NHS
Devon Partnership
NHS Trust

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Mr Ian Arrow
HM Senior Coroner for the County of Devon
1 Derriford Park
Derriford Business Park
Plymouth
PL6 5QZ

21 May 2021

Dear Sir

Glenn MacMartin (deceased)
Inquest date: 15 and 24 March 2021

I write on behalf of the Devon Partnership NHS Trust ("the Trust") further to the Inquest touching the death of the above named and the Regulation 28 Report to Prevent Future Deaths ("the Report") issued by you on 7 May 2021.

I note that the Report is addressed to the Trust, the Care Quality Commission ("the CQC") and Plymouth Safeguarding Adult Partnership.

I note that in section 5 you have raised the following matter of concern:

"The deceased was accommodated in a Care Home that was subsequently formally closed due to poor service.

The selection of the accommodation was made without a physical inspection of its suitability for the deceased by the organisation with responsibility for providing the accommodation before the deceased took up residence."

Further I note that in section 6 of the Report that you set out action should be taken as follows:

"In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

Please review the selection and monitoring of care home provision and care given by private care home providers who are funded by Devon Partnership Trust.

Please review what action to take when care homes are closed to ensure lessons are learned from such closures.

Please indicate when a report on such a review may be forthcoming."

We had not understood on the conclusion of the inquest that you were intending to issue the Report, and it would be helpful to understand the subsequent information or concerns you have received that has resulted in this. Notwithstanding this, the Trust sets out its response below.

Response of Devon Partnership NHS Trust

I understand at the Inquest you admitted into evidence the witness statement of [redacted] dated 5 March 2021 and also heard oral evidence from [redacted] on 15 March 2021. [redacted] is the Head of Profession for Social Work and Directorate Manager for Social Care. As such, she is in a position to address the extensive questions in relation to the commissioning of Mr MacMartin's placement raised by the family and yourself at Inquest.

Selection of accommodation without physical inspection

In line with the evidence set given by [redacted] at the Inquest, in the time since Mr MacMartin's death, a decision has been made that mental health social care will not contract with new providers without visiting the facilities to gain assurance of suitability.

I hope that this reassures you that where the Trust is responsible for commissioning care at a new placement, that a physical inspection of that placement is undertaken to ensure that it is a suitable and appropriate environment according to the person's assessed care needs.

Selection and monitoring of placements

You will, I am sure, appreciate that it is not only the Trust which commissions individuals' care with private care home providers. Furthermore, in respect of the ongoing monitoring and regulation of those providers, I can only provide reassurance on behalf of this Trust.

The Trust does reasonably rely on the inspections and ratings provided by the CQC in terms of quality assurance and adherence to any relevant regulations. I understand that at the time of Mr MacMartin's placement at Annette's Care Home ("the Care Home") in Plymouth the corresponding CQC report was reviewed. It was confirmed that the Care Home was rated by the CQC as "Good". Furthermore, at the time Devon County Council had an existing contract in place with the Care Home. The contract for services entered into included the following provisions around quality assurance:

- The provider shall provide the service in accordance with its obligations under the contract and with the skill, care and diligence to be expected of a competent provider of a residential care home service.
- The provider must comply with all requirements of the Care Standards Act 2000 and the National Minimum Standards.
- To provide and supervise the proper provision of the service and to meet the assessed needs of the service users, including outpatient appointments, emergency hospital admissions and to partake in other activities outside of the home.

The Trust was further reassured by the fact that Mr MacMartin had periods of formal leave under section 17 Mental Health Act 1983 ("the MHA") to the Care Home from 17 to 20 May 2018; 24 to 30 May 2018; 8 June 2018; 13 to 15 June 2018; and 13 to 28 August 2018. All of these periods of leave went ahead without incident, allowing Mr MacMartin to become familiar with the Care Home and its staff and enabled the Care Home to become familiar with Mr MacMartin's individual needs.

At the time therefore the Trust's Mental Health Social Care Panel were reassured that the Care Home was an appropriate service with which to contract and place Mr MacMartin.

Such processes will continue to take place in order to ensure that patients who are being discharged from liability to be detained under the MHA receive suitable and appropriate care in the placement to which they are being discharged.

The Trust's discharge policy also includes a seven day follow up directly with the patient. Although not a formal review, it is an opportunity to "touch base" with the person and act upon any identified needs. No concerns were raised in Mr MacMartin's case.

Again, this seven day follow up is a process which continues to take place in line with good practice.

As a person who had been detained under section 3 MHA, Mr MacMartin was in receipt of section 117 MHA aftercare. As identified in the evidence provided by Ms Adams, the Trust's policy for section 117 MHA aftercare requires a review of the care and care plan at six months. I understand that in Mr MacMartin's case, this review in fact took place after three months.

Again, this is a process which continues to date, not only giving assurance that the person is adequately cared for but also to ensure there is appropriate clinical input for the individual and to address any concerns or change in the person's needs.

Learning lessons

Where concerns about an individual's care are raised with the Trust, whether by the care provider, family members, professionals or the individual themselves, the Trust is under a duty to consider whether a safeguarding referral needs to be made to the relevant Local Authority. It is then for the relevant Local Authority under section 42 Care Act 2014 to identify whether further investigations ought to be undertaken and if so by whom. This provides further safety netting in respect of any concerns which could be raised by or on behalf of the individual.

As above, it is otherwise for the CQC to monitor, review and if necessary enforce any of the relevant regulatory provisions of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Insofar as any incidents relating to any individuals for whom the Trust responsible, the Trust will consider whether the relevant thresholds are reached for it to undertake its own review by way of a Root Cause Analysis investigation. This entails a detailed review of the incident(s), identification of the root cause(s) and recommendations and actions to be taken. It also identifies who is responsible for undertaking those actions and by when. This enables the Trust to learn from incidents (which could include, but not limited to, the closure of a care home) and ensure actions are implemented.

Improvements in service delivery

Again, I can otherwise reassure you that additional improvement measures have, or will be taken as follows:

- A redesign of social care delivery within the Trust is now complete, with dedicated social workers in each community mental health team, who are responsible for both the sourcing and review of social care placements and support;
- There is a comprehensive, Care Act compliant assessment completed with the person. This documents the person's needs, strengths, wishes and family and social networks. This is used in conjunction with health assessments to inform both care and support plans and commissioning;

- Social workers form a system with the social care contract and review team and associated processes. The senior commissioning officers and the locality social work managers work closely together and have scheduled monthly meetings;
- The community social work managers have linked with the forensic social work team at Langdon Hospital (a secure service for which the Trust is responsible, and where Mr MacMartin had been detained) to strengthen links and ensure that processes and practice relating to the sourcing and review of social care is uniform across all services and that the contract and review team are fully cited on all proposed placements prior to any contracting taking place;
- Funding has been secured for a Local Authority assigned social worker to join the community forensic team from 1 April 2021. This social worker will provide a vital link between the social care teams and forensic services at the point of transition;
- A protocol to specifically address the placing of people outside of the Trust's geographical area has been developed. This will strengthen our existing practice by providing a clear guide for our teams and follows the guidance within the advice note for directors and of adult social services commissioning out of area care and support services produced by ADASS. It also highlights the need to ensure the provider has arrangements in place and contains provisions to assure of suitability of service and face to face reviews. The Trust has also developed an Out of County Care Provider Monitoring form as part of its provider assurance service. I attach the protocol and Monitoring form for your information.

We trust that the above provides you with the reassurances that you seek but if you have any queries please do not hesitate to contact me.

Yours sincerely

Executive Director of Nursing and Professions