Essex Partnership University
NHS Foundation Trust

1st April 2022

Private and Confidential
Mr Sean Horstead
Area Coroner
Coroner's Office
Seax House
Victoria Road South
Chelmsford
CM1 1QH

Trust Offices
The Lodge
Lodge Approach
Wickford
Essex
SS11 7XX

[redacted]

Dear Mr Horstead,

I am writing 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 8 February 2022, which was issued following the inquest touching the death of Mr John Moore.

I would like to begin by extending my sincere condolences to the family and friends of Mr Moore. This has been an extremely difficult time for them and I hope that my response provides assurance that the Trust takes their loss seriously and has taken action to address the issue of concern raised in your report.

In response to the matters of concern:

1. *EPUT Care Coordinators receive inadequate training for the role. Care Coordinators carry significant responsibilities to coordinate the care provided to an often extremely vulnerable cohort of patients. This responsibility was significantly heightened in the context of the Covid-19 pandemic, and the accompanying periods of 'lockdown', when vulnerable and often isolated sufferers of mental health illness and disorders, including those with substance misuse issues, became increasingly isolated and thus increasingly vulnerable. Notwithstanding the imposition of this additional responsibility, the evidence in this and similar coronial investigations has established that Care Coordinators receive no formal training for the role and, at best, are introduced to it via the 'shadowing' of colleagues 'on the job'. At inquest evidence was provided by an experienced (Band Ba) EPUT Clinical Manager that the lack of formal training for the pivotal role of Care Coordinator within EPUT is one that reflects the same practice in NHS Trusts across the country.*

The Care Programme Approach (CPA) was introduced by the Department of Health in 1991 and updated in 2008. It was intended to provide greater shape and coherence to local approaches supporting people with severe mental illnesses in the community. This was based on care coordination, care planning and case management and had a central role in the planning and delivery of secondary care mental health services since its implementation.

In January 2019, the NHS published its Long Term Plan which committed to transforming community mental health services by funding and implementing new and integrated models of primary and community mental health service for people with severe mental health problems across England. The Community Mental Health Framework (2019) proposed the replacement of CPA for community mental health services while retaining the principles based on good care

coordination and high quality care planning. In recent years, there have been a number of concerns raised by stakeholders that the way in which CPA is used represents a major barrier to providing the higher quality, more flexible and personalised care that the Community Mental Health Framework envisages and that patients need.

In July 2021, NHS England published a position statement with regard to the planned future of CPA. This document states:

> *The Community Framework makes clear that one of its purposes is to enable services to shift away from an inequitable, rigid and arbitrary CPA classification and bring up the standard of care towards a minimum universal standard of high-quality care for everyone in need of community mental healthcare. A flexible, responsive and personalised approach following a high-quality and comprehensive assessment means that the level of planning and co-ordination of care can be tailored and amended, depending on:*
>
> - *the complexity of an individual's needs and circumstances at any given time*
> - *what matters to them and the choices they make*
> - *the views of carers and family members*
> - *professional judgment.*
>
> *The new approach is based on the following five broad principles, some of which are further outlined below:*
>
> - *A shift from generic care co-ordination to meaningful intervention-based care and delivery of high-quality, safe and meaningful care which helps people to recover and stay well, with documentation and processes that are proportionate and enable the delivery of high-quality care.*
> - *A named key worker for all service users with a clearer multidisciplinary team (MDT) approach to both assess and meet the needs of service users, to reduce the reliance on care co-ordinators and to increase resilience in systems of care, allowing all staff to make the best use of their skills and qualifications, and drawing on new roles including lived experience roles.*
> - *High-quality co-produced, holistic, personalised care and support planning for people with severe mental health problems living in the community: a live and dynamic process facilitated by the use of digital shared care records and integration with other relevant care planning processes (eg section 117 Mental Health Act); with service users actively co-producing brief and relevant care plans with staff, and with active input from non-NHS partners where appropriate including social care (to ensure Care Act compliance), housing, public health and the voluntary, community and social enterprise (VCSE) sector.*
> - *Better support for and involvement of carers as a means to provide safer and more effective care. This includes improved communication, services proactively seeking carers' and family members' contributions to care and support planning, and organisational and system commitments to supporting carers in line with national best practice.*
> - *A much more accessible, responsive and flexible system in which approaches are tailored to the health, care and life needs, and circumstances of an individual, their carer(s) and family members, services' abilities and approaches to engaging an individual, and the complexity and severity of the individual's condition(s), which may fluctuate over time.*

With regard to the shift from generic care coordination to meaningful interventions, the position statement states:

Care co-ordination is important work and has often been under-appreciated as a function which should provide high quality care to service users, often within an outmoded and historically resource-constrained system. While many service users find care co-ordination valuable – and while care co-ordination may form a significant part of the overall support that someone with a severe and complex mental health problem receives – care co-ordination is not a meaningful intervention in and of itself.

In order to achieve the transformation of community mental health services that we want to see across England, providers and their partners should therefore move away from care co-ordination as an intervention in itself and focus delivering compassionate, meaningful, intervention-based care which has been planned between the service user and their care team (eg timely commencement of a course of psychological therapy). At the same time, the Framework's emphasis on ensuring that flexible, longer-term systems of care are in place for people with severe mental health problems should be maintained. This will allow the easy 'stepping up' or 'stepping down' of care as needed, and will remove the harmful prospect of people in need of long-term care being 'discharged' and left with no support, or having to battle to re-enter services.

Current systems relating to CPA will remain in place until implementation of the new framework is agreed. In light of this, the Trust are delivering an enhanced care coordination training package as we recognise from recent incidents that whilst a person's professional training and preceptorship equips them with the skills for care coordination, there is clearly a need for further support for staff in this area.

The training has been developed and has a planned roll out this month. All staff within community mental health services will be required to undertake the enhanced training and I would be happy to share the training slides with you should you like a copy for your records. This training will remain in place until the new Community Framework, setting out the new universal standards, is agreed.

2. *The evidence in this case, and in other recent inquests heard by me and fellow coroners in this jurisdiction, establishes the following common themes in respect to the inadequate performance of several EPUT Care Coordinators. In my settled view, these themes are (at least to a significant degree) a consequence of inadequate training for the role:*

    (i) *failure to maintain basic record keeping generally and, particularly, with respect to the recording of contacts or, potentially importantly, failed contacts with the deceased in the weeks and months prior to a self- inflicted death;*
    (ii) *a failure to formally up-date Care Plans and Risk Assessments in a thorough and/or timely fashion, or at all;*

The Trust accepts that it needs to improve record keeping and there are a number of methods in place to monitor and review the completion of timely and accurate documentation, which include:

- 95% target for recording within 24-48 hours of contact.
- Caseload review in line management supervision.
- Monthly performance reports which identify activity by clinical staff and what, if any, documentation is incomplete. Where this is the case, individual conversations taking place with clinical staff to address in a timely way to ensure that appropriate action is taken to address the issue.

The Trust is in the process of gathering data in order to implement the Management and Supervision Tool (MaST) caseload management tool, which will help the care coordinator to

electronically manage their caseload more effectively. 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; factors that would be discussed within a Multi-Disciplinary Team (MDT) meeting. In addition, the tool would automatically RAG a patient based on the inputted data, and this would support clinical decision making around which patients are to be presented to the MDT meeting. Evidence from the research nationally is that staff using this tool become more effective at recognising patients at risk and improving record keeping. Pilot sites have been agreed and they will implement MaST initially.

(iii) inadequate communication with other primary and secondary care providers;

The Trust has identified mental health clinicians working within the Primary Care Networks across Essex which will increase the efficacy of communication between primary and secondary care providers. In addition to this, we have ensured that the importance of communication with other services and organisations forms a key part of the enhanced care coordinator training.

(iv) consistently, insufficient attention to the potential clinical significance of 'disengagement' with services by patients;

I can confirm that the Trust's Disengagement Guideline is currently under review and the updated version will include the use of "Purple" RAG rating which will be used by community mental health teams to identify disengaging patients and ensure that they are discussed regularly in MDTs.

(v) failure to recognise the need to raise issues relating to a patient with the Multi-Disciplinary Team Meetings or in supervision with experienced supervisors.

It is within a professional's role to determine whether a patient's care would need to be presented to the MDT meeting and this is based on clinical judgement. A care coordinator is a registered professional who would work within their code of conduct, which provides a clear framework for accountability and responsibility, and the Trust values. Care coordinators would have undertaken Trust induction and training in order to support their role and would be deemed to be equipped to independently make clinical decisions around presentation to MDT. Their decision would be based upon dynamic risk assessment of the patient, the therapeutic relationship they have with the patient and their family, and their identified needs. Not all patients on caseloads would require discussion at the weekly MDT meeting as there are other means of formulating discussions to meet the needs of the patient.

3. *The evidence received in the course of Mr Moore's inquest disclosed that the record keeping of supervision sessions, where a Care Coordinator might seek or be provided with further advice and support from a senior colleague, was incomplete and inadequate.*

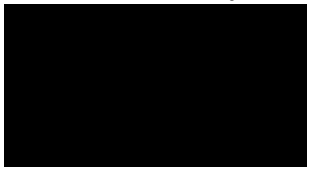
The requirement for undertaking and recording supervision is clearly outlined in the Trust's 1:1 Support and Appraisal Policy and Procedure and I will ensure that all care coordinators receive additional guidance on this subject.

4. *A lack of formal (or even informal) records of the nature, extent or duration of ad hoc 'on the job/shadowing' training, apparently provided to new Care Coordinators.*

As mentioned in point 1 above, the Trust is implementing enhanced care coordination in April 2022.

I hope that I have provided you with robust assurance that the Trust has taken steps to address the issues of concern in your report, that we are continuing to take action to strengthen the care provided to our patients, and that patient safety is the Trust's top priority.

Yours sincerely,



Chief Executive