued by other Trusts on this matter. As a result, an updated guidance leaflet is being created to assist staff in better communicating with families and carers.

3. **Sharing lived experience:**

A bereaved family were recently invited to speak to Trust staff at the Trust Fundamental Standards Group about their lived experience particularly around the importance of communicating effectively with families and carers of those experiencing mental illness, to offer staff an incredibly useful insight from their perspective. Attendees at the meeting worked with the family to identify impactful ways to share their experience further, and to identify practice changes that could be made organisationally and at service level. The group sought to identify short, medium and long term goals relating to training, process, environment and culture, working with the family to consider impactful changes to service delivery. We committed to identifying the priority actions and identify leads to take those actions forwards. The Trust also committed to sharing the message from the campaign and has shared the message on the Trust Intranet; created a slide to be shared with the CQC as part of our monthly updates and discussed the campaign with the Chair of the Board. The family also attended our Board of Directors meeting 13th June 2024 to ensure the Board would understand from a bereaved family the importance of giving families the opportunity to share their understanding of a situation and their loved ones needs.

In addition to our commitment to carers has been restated in our Carers Charter which is signed by our Chairman and myself. We have recently had the success of our Triangle of Care (an initiative from the carers trust which aims to improve the quality of care and support for patients and their carers) recognised with national accreditation.

I trust that this provides assurance that these concerns have been taken very seriously by the Trust and we will continue to strive to improve the service that we offer.

Our Chief Nurse, Medical Director and I have made repeated offers to meet with the Coroners in the Durham and Darlington jurisdiction and all offers have been declined. We do

meet with other Coroners, and we are aware of some of our partners who meet with Coroners in this jurisdiction. I would like to repeat our sincere offer to meet at your convenience and discuss the developments at TEWV and how we are working with our partners and the people who use our services to improve care.

Yours Sincerely

Brent

Chief Executive