North, Central and South Manchester
Clinical Commissioning Groups

Citywide Commissioning, Quality & Safeguarding
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[redacted]

CH/CAC

3rd January 2014

Mr N Meadows
HM Coroner
Coroner's Court
Crown Square
Manchester
M60 1PR

Dear Mr Meadows

Re: Regulation 28; Prevention of Future Deaths Report (Stephanie Daniels - deceased)

Thank you for your report under Regulation 28, Prevention of Future Deaths following the inquest into the death of Ms Stephanie Daniels. As requested this is the response from the Citywide Commissioning, Quality and Safeguarding Team on behalf of the CCG.

I respond to two concerns raised by your report; number 1 regarding the Serious Untoward Incident investigation and number 3 with regards to bed availability. I deal with them separately below. I am unable to respond specifically in relation to the other issues you raise but have noted your comments.

By way of an introductory comment I provided a detailed statement to you during the inquest into Ms Daniel's death about the manner in which the CCG commissions inpatient beds and the steps it has taken to ensure that there is sufficient mental health inpatient capacity within the Manchester area and the steps it has taken to monitor inpatient capacity (amongst other things) within the Manchester Mental Health and Social Care Trust ("the Trust"). I also provided comments in my statement about the CCG's input into the Serious Untoward Incident investigation carried out into the death of Ms Daniels and I will therefore confine my response to your first concern to a more general explanation of the CCG's overview of untoward incidents occurring within NHS Trusts from which it commissions services.

Concern No 1 - Internal NHS Serious Untoward Incident Investigation

A revised governance process has been developed within the Citywide Commissioning, Quality and Safeguarding Team and the Trust now attends an established Citywide Patient Safety Committee. This committee meets monthly and is responsible for the review and monitoring of serious incidents requiring investigation reported by the Trust as well as any other patient safety related issues including those highlighted at inquest via Prevention of Future Death Reports.

Lessons learnt from the Serious Untoward Incident investigations carried out by the Trust are shared at this meeting and are cascaded to the three CCG's within the City via their Quality Leads who also attend. Lessons identified from Serious Untoward Incidents that occur in other NHS Providers are also shared at this Committee with Manchester Mental Health and Social Care Trust.

The City Wide Commissioning, Quality and Safeguarding Team are represented at all High Level Investigation Panels (HLIP) held by the Trust. The HLIP's were established by the Trust in order to allow scrutiny of their investigations and reports. Prior to the HLIP the Trust provides the City Wide Commissioning, Quality and Safeguarding Team with a draft copy of their investigation report. This allows the City Wide Commissioning, Quality and Safeguarding Team representative to review the report and challenge its robustness, contents and findings. Following the HLIP the Trust develops an action plan and the City Wide Commissioning, Quality and Safeguarding Team representative reviews this to ensure that the actions identified are Specific, Measurable, Achievable, Realistic and Time based (SMART) to reduce the likelihood of a recurrence of the incident.

Challenges into the investigation report and its findings regularly take place at HLIP's and should concerns regarding the investigation and its robustness be identified further higher level actions would be taken via Executive to Executive discussions.

The Trust's response to the Prevention of Future Deaths Report in this case will be scrutinised by the CCG and assurances will be sought from the Trust in relation to any actions it proposes to take to ensure that they are appropriate and robust and that they are implemented.

Concern No 2 - Bed Availability

The commissioning of beds is based on evidence of past need and emerging needs from commissioning intelligence. The CCG does not directly instruct Manchester Mental Health and Social Care Trust, or any other NHS Trust about how its beds should be utilised and although it monitors the Trust's bed utilisation decisions on patient management are solely the responsibility of the Trust as the provider of NHS care.

Commissioners can, by negotiation, influence a Trust's use of resources and can shift resources around the system but decisions about admitting and discharging patients rest with the provider NHS Trust.

As a result of the CCG's concerns relating to out of area placements the following process has been set up and has been operational since August 2013:

- There are daily bed management conference calls between the CCG and representatives of the Trust to review admissions, discharges, patients waiting for assessment (who may then need a bed) and out of area placements
- There is a weekly teleconference where delayed discharges are discussed with Manchester City Council. Representatives of the CCG and the Trust attend this conference call.

- There are weekly mental health inpatient capacity meetings with representatives from the Trust. Additional capacity has been purchased in neighbouring NHS facilities and via the charitable sector.

The number of out of area placements utilised by the Trust is significant and the CCG monitors usage on a daily and weekly basis (as above) to ensure that patients are either allocated a bed quickly or are repatriated as quickly as possible when a bed is available within the Trust.

An escalation protocol was agreed with the Trust in the financial year of 2011/12 which enabled the Trust to utilise private sector beds when it did not have the capacity to accommodate a patient in need of an inpatient bed. This protocol was reviewed following the inquest into the death of patient FK and has been reviewed again in July 2013 to ensure it remains robust. The CCG is confident that the protocol is appropriate and robust.

An inpatient capacity management plan has been developed and implemented by the CCG. The overall aims of this plan are:

- To address the financial pressure within the Manchester health economy resulting from out-of-area placements
- To improve patient experience
- To maintain bed flows most effectively and efficiently
- To promote an effective and joint working approach across the stakeholder organisations

The Commissioner Assurance Plan for Quality Improvement (CAP-QI) was agreed by the Joint Commissioning Management Board in September 2013 and is monitored monthly as part of quality and performance monitoring processes that are in place within the Citywide Commissioning, Quality and Safeguarding Team.

Conclusion

To summarise: the City Wide Commissioning, Quality and Safeguarding Team on behalf of the CCG's has robust monitoring processes in place to monitor action taken by the Trust in response to this incident and other serious incidents requiring investigation reported by the Trust. Assurance is sought with regards to progress on a monthly basis.

The Team also monitors bed availability on a daily and weekly basis to ensure that patients are not waiting unnecessarily for a bed or that they are not placed out of area for extended periods of time (which can impact on patient experience and also NHS budgets).

Yours sincerely

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Executive Nurse and
Director of Citywide Commissioning, Quality
And Safeguarding