NHS
Greater Manchester
Mental Health
NHS Foundation Trust

PRIVATE & CONFIDENTIAL

Trust Management Offices
First Floor, The Curve
Bury New Road
Prestwich
Manchester
M25 3BL

[redacted]
Web: www.gmmh.nhs.uk
WE ARE SOCIAL

Mr Nigel Meadows
Senior Coroner for Manchester City Area
HM Coroner's Court and Office
Exchange Floor
The Royal Exchange Building
Cross Street
Manchester
M2 7EF

Date 6th December 2021

Dear Mr Meadows

Re: Jude Lloyd (deceased) Regulation 28 Preventing Future Deaths Response

On behalf of GMMH I would like to offer Mr Lloyd's family our sincere condolences at this difficult time.

Mr Meadows, thank you for highlighting your concerns during Mr Lloyd's Inquest which concluded on 30 September 2021.

On behalf of the Trust can I apologise that you have had to bring these matters of concern to the Trust's attention. I hope the response below demonstrates to you and Mr Lloyd's family that GMMH have taken the concerns you have raised seriously and will learn from this.

Please see the Trust's response in relation to the concerns you have raised and the actions taken by the Trust:

(a) **No thorough comprehensive risk review and care plan was formulated in relation to his Diabetes monitoring and management prior to his discharge from the Inpatient Unit. This was not recognised before he left the ward and it was not discovered by the CMHT when they took over his care.**

The lack of a thorough comprehensive risk review and care plan was identified as part of the Trust's Root Cause Analysis Investigation and included within the care and service delivery issues. Following the issues being highlighted, recommendations were made to address these concerns. The Trust's RCA report highlighted that in respect of inpatient monitoring of Mr Lloyd's diabetes, the care plans and risk assessments were completed on signs and symptoms of hypoglycaemia, but it was recognised these were not tailored to Mr Lloyd's specific needs.

A further recommendation was to raise awareness and education on monitoring for signs of diabetic ketoacidosis for CMHT staff. To address this an eLearning training package is in place in respect of supporting and monitoring physical health of a patient under mental health services. All

Registered Nursing Staff, Allied Health Professional and Social Work staff are expected to undertake this training every 3 years, one module of this training is specific to management of diabetes and there are questions to test learning at the end of the training.

There is a physical health nurse employed within each of the CMHT's who undertakes a physical health assessment, based on the Lester Tool, as a minimum annually. The Lester Tool helps frontline staff make assessments of cardiac and metabolic health, helping to cut mortality for people with mental illnesses. Results of these assessments and any investigations are communicated to the GP via letter. The completion of these physical health assessments and communication with the GP are monitored by the Trust.

Going forward the Trust physical health care group will reinstate a Diabetes workstream to continue to improve the management of people with diabetes across the Trust. We will ensure that the Diabetes workstream have oversight of compliance with training about diabetes management and are involved in the management and risk analysis incidents around diabetes care. We intend to make the care of someone with diabetes as one of our main quality improvement care projects in the organisation that will be led by the physical health care group who will act as the lead for this. This will involve further enhancing the connections and communication with primary care and will involve the new primary healthcare practitioners, which are new joint posts working across the new primary care networks and GMMH.

The findings of the Trust's review were presented to the Inpatient and CMHT Teams in a learning event on 28 September 2021.

(b) **No appropriate formal mental capacity assessments were made and properly recorded although this would also be relevant in managing his mental and physical conditions.**

This was identified in the Trust's investigation report under the sub-heading Summary of Inpatient Concerns and was addressed in recommendation 5 of the report. There are now clear processes in place in the inpatient service where any concerns raised in respect of a person's capacity to consent to or refusal of physical health treatment would trigger a formal Mental Capacity Assessment and a Best Interest Meeting as part of the ward MDT meeting. This process has been shared at departmental meetings by the Lead Consultant for Salford Inpatients and the Salford Inpatient Operations Manager. In addition to this the Lead Consultant has introduced complex case meeting every 2 weeks. This is a medical peer group where cases can be brought for further discussion in respect of care planning.

The Trust expects all professionally qualified staff to undertake eLearning training in respect of the Mental Capacity Act (MCA). The current compliance with this training is; Salford inpatient wards 80-100% and CMHT 76%. In addition to the eLearning the social care lead for Central Manchester has developed and delivered 4 face to face sessions to CMHT staff regarding when MCA should be considered, using case studies to support learning. This delivery of these MCA training sessions is ongoing.

All Consultants, who are Approved Clinicians, have specialist training in respect of MCA and Mental Health Act (MHA) to enable them to have the highest level of scrutiny of the interface between the MCA and MHA.

(c) **The transfer and communication process from inpatient care to the CMHT was inadequate and incomplete.**

The Trust's investigation report detailed that Mr Lloyd's Care Coordinator attended the discharge Care Programme Approach (CPA) meeting and participated in agreeing the discharge plan but did not complete a discharge CPA plan in line with Trust expectations when a patient is discharged from hospital. These expectations are already covered in the Trust CMHT Standard Operating Procedure and are monitored through audit of clinical records during management supervision of staff.

As part of the discharge process, Mr Lloyd was discharged on a Community Treatment Order and the discharge plan was shared with the GP requesting the GP to monitor Mr Lloyd's HbA1C and blood glucose levels. Further, there was a request for the GP to review Mr Lloyd in regard to his diabetes medications and non-compliance of these. The rationale for asking the GP to manage Mr Lloyd's blood glucose levels was due to Mr Lloyd's refusal to discuss his diabetes with mental health staff and the fact he was happy to work with his GP in respect of his physical health. The GP was advised Mr Lloyd had refused all his diabetic medication whilst an inpatient and was further advised that Mr Lloyd's BMs were found to be over 25 and the HbA1C was 135 on admission. The HBA1c is a measurement of control of blood glucose (glycaemic control) over the weeks prior to the test being taken so the HBA1c of 135 suggested extremely poor glycaemic control in the community whilst Mr Lloyd was under the care of his GP prior to admission. We agree that sadly, the plan to ask the GP to follow this up on discharge was unlikely to have led to any improvement in glycaemic control and was not a robust plan to manage this. We will address discharge diabetes management coordination via the diabetes steering group.

In respect of Mr Lloyd's mental health, the responsibility for this rested with his Care Coordinator and the plan included attending for his depot injections manage his mental health diagnosis of a schizoaffective disorder.

At the follow up review post discharge Mr Lloyd was reviewed by a specialty doctor and Care Coordinator with a plan at that time that there would be no change to the depot medication, there was to be a further outpatient appointment with either a speciality doctor or Consultant Psychiatrist within three months and Mr Lloyd's Care Coordinator was to follow him up. During this appointment on 25 February 2019 Mr Lloyd was asked if he was complying with his diabetic medication to which he responded that he was.

(d) **No appropriate contacts were made with the GP whilst the deceased was an in-patient to obtain relevant clinical information to assist in managing a serious physical health condition with potentially life threating complications and assist in the discharge planning. Nor were regular appropriate contacts made with the GP after discharge which would have highlighted the absence of medical management for a serious physical health condition.**

As has been indicated above, the Trust's investigation report highlighted these as care and service delivery problems. The concerns raised were raised within the Trust's learning event held on 28 September 2021 and were addressed by both the Salford Inpatient Operations Manager and the Operational Manager and CMHT Team Manager.

On admission to an inpatient ward contact is made with the GP surgery to undertake medication reconciliation and get any information about physical health concerns being treated by the GP. This will include details of any recent contact with the GP. Furthermore, the patient is reviewed during the admission by the junior doctor who will review any physical health issues. All physical health issues are then discussed at the patient's first MDT ward round as part of the admission process. Should any further information be required then the GP would be contacted.

On discharge, an immediate discharge notification with medications prescribed and any urgent actions for the GP to carry out is shared with the GP within 48 hours of discharge. An additional discharge letter is shared with the GP outlining the reason for the admission, any treatment, medication on discharge and any further actions for the GP which is sent to the GP with 7 days of discharge. In Mr Lloyd's case his GP this was to request the GP's involvement in the ongoing management of Mr Lloyd's diabetes.

When under the care of the Community Mental Health Team the service user's physical health should be included as part the holistic assessment and resulting care plan, the GP should be involved in this process. The Trust Care Programme Approach policy outlines the process for contacting all people involved in a patient's care, at least annually, as part of the CPA review and update of the care plan. The contact should review what input the person has had in relation to their physical health and whether arrangements need to be made for them to see their GP, a member of staff from physical health pathway or another professional in relation to their physical health needs. The patients GP should be invited to attend the CPA review or asked to provide written feedback for the review. The Trust acknowledges that the CPA review carried out on Mr Lloyds discharge form hospital did not follow this process, therefore missing an opportunity to liaise with the GP in relation to the management of Mr Lloyds diabetes.

Compliance with the Trust CPA policy is monitored individually through staff supervision and through the Trust annual CPA audit.

(e) **Whilst a psychiatric inpatient and suffering from a serious physical health condition which requires monitoring and treatment it was not possible to obtain appropriate specialist advice because the deceased was not an inpatient in hospital and was not registered with a GP in that area. Consequently, there was a gap in care provision which requires local NHS primary and secondary care procedural review to resolve**.

The learning from Mr Lloyd's death and the subsequent review will be shared by the Trust with our commissioner colleagues and will be an agenda item at the Quality and Performance meeting so an open discussion can be held with all our commissioners in relation to the provision of physical health care to our services users when they are an inpatient outside their usual GP area and how this can be taken forward across the Trust footprint.

(f) **Despite complaining of side effects, there was no apparent awareness of or consideration given to the risk and likelihood that these may be associated with his diabetes. No appropriate clinical advice was sought.**

As outlined in point (a) of this response the CMHT staff now undertake eLearning in respect of management of the physical health of a patient in mental health services. The CMHT's have nurses employed within a specific physical health role who can support the care coordinators in identifying physical health concerns. Care plans should identify any physical health concerns and treatment plans, including who is managing this. Care plans are monitored through supervision and through audit.

(g) **There were a number of missed opportunities for the CMHT to assess changes in his presentation and risk profile due to a lack of appropriate communication between mental health and primary care professionals.**

GMMH services across Manchester have access to the GM care record that means they can check when someone last saw their GP. The CMHT's also, as outlined in the Trust RCA report access Graphnet, an interface system between Primary and Secondary Care. Any results or investigations carried out by GMMH staff are uploaded to Graphnet as well as being sent to the GP in a letter. The CMHT staff can access the system to see any results uploaded by the GP. The CMHT manager has carried out audits to give assurance that this system is being used to communicate with the GP's. The audit and any resulting actions plan will be shared at the Trust audit committee.

In respect of communicating with the GP about physical health, and as outlined in point d & f of this response, the Trust recognises the importance of providing a holistic care package to service users addressing both physical health and mental health care needs either through the CPA process or through individual care planning as appropriate to the service. Care plans are shared with the GP and are monitored through supervision and through audit.

(h) **There was no robust audit system for checking compliance with the Trusts own policies and protocols in particular with regard to medical record keeping, risk assessments and reviews.**

There is an audit process for checking compliance in respect of record keeping. All staff have a line manager who undertakes supervision with the staff they manage. Part of supervision is the review of performance against Trust policy. Supervisors undertake a sample audit of patients' clinical records as part of the preparation for monthly supervision with staff and there is an expectation that any issues relating to the quality of medical record keeping, risk assessments and reviews would be picked up and addressed with staff during management supervision sessions. The CMHT currently has an 88% compliance with management supervision. In addition to individual reviews of documentation Ward and Team Managers should carry out regular audits on a selection of records to ensure that SOPs and Trust Policy is being adhered to as outlined earlier in this response.

(i) **The GMMH SUI investigation report contained several factual errors and misinterpretations. The CMHT Responsible Clinician did not provide a statement or was interviewed despite him being a crucial witness. This meant the all the lessons for future care and planning were not learnt. There was inadequate overview of the report before it was signed off.**

We apologise if there were factual errors within the Trust Serious Incident (SI) investigation report. We acknowledge that the CMHT RC could have been interviewed as part of the review, although this would not have changed the findings of the review.

The RCA investigation lead in this case acknowledged that the Responsible Clinician (RC) was not interviewed during the review and explained his rationale during the inquest. He has since reflected on his decision not to interview the RC and what he could do differently when carrying out future reviews with the Trust Head of Patient Safety. The Trust Executive Serious Incident panel has oversight of all reviews being undertaken and commission the reviews, including the terms of reference and who should be involved in the review.

The Trust process for obtaining information from staff involved in an SI has been updated to ensure we gather statements from staff at an early stage following the SI and use these statements in the SI review.

When a team of clinical staff are allocated to complete a review following a serious incident, they are allocated a Patient Safety Practitioner to support and advise the review team throughout the review process. The Patient Safety Practitioner is an experienced professionally qualified member of staff who has additional knowledge and skills in incident management.

Following completion of the review the final draft is shared with Senior Managers and Clinical Leads in the area of the Trust where the SI occurred to check for factual accuracy and approve content and recommendations.

The report is then taken to a Post-Incident Executive Review Panel who can raise questions of the review authors and the service managers. Following any amendments, the Executive panel approve the report and its content for release to the family and other concerned stakeholders, i.e., commissioners, coroners.

Mr Meadows, if you or Mr Lloyd's family have any further questions in relation to the Trust's response, please do let me know.

Yours Sincerely,

[redacted]

Medical Director

[redacted]