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Mr Meadows
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Tuesday 30th August 2016

Dear Mr Meadows

Re: Mr Leslie Morrison – Regulation 28: Report to Prevent Future Deaths

I have now had the opportunity to look into the concerns you raise in respect of this case. The response required from Central Manchester University Hospitals NHS Foundation Trust was relating to two specific points:

1. It is suggested that the Hospital Trust, the Mental Health Trust and any caring organisation should have policies and protocols which are applied to ensure that up to date information about patients particular conditions (both mental and physical) are supplied between those caring for the patient when they are admitted to hospital, and back into the community when they are discharged.
2. It is suggested that in practice on admission to hospital an appropriate review of a patient's records and care plan should trigger a mental capacity assessment and an application for a DoLS authorisation if appropriate.

For ease I will respond to each of your points in turn.

You note that on Mr Morrison's admission to the Manchester Royal Infirmary his carers did not provide an up to date care plan, and the acute hospital staff did not actively seek to receive a copy of his care plan from either his carers or primary care.

Whilst in the community Mr Morrison had been assessed by the Speech and Language Team as requiring supervision whilst eating, and for a period of 30 minutes after to ensure that he remained safe. As this information was not passed on to the acute team this was not continued whilst he was in hospital. The admission documentation and nursing assessments on the Acute Medical Unit when Mr Morrison was admitted note that he took diet and fluids normally and was not noted to have any swallowing difficulties; as a result of this no referrals were made for a Speech and Language Therapy assessment. He was however on a soft diet, and having discussed this with the Speech and Language Therapy team, they have confirmed that an egg mayonnaise sandwich would be acceptable as part of a "soft normal diet" with the caveat that if the bread had a hard crust, the crust would need to be cut off. Had the acute team received, or actively sought out, information regarding Mr Morrison's

nutritional care plan and feeding requirements, the 30 minute observation period would have been implemented which may have meant that he received more timely intervention when he aspirated after eating.

With regards to the handover of information between care environments, I am in agreement that it is a matter of good practice to hand over all salient care issue. This is universally accepted in the NHS and there are many examples of good practice guidance available for this purpose. Achieving effective and safe hand over in all circumstances, particularly for complex and vulnerable cases, remains a considerable concern in all parts of the public health and social care sector.

It is accurate to say that handover between acute and community services, and vice versa, for all vulnerable adults remains at times of an inadequate quality and consistency, as was the case for Mr Morrison. Remedy for this is a system wide problem however we need to take local responsibility for ensuring that this takes place for patients within our care.

Currently as a Trust we do not have a formal policy in place for the sharing of up to date information for patients who are vulnerable or have complex conditions. Whilst staff will informally liaise with care agencies or primary care, this is ad hoc and not an embedded process therefore relies on the staff providing care to a patient to proactively consider the information that may be held elsewhere. There are exceptions to this however, such as patients with learning disabilities, where there is a formal process in place through the use of their LD passport; however this is not consistent across other patient groups. As a result of the findings of this case we will implement a Trustwide initiative regarding the development of a policy or pathway for complex and vulnerable patients which will include proactively gathering information from health providers outside of the Trust. This will include representation from all of our hospitals and Divisions to ensure that this is implemented across all of our services.

You also note in your letter that it was apparent that Mr Morrison lacked mental capacity however a DoLS application was not completed whilst he was in the community or whilst in was an in-patient at the Manchester Royal Infirmary.

As I am sure you are aware, mental capacity (as defined in the Mental Capacity Act 2005) is decision specific and a finding of 'lack of mental capacity' alone is not sufficient to justify a DOLS emergency or standard authorisation. This requires a finding of lack of mental capacity to make decisions about location and manner of care and judgement about the specific manner of care in place at the material time. With regards to a DOLS emergency or standard authorisation, this is about the manner in which a person is cared for not about the care provided per se. It is therefore a matter of judgement for the responsible person with overall responsibility for the environment in which a person is cared for, to decide whether there has been or is a risk of an Article 5 breach in which case authorisation can be sought.

Currently when patients are admitted to the hospital an assessment is made as to whether there are any apparent concerns with their ability to make decisions about their care, in order to ensure that we are providing the most appropriate care for patients. This is an on-going process and can be both formal and informal to ascertain if a patient understands where they are and what is happening to them, and if they can consent to whatever care and treatment is being undertaken. If there is any doubt about their inability to understand, consent to treatment or make decisions about their care and treatment, a mental capacity assessment will be completed which will be decision specific. This will support staff to make appropriate decisions about whether a patient lacks capacity. If it is assessed that a patient lacks capacity, it will be ascertained if additional safeguards are needed and if these additional restrictions and/or restraint used would deprive a person of their liberty. If this was

the case then a Deprivation of Liberty Safeguard application would be made.

The Trust is in the process of implementing a transformation project regarding a delirium tool and a frailty flag to help identify those patients who may have reduced capacity. The Trust are working with Patientrack, our partners for the electronic Early Warning Score system, to embed a frailty screen in patients aged over 75 which would then identify patients requiring a comprehensive geriatric assessment. The next stage would be to embed a delirium screen into Patientrack. This work continues to progress and currently a pilot of frailty screening, CGA and delirium screening is taking place at our Trafford site, from which the initial feedback is positive. This will then be developed to produce a unified tool across Trafford and central site and support the care provided to our vulnerable, frail and elderly population.

With regards to staff training around mental capacity and DoLS, I can confirm that we have monthly DoLS training sessions in place regarding awareness of the process and the completion of DoLS and mental capacity assessments. In addition there have also been sessions arranged with our Solicitor partnership firm for external training sessions to be held.

In addition we also mandate within the Trust that all registered nurses complete level 3 Adult Safeguarding training, which is the most advanced safeguarding training we offer clinicians; DoLS and mental capacity is covered within the body of this training. The safeguarding team also offer bespoke sessions to areas who require further support or detail regarding the completion of DoLS.

We are also considering the inclusion of safeguarding at each of our quarterly Audit and Clinical Effectiveness Days, focusing in particular on DoLS and mental capacity. This will be discussed further and plans for implementation made.

Moving forward and in order to improve the consideration given to mental capacity assessments and DoLS authorisations, your letter will be discussed at the Trust Clinical Effectiveness Committee to note your concerns and consider how this should be addressed. Any further action will then be monitored via this committee and allocated to the relevant leads.

Please accept my assurances that lessons have been learned from this case and appropriate actions have been put in place to address the issues that you raise. I am confident that these actions will lead to improvements in the care we provide to our patients, particularly those that are vulnerable or have complex conditions.

Yours sincerely

Professor R C Pearson
Medical Director & Caldicott Guardian
MAHSC Honorary Clinical Professor, University of Manchester