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Please ask for: Fiona Noden
Our Ref: FN/VCL (I.002459)

NHS Bolton NHS Foundation Trust

17th June 2020

Bolton NHS Foundation Trust
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Farnworth
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BL4 OJR
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Mrs A Mutch OBE
HM Senior Coroner Manchester South
HM Coroner's Office
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Mrs Mutch,

**Re: Barry Preston**

**Re: Regulation 28 Report to Prevent Future Deaths**

I am writing in response to your Regulation 28 Report to Prevent Future Deaths, issued following the Inquest touching the death of Barry Preston on 19th and 20th February 2020 dated 4th May 2020.

On behalf of Bolton NHS Foundation Trust, it is clear that there was lack of coordination in Mr Preston's care and for that I would like to offer my sincere apologies.

Following receipt of the Regulation 28 Report, I requested that that the Deputy Medical Director, Deputy Chief Operating Officer, Divisional Governance Lead for the Integrated Community Services Division and the Service Manager for the Integrated Discharge & Therapy Service review the concerns that related to Bolton NHS Foundation Trust.

I would like to assure you that Bolton NHS Foundation Trust (BFT) has liaised closely with relevant colleagues at Bolton Council and Greater Manchester Mental Health Foundation Trust (GMMHFT) in order to fully ensure that a collaborative approach was taken to respond to the concerns raised. I am now in a position to respond to the points as outlined in Section 5 that are relevant to Bolton NHS Foundation Trust. Where relevant, I have noted that Bolton Council and/or the GMMHFT will also provide a response for services that are integrated.

**Section 5 (1):** ***The quality of documentation was not always of a good standard and part of the reason why his catheter was incorrectly believed to be a long-term catheter.***

Since the death of Mr Preston, Bolton NHS Foundation Trust has introduced an Electronic Patient Record (EPR). This is the single electronic record on which all patient details, notes and actions are recorded.
All staff within Royal Bolton Hospital have access to view and record patient details on the system. The Integrated Discharge Team and the Intermediate Tier Services can also view and input into the electronic patient record which has improved the standard and consistency of documentation in real time.

**Section 5 (2):** ***The inquest heard that he was kept on wards that were not suitable for him or his needs. The inquest was told that this was due to capacity and flow issues within the Royal Bolton Hospital.***

With regards to Mr Preston's first admission on 28th October 2018 until 10th November 2018, a review of the hospital's bed flow has indicated that speciality beds on the complex care wards were low in number. Mr Preston's clinical predicament required him to have an observable bay and there were a high number of patients on the complex care wards requiring an observable bay and an enhanced level of care at that time. This led to Mr Preston's extended stay on the Medical Admissions Unit when the usual planned length of stay on a Medical Admission Unit is 48 hours. It was deemed safer for Mr Preston to remain on the Medical Admission Unit in an observable bay.

When Mr Preston was readmitted to hospital on 11th November 2018, he was admitted under the care of the Emergency Department's Medical Team and transferred to ward F3, this is the admitting ward for the Emergency Department as well as the Surgical Assessment Unit. Mr Preston was moved when a bed became available on the complex discharge Ward (A4).

The Trust seeks to make every effort to minimise the number of patients who are placed on an outlying ward and recognises that at times, when bed capacity within the hospital is compromised, decisions to outlie a patient may be necessary. With hindsight, more effort should have been made to ensure he was on the right ward to support the provision of the best possible care.

Currently, a review of the Patient Outlier Policy is being undertaken to ensure there is clear guidance in order to minimise the risks associated with patients being cared for on all wards irrespective of the speciality nature of the ward. This review is being undertaken throughout June and July 2020, engaging relevant stakeholders and led by a senior manager in consultation with the Deputy Director of Operations, Director of Quality Governance and senior Nursing and Clinical staff. The new Patient Outlier Policy will be rolled out across the Trust on 1st August 2020 provided the current COVID-19 pandemic circumstances do not delay its introduction.

Action being taken:

- BFT is currently undertaking a review of the Patient Outlier Policy

**Section 5 (3)** ***The inquest heard that he had a care coordinator in the community. However, the care coordinator did not take a lead in ensuring he was being supported in the acute settings or that best interest meetings were taking place. There was a lack of understanding between agencies of role and responsibilities under the integrated care model.***

The Bolton Council Local Authority and GMMHFT will provide a full response to this concern, this has been with the benefit of input from the Integrated Discharge Team (IDT).

**Section 5 (4):** ***The inquest heard that whilst he was being treated in acute settings there was no coordination or ownership of his care. It was unclear as to who was making decisions and assessing suitability of placement.***

During the period of time that Mr Preston was an inpatient he was seen by multiple teams including the Home First Team, inpatient therapy services and the Integrated Discharge Team (IDT). Since this incident it has been recognised that there were multiple handovers between teams and these teams have now been brought together under a single management structure in order to provide improved communication between staff groups and lead to better patient experience.

At the time of this incident the IDT did not provide a comprehensive service to inpatient assessment areas such as ward D2, operating an in-reach model which was reliant on other professionals to identify those patients who had existing social care needs prior to admission to hospital . The team has been reconfigured to ensure that patients with complex health and social needs are identified through the same multi-disciplinary team process that has been in place on base ward areas. Since May 2020, all assessment wards, as well as the Emergency Department are provided a full service and a lead care coordinator is assigned to oversee the coordination of the discharge planning process from admission to discharge.

As a combined service it has been identified that there are a number of skills and competencies which all members of the team will need to have in order to identify those patients with complex onward needs. The development is underway but has not been finalised due to the COVID-19 response. Additional training of existing staff is being undertaken and will be completed by the end of August 2020.

The IDT has identified that the role of a seconded mental health post within the team was a key omission in the management of Mr Preston's journey. The use of different organisation's case recording systems also resulted in the failure to identify that the patient already had a care coordinator in the community and the needs to identify an IMCA to represent the patient's best interest. Since this incident the IDT has in conjunction with GMMHFT, removed this role from the service in order to provide a single care coordinator (this will either be a social worker or discharge nurse) for each patient who is hospital based and will liaise with other organisations where needed. All input will be recorded in the patient's electronic patient record and social services case recording systems.

Action being taken:

- Development of a competency framework to address the skills gap in assessing patients with complex needs by 31st August 2020.
- Training of all staff to be completed by 30th September 2020.

I am advised that Bolton Council Local Authority will also be providing you with a detailed response to Section 5 (4).

**Section 5 (5):** ***The inquest was told that for a long period of time whilst in the care of the NHS there was not a clear understanding of his lack of capacity to make decisions about his care. Acquiescence by him was seen as him understanding and having capacity.***

In response to the concern raised of poor appreciation of the gentleman's lack of capacity to make decisions about his care, BFT has completed a review of the 'Mental Capacity Act 2005' policy. The narrative in the policy has been strengthened in respect of defining roles and responsibilities in the completion of mental capacity assessments , and there is clarity as to whom should be 'The Decision Maker' and the legal requirement for referral and involvement of Independent Mental Capacity Advocates in the absence of a relevant representative. The revised policy has been ratified by the Safeguarding Committee on 16th June 2020.

In conjunction with the review, Bolton NHS Foundation Trust is revising mandatory and non-mandatory training provision in respect of the Mental Capacity Act which Medical Staff, Nurses and Allied Health Care Professionals undertake, ensuring clarification of roles and responsibilities.

Action taken:

- Review of BFT's Mental Capacity Act Policy.

- There has been a review of training provision in respect of the Mental Capacity Act (MCA). Bespoke training is now provided to designated cohorts and will be completed by 30th September 2020.
- MCA forms are now available for completion by all designations of staff on the Electronic Patient Record.

I am advised that GMMHFT will also be providing you with a response to Section 5(5).

**Section 5 (7): *His placement at Laburnum Lodge was made without clear understanding of his needs. He fell twice within 24 hours sustaining a further bleed to his brain and readmission to the acute hospital.***

The Home First team is a therapy based team which aims to support those patients in the ED and assessment wards to return home without a longer period of hospital admission. It has been identified that there is a skills gap within this team and a competency framework has been developed to support staff in making the appropriate recommendation for placement at intermediate care units. In order to ensure all transfers are safe these will be reviewed on a daily basis by a member of the nursing team within the IDT.

Actions being taken:

- All wards have been advised that the decision to reduce the level of enhanced care should not be undertaken by ward staff without a full multi-disciplinary meeting
- Ward Managers have been instructed that any patient with complex needs should be escalated to the IDT for a full MDT meeting where any transfer of care is being considered.
- Development of a skills and competency framework.

The IDT have liaised closely with the Local Authority and a response detailing actions taken by the Local Authority in relation to Section 5 (7) will be provided.

I hope that the response of Bolton NHS Foundation Trust has provided you with the assurance that the Trust has taken appropriate action to mitigate the risk of future deaths.

Please do not hesitate to contact me in the event you require any further assistance.

Yours sincerely,

**Fiona Noden**
**Chief Executive**

Cc Chief Executive, Bolton Council
Chief Executive, GMMHFT