Essex Partnership University
NHS Foundation Trust

19 September 2024

Private and Confidential - By Email Only

Miss Nadia Persaud
HM Area Coroner for East London
Coroner's Court
124 Queens Road
Walthamstow
E17 8QP

Chief Executive Office
The Lodge
Lodge Approach
Wickford
SS11 7XX
Tel: 0300 123 0808
[redacted]

Dear Miss Persaud,

Danny Jay Anderson (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 25th July 2024 in respect of the above, which was issued following the inquest into the death of Danny Jay Anderson (RIP).

I would like to begin by extending my deepest condolences to Danny's family on behalf of the Trust.

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

Concern a)

There was no evidence of any adequate formulation of risk prior to Danny's discharge from hospital on the 14 December 2022 and no evidence of any adequate risk formulation prior to Danny's discharge from the community mental health team in January 2023.

Response:

The Trust have made improvements, at pace in respect of the processes for formulation of risk on discharge with the implementation of discharge steps developed by the Trust Patient Flow Team. There has also been a change in practice to ensure we hold a discharge planning meeting with the Multi-Disciplinary Team (MDT) before discharge from hospital. Clinical service managers and matrons join discharge meetings to ensure a collaborative approach.

Improvements have also been made to the joint partnership working with community teams for all patients, part of this change encouraging transparent conversations, including with friends/family, to ensure risks are identified and mitigated

The Trust recognises that there was confusion around responsibilities of the named nurse, which includes risk assessment and formulating risks including plan at point of discharge. The Trust Quality Matron for Fundamentals of Care is leading on an improvement project looking at processes for the named nurse which aims to ensure there is consistent understanding of the named nurse role

and responsibility across all inpatient wards and will include the review of the Trust named nurse guidelines.

The organisations recognises that the quality of the narrative used in risk assessment is essential for staff to understand risk. This will always be dependent on the staff member completing this. The Trust has clinical risk assessment training in place and a clinical risk policy to guide staff. For ongoing support the Trust has implemented review of risk assessments and documentation completed as part of staff members' clinical supervision, this enables discussion and immediate learning support for each staff member.

The Trust is on an ongoing journey for improved documentation, which has included training sessions and a specific focus on this within supervision reviews. Work has been undertaken to update the discharge letter template to include discharge planning prompts and the incorporation of carer involvement in the Care Programme Approach review documentation. Discharge letters have been reviewed by the Service User Network Group to review content and tone of correspondence.

Additional training has been undertaken Trust wide in Community Mental Health Teams to support enhanced transition care planning.

Concern b)

The statement "Danny does not present with any suicidal ideation or self-harming behaviour" was copied and pasted multiple times throughout the risk assessment template on the 14 December 2022. There was no analysis or formulation of risk for Danny.

Response:

The Trust recognises that copying and pasting and the quality of documentation continues to be an area for improvement. A number of improvement initiatives have been completed including copying and pasting safety alert being issued, enhanced documentation training and having a robust process in place which ensures records auditing (including checking for copying and pasting), where this is found the staff member is contacted and asked to complete a reflective piece.

Our next steps on this improvement journey is the roll out of the new inpatient operating model which will include quality focus on key learning areas including copying and pasting and focus on the expectations of roles and responsibilities.

A professional standard of record keeping is part of qualified staff professional registration. The Trust expects that this standard of record keeping is met by all staff; again this is reviewed and discussed as part of supervision review meetings directly with staff.

We are taking action to further strengthen response when staff are found to have copied and pasted in patient records and are exploring options with Human Resources.

Concern c)

From review of the records throughout the admission, I am concerned that there was an over-reliance upon Danny's answer to questions posed about suicidal ideation and intent. At the point of discharge, there was no evidence of information gathering around Danny's mental state, behaviour, psychiatric history, history of abuse, social situation – and evidence that this information was used to form a judgment about the likelihood or probability of an adverse or harmful outcome (in accordance with the Trust's risk policy).

Response:

The Trust has established a new oversight system to enable managers to identify any gaps in risk

formulation and crisis summary. This is part of a clinical dashboard which shows if these key parts are missing. This dashboard is available to staff and is reviewed by the nurse in charge and ward manager to ensure any gaps can be addressed.

As part of all staff one to ones, supervisors work with inpatient named nurses/ community care coordinators reviewing their care plans and risk assessment to check quality of the clinical entries.

There is medical oversight at point of discharge from inpatient services and this feeds into discharge summaries

In addition the Trust has clinical audit processes which include a record keeping audit and a '*matron's records audit'* which includes review of risk formulation and crisis summary. Audit results are taken back to staff and highlighted through discussed in team meetings. The audit process has been reviewed and the Trust now has a person centred audit undertaken were possible with the names nurse to review an individual's care and documentation thereafter.

Within Trust community teams, key information is included in the discharge Care Programme Approach (CPA) review.

The Trust has two main electronic records systems for mental health services (Mobius/Paris) means that information can be recorded in two difference places. To enable staff in information gathering across the two systems the trust has implemented the Health Information Exchange (HIE) to provide one place for staff to review key information.

There are further plans to move to one central electronic records system as part of the Trust digital strategy which will further enhance the records systems.

The Trust is seeking further improvements in this area through the new operating model which reinforces safe discharge. The operating model launch date commences on the 26th September 2024 and will be underpinned by a series of standard operating procedures co designed with staff.

Concern d)

There was no evidence of any consideration of Danny's historical factors and experiences, more recent problems and existing strengths and resources (in accordance with the NICE guidelines 2022).

Response:

The Trust has implemented a new processes of 1:1 engagement forms that are completed daily with each patient.

Trust care plans have been improved to ensure they are personalised and historic factors, experiences and risks are pulled through into care planning.

The Trust is transforming its approach to providing *trauma informed care* which aims to create a fundamental paradigm shift to considering what has happened to a person rather than what is wrong with a person.

Strong and consistent family and carer engagement is essential for the Trust, as this supports understanding of historical risks. This is being encouraged through the new operating model with engagement throughout admission and at discharge.

The Trust has recently launched a programme for quality of care; focusing on the key element of safety, effectiveness and experience. This programme has important Trust wide quality priorities, one of which is suicide prevention, one of the current year's focus areas is enhancing the training

and development of our staff with the new Skills Training on Risk Management (STORM) training. This is an evidence-based training methodology given to frontline team members who have the opportunity to practice, reflect, and give and receive feedback on skills in a safe and supportive learning environment. It uses the highest standard level of skills development, which includes filmed skills practice for the more advanced courses. The focus is on the person, collaboration, assessment, and safety planning, and they are joined by new skill sets including Suicide and self-harm – exploring the similarities and differences for assessment. We aim to have 60% of all registered practitioners across all urgent care pathways trained by end of 2024. Achievement of this training roll out is over seen by the Trust's suicide prevention quality priority group. In addition, the Trust's transformation programme 'Time To Care' has recognised the importance of enhancing clinical education within the clinical environment and has therefore invested in the introduction of six Professional Nurse Educators; this role has been developed for our in inpatient mental health wards following a national pilot of the role

The 'Time to Care' programme involves a complete transformation of the way in which we operate our mental health inpatient wards, with the overriding aim to free up more clinical time to spend on direct patient care. The Time to Care Programme has redesigned how we deliver inpatient mental health services, based upon learning from the past, the latest national and international expert guidance for best practice, and most importantly input from our patients, their families and carers.

Working alongside patients, staff and partners we have created a model of care that will offer every patient personalised care to support their long term recovery**.** We will also ensure our care takes into consideration how traumatic events affect a person's behaviour and health, so that we can best support them in their recovery**.**

At all ward MDTs there is a review to look back at the person's history. This also ensures that there has been a review of both systems / HIE.

Concern e)

Witnesses from consultant level to care co-ordinator level, were unable to describe a robust risk assessment process. I am concerned that staff do not fully understand how to assess and manage risk.

Response:

Please see previous responses re programme of workforce training and records monitoring.

In addition we have re-shared the clinical risk policy with staff supported with poster for wards on safety discharge steps

Work has been undertaken by the Director NE Essex Community Services, Trust Wide Perinatal, Children`s Learning Disability and Allied Health Professionals Operations to review the role and responsibilities of care coordinators and ongoing quality improvement for risk assessment is part of the Trust Disengagement Safety Improvement Programme

Concern f)

There was no safety plan on discharge from hospital, or prior to discharge from the community team, to address the clear risks that Danny posed.

Response:

Action is already underway as part of the Safety Action Plan to ensure there are clear documented actions agreed at discharge meetings and that the MDT outcome form is completed for each person clearly stating any actions and an overview of relapse signatures and recorded in the patient record.

This is being monitored through Matron auditing of patient records. Staff having been provided with a quick reference guide for Discharge and Transfer.

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 are focused and committed to ensure that our quality improvements and transformation are consistent and sustained, and that we will continue to embed a culture of learning to support this. We will monitor the impact and delivery of 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 Trust that your Court will share, as standard, a copy of this reply with Danny's family

Yours sincerely,

[redacted]

Chief Executive