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NHS Foundation Trust

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HM Coroner
East London Coroners Service
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[redacted]
Chief Executive Officer
Trust Head Office
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28th January 2025

By email only to:
[redacted]

Your ref: [redacted]
Trust ref: [redacted]

Dear Madam

Re: Inquest touching upon the death of Dean Ford

I refer to your Regulation 28 report, dated 04 December 2024, following the recent Inquest into Mr Ford's untimely death. I should first like to extend my sincere condolences to Dean Ford's family. This must have been an extremely difficult time and I hope that my response provides them, and you, with assurances that North East London Foundation Trust (NELFT) is taking action to address the issues set out in your report.

NELFT acknowledges your concerns and wishes to advise that before and since the sad passing of Mr Ford, NELFT has implemented a number of changes. These include the following:

1. **Despite clear guidance from NICE in September 2022 relating to the need for a holistic formulation of risk to self, two NELFT teams involved in Mr Ford's crisis care failed to carry out a holistic formulation of the risk he posed to himself.**

   Risk assessment and formulation remain, of course, key to the work of teams across the Trust. We have a number of processes in place to support practice in this area, including supervision, audit and the cascade of guidance to staff (supported by trust wide learning lessons events). Multi-disciplinary working within teams is also an important part of practice across the Trust, that aims to support safe and effective working within our teams.

To implement the significant developments in practice outlined in NICE guidance, we established a formal steering group in August 2023 after a period of national scoping and a review of the available literature. We made contact with Oxford NHS Trust and Kent and Medway NHS and Social Care Partnership Trust (KMPT), who we understand were some of the very few NHS trusts to have begun full implementation of this guidance at this point in time.

We have undertaken a very thorough review of all policies, procedures and associated training and worked closely with our experts by experience. We launched our Risk Formulation training in September 2024 and have been delivering a day-long face-to-face training. The training utilises videos we made of experts by experience and carers talking about their experience of risk and suicide. We have now trained some 80% of our acute and rehabilitation colleagues, and moved to Borough based training in January 2025 and have started training colleagues in Barking and Dagenham.

This is a significant change to how NELFT staff conceptualise risk as they move from Risk Stratification (Low, Medium, High – Green, Amber, Red) to Risk Formulation. The aim of this work is to support NELFT staff to change the way that they perceive and react to risk to incorporate a more holistic and individualised approach, and how risk is fluid and not static. This will be a significant change in the working culture, and the structure that has been established to support this work is intended to support the effective transition to these arrangements (a process that brings risk in its own right). Once established, this training will be part of new starters induction programme (approximately 60 staff per month) so that risk formulation is embedded at the beginning of the staff NELFT journey.

2. **A clinical lead for the mental health and wellbeing team within NELFT, gave evidence at the inquest in December 2024 that Mr Ford's risk was deemed to be low because "the main factor around risk is that he denied any risk to self and denied any suicidal thoughts". This simplistic assessment of risk is not compliant with the NICE guidelines. It is of concern that a senior member - clinical lead - within the mental health and wellbeing team is not applying the correct risk formulation.**

We have addressed this specific feedback with the member of staff involved, but, more broadly, we do have processes in place to support effective risk assessment within teams. For example, in the Mental Health Direct service that was involved in Mr Ford's care a monthly sample audit is place that includes audits of the risk assessment of calls to MHD clinicians, and the follow up action to help address any risks identified. This includes one third of all calls every month. The staff involved in the work of this realm are, of course, also part of the risk formulation training that has taken place.

Within this service specifically, we have also changed the triage tool that is in use and are currently rolling out the nationally recognized Mental Health Triage Tool which supports the appropriate prioritization and responses for all mental health crisis calls. We will continue to support the embedding of the tool, by monthly monitoring of call outcomes, meeting monthly with local services and stakeholders for feedback, as well as engaging carers and service users for feedback, which is monitored centrally by the patient experience team in NELFT.

From January 2025, the service will also have additional staffing in place to enable the service to be more responsive to calls, thereby improving the capacity of the service to monitor and respond to call activity.

Within the Mental Health and Wellbeing Teams (MHWTs) there are multi-disciplinary team processes that support effective working. All new referrals are discussed in a daily morning MDT meeting in the Mental Health and Wellbeing Teams (MHWTs), and the consultant is now present in the decision-making process. If the decision is made to gather more information, staff allocated to the duty team on the day will phone the patient, arrange a face-to-face appointment or conduct a home visit, and these are all dependent on the discussion that takes place in the morning meeting. There is another daily meeting in the evening to discuss the outcomes of all the assessments that take place during the day and again the consultant is present in the meeting.

3. **The Trust carries out risk assessment audits for clients who are accepted into the mental health and wellbeing team. There are no audits into the risk assessments for those persons who are referred to the team, but not accepted by the team. As these patients have no safety net of ongoing mental healthcare, it is of concern that the quality of risk assessments for these patients is not audited.**

   In the directorate, all new referrals are discussed in a daily morning MDT meeting in the MHWTs, and the consultant is now present in the decision-making process. If the decision is made to gather more information, staff allocated to the duty team on the day phone the patient, arrange a face-to-face appointment or conduct a home visit, and these are all dependent on the discussion that takes place in the morning meeting. There is another daily meeting in the evening to discuss the outcomes of all the assessments that take place during the day and again the consultant is present in the meeting. This along with risk formulation training, combine to improve decision-making. Patients not needing secondary care are sign-posted to other services and an outcome letter is sent to the referrer.

   For those patients who are not accepted, the current process is for patients to be contacted either by phone, face-to-face or at a home visit to conduct an assessment, so as to ascertain whether secondary care is required.

If I can be of any further assistance or if you would like a further update on the progress made to address your concerns, I would be happy to provide a further update.

Yours sincerely

[redacted]

Chief Executive Officer

[redacted]

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