Essex Partnership University
NHS Foundation Trust

19 December 2024

Private and Confidential
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Chair: [redacted]
Chief Executive: [redacted]

Dear Sir,

Mr Jamie Harding (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 29th October 2024, received by the Trust on 7th November 2024 in respect of the above, which was issued following the inquest into the death of Mr Harding, whose Inquest concluded on 12th April 2024

I would like to begin by extending my deepest condolences to Mr Harding'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 Mr Harding's family with comprehensive assurance of changes that have been made at the Trust to address the concerns you have raised.

It is noted that the Regulation 28 report includes concerns relating to the Dual Diagnosis support provided by the Trust. In order to provide clarity and by way of context, EPUT employs the *definition* of dual diagnosis to refer to people with a severe mental illness (including schizophrenia, schizotypal and delusional disorders, bipolar affective disorder, and severe depressive episodes with or without psychotic episodes and personality disorders) and those with active misuse of substances (the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage) as per the NICE CG180.

EPUT acknowledges that for people with Mental Health and Substance Misuse issues as National Guidelines suggest, having dual diagnosis teams/ services does not work as this could lead to further marginalization and social isolation (NICE Guidelines Quality Statement QS188). Dual Diagnosis is too common to be only handled by specialist workers. EPUT's provision is there are individual specialist workers working across west, north east, south and mid Essex.

In mainstreaming care for this service user group, the aim is to assist with social inclusion, tackle stigmatisation and provide timely access into appropriate support. Both Mental Health and Substance Misuse workers are experts in their own fields any therefore effective joint working is key to successful recovery and in EPUT there are Dual Diagnosis clinicians who provide a wrap around, add on service to clinicians with those clients in active addiction with complexities that require extra support into treatment.

The Dual Diagnosis workers are registered Social Workers employed at band 6 or 7 on the NHS pay scale. We have previously had nurses in this position but at present, all our Dual Diagnosis Workers are Social Workers. The Dual Diagnosis workers work with the mental health teams and drug and alcohol services part of the Essex Drug and Alcohol Partnership (EDAP). They work within drug and alcohol services office one day a week. The rest of the week they work out of the offices of the community mental health services.

The Dual Diagnosis workers provide short term interventions for up to eight weeks to support engagement with services, joint working and working with clients around motivation to change. They use solution focused practice and motivational interviewing techniques to do this. The aim of these interventions is to improve access to treatment and support, enable effective joint working and communication and, to actively involve clients in their treatment journeys. The Dual Diagnosis Workers also provide advice, guidance and consultation where needed.

Concern a) The accepted absence of effective formal, compulsory training for clinicians regarding the Dual Diagnosis (DD) pathway and what it does and does not provide, how to access it and the potential benefits of it. The evidence confirmed that practitioners outside of the DD workers/pathway were unaware how they could contact them, including directly.

Response:

In carrying out our review of this case, it has been noted that the First Response Team (FRT) are aware on the process for contacting / accessing Dual Diagnosis support. However in light of the findings in this case, the FRT / the wider Trust have been reminded via Trust wide communications of the available support streams which includes access to the Trust's quick access intranet page for dual diagnosis which gives clear guidance for staff.

Additionally, the Trust provides Dual Diagnosis training within EPUT which covers the referral process and how to access support for an adult who has alcohol/substance misuse issues. This currently does not fall within the core requirement of all EPUT staff and the Trust is looking to extend this to all registered clinical staff within EPUT. The current expectation is for training to be completed once and the Trust is exploring the benefit to changing the requirement to be undertaken every 3 years.

As was highlighted through the evidence presented at this Inquest, a key area of dual diagnosis working is robust system partnerships. We currently host an Essex Wide

Dual Diagnosis Working Group to ensure better working relations with system partners and develop/improve the services through any learning and concerns raised within this forum. There is also a Dual Diagnosis Learning from Deaths Group hosted within EPUT that discusses any recent learning points from Internal Reports with a view to identify, action and share learning and implementation accordingly.

There has been a re-launch of Dual Diagnosis steering group in April 2024. This group includes EPUT, primacy care and 3rd sector coming together with an aim to foster partnership / collaborative working.

The First Response Team (FRT) has a dual diagnosis worker attached to the team who provides specialist advice and guidance and links when referred. Whilst this member of the team does not hold their own case load, they are a source of advice and support generally across the Trust.

Concern b) In addition to weak record keeping and poor communication with patients and their families, the evidence revealed the lack of a robust and reliable system to ensure that the FRT deals with its caseload efficiently and effectively and particularly how it flags and then follows up referrals to and queries from other services/clinicians contributing, in turn and on the facts of this case, to the significant failure to hold an MDT. The FRT did not follow up (as it was accepted it should have) the referral (via a self-referral) to Open Road or the referrals for a medication review. Had there been such follow up, EPUT evidence confirmed that there would likely have been a discussion of Jamie's case at a full MDT with the likely allocation of a Care Coordinator, the likely involvement of the Dual Diagnosis pathway and the likely use of the RAG rating system to ensure on-going risk assessment.

Response:

The Trust has implemented the Management and Supervision Tool (MaST) caseload management tool, which is improving how our care coordinators (and their supervisors) electronically manage their caseloads.

This is a nationally developed framework which links in with current electronic systems to provide algorithms and indicators for increasing risk as well as disengagement and other relevant factors that would be discussed within an MDT setting. In addition, the tool would automatically generate a RAG rating for a patient based on the inputted data; by way of further safety netting this this would support clinical decision making around which patients should be presented to the MDT meeting based on relevant / emerging risk factors.

In addition, the Trust has established a Trust Safety Improvement Plan focusing on disengagement, with a clear objective of supporting patients who may require additional layers of overall support.

The Trust is monitoring the use of this tool via regular audits. It is encouraging to note that national research evidence demonstrates that staff using this tool become more effective at recognising patients at risk, and has also improved clinical record

keeping, which is a further area of priority focus for the Trust. Again, the use of this tool is being monitored.

The Trust is working to ensure, as far as we can, we take a consistent approach to patient care, however as each case is different, there is a need to apply clear clinical judgement and safe practice to each patient interaction, whilst at the same time appreciating context, available clinical tools / policies and guidance as required.

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. No doubt a copy of this reply will be shared with the family of Mr Harding.

Yours sincerely,

Chief Executive