GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Health and Social Care Partnership
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London Road
Manchester M1 3BN

[redacted]

Date: 14 July 2021

Alison Mutch OBE
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Re: Regulation 28 Report to Prevent Future Deaths – Martin Gibbons 24/03/2020

Thank you for your Regulation 28 Report dated 22/04/2021 concerning the sad death of Martin Gibbons on 24/03/2020. Firstly, I would like to express my deep condolences to Martin Gibbon's family.

The inquest concluded that Martin's death was a result of 1a Hypovolaemic shock, 1b Neck laceration

Following the inquest you raised concerns in your Regulation 28 Report to Greater Manchester Health and Social Care Partnership (GMHSCP) that there is a risk future deaths will occur unless action is taken.

This letter addresses the issues that fall within the remit of GMHSCP and how we can share the learning from this case.

Tameside and Glossop Integrated Care NHS Foundation Trust (TGICFT) and Pennine Care NHS Foundation Trust (PCFT) conducted a joint investigation following the tragic incident on 24 March 2020, allowing one point of contact for the family, and learning across both trusts.

As an outcome of the investigation both trusts recognised the need to develop shared care principles and an agreed risk stratification/triage tool, including actions required should a person present to the emergency department (ED) who is considered a high risk to themselves. This document also needed to specify who is responsible for caring for the patient at given times when in the ED and include

escalation procedures as required. Additionally, it was acknowledged that a system to aid the communication and handover of clinical information between the two organisations was needed to be implemented. This included a handover sheet developed by both teams and increased access for the Liaison Mental Health Team's (LMHT) access to the ED system. Further detail around how this work has developed is provided below:

- The LMHT has now completed a joint piece of work with their ED colleagues at TGICFT. A triage assessment tool has been implemented which guides the triage nurse to consider the most appropriate pathway for the patient based on their risk/presentation at that time.
- A joint risk assessment tool has now been implemented. This is initially completed by the triage nurse and guides them into rating the patient's risk at that time in terms of high (red), medium (amber) and low (green). This then informs the level of observation required for the patient whilst in the ED.
- A mental health presentation engagement record is now in use. This is used to document the observation of the patient whilst they remain in the ED. Whilst the LMHT makes every effort to provide a staff member to complete these observations, due to service provision, this is not always possible. In these circumstances, an agreement is in place that this staff member will be provided by the ICFT.
- On assessment by the LMHT, the risk assessment is reviewed alongside a suicide risk screen being completed. The practitioner is then asked to rate the level of risk again using the same levels described above and agree an observation level for the patient. This joint working document then details the outcome of the assessment and the plan for the patient (inclusive of a plan should they be waiting for a bed in the ED) which is agreed and signed by the LMHT practitioner and the ED team leader. This evidences the handover and working plan for the patient. Additionally, both teams have a handover sheet in use. PCFT's handover sheet requests the name of the ED practitioner that a handover has been given to.
- Whilst not an action arising from this incident, the service has also implemented a patient information leaflet which is provided to the patient at the point of the referral to the LMHT and details what they can expect from the team. This encourages those thinking about leaving the department to inform a member of staff who may be able to look at alternative support for the patient.
- A standard operating procedure is being embedded for both organisations to reflect the shared care principles.

As noted in the Regulation 28 Mr Gibbons was assessed as needing admission for a period of assessment and possible treatment and an informal admission was agreed. A plan was put in place at this point to obtain a bed for Mr Gibbon's and Bed Management in Manchester were notified as he was registered on the national spine with a GP in Trafford. Efforts were then made to source a bed for Mr Gibbons and the family were advised there could be a delay in doing this.

Trusts are commissioned to provide inpatient beds to people who are resident in the areas they serve. The inpatient stay is only part of the whole pathway of care that a

service user has during their time in the trust and providing effective and safe transition between parts of the system (e.g. on discharge or on leave/liaison with community services) is best done in an inpatient service as close to their own community as possible, particularly as different trusts use different clinical information systems and have different pathways of care. In some circumstances, where there may be a significant delay in a bed being available in another trust, the assessing trust may extraordinarily temporarily admit a patient. However, to do this regularly would incur other risks around transitions of care of an individual either during the acute stage of their illness or on discharge from hospital when they are supported by community teams who will not have been able to develop a relationship with the patient due to geographical distance.

There has been an overarching reduction in the mental health bed base capacity across the country over a number of years.This is having an ongoing impact in terms of local systems having the necessary capacity to meet the ever-increasing demand on services. In Greater Manchester we are investing significantly into our community and crisis services so that we have a holistic service offer, which will ensure that the demand on mental health beds is manageable.

Actions taken or being taken to prevent reoccurrence across Greater Manchester.

1. Learning to be presented/shared with the Greater Manchester Quality Board. This meeting is attended by commissioners, including commissioners of specialist services, regulators, Healthwatch and NICE.

2. Learning to be shared with the Greater Manchester commissioners of services to consider the findings of the investigation within the context of the services they commission.

In conclusion, key learning points and recommendations will be monitored to ensure they are embedded within practice. GMHSCP is committed to improving outcomes for the population of Greater Manchester.

I hope this response provides the relevant assurances you require. Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely

Dr [redacted]
Chair of GM Medical Executive, GMHSCP