5 Boroughs Partnership NHS
NHS Foundation Trust

Our Ref: SB/SA

Your Ref: APW/GEB/H.S-Sankey

20 February 2014

Chief Executive's Office
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Mr A P Walsh
HM Coroner
Great Manchester (West)
HM Coroners Court
Paderborn House
Civic Centre
Howell Croft North
Bolton
BL1 1JW

Dear Mr Walsh

Re: Howard Simon Sankey - deceased

Thank you for your letter dated 27 December 2013 with regards your findings into the death of Mr Howard Simon Sankey and the directions given under Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. I would like to advise you of the actions the Trust has taken both since the inquest and since receiving your letter.

Your letter specifically refers to your concerns about the management of referrals received within the Trust's Assessment Team for Wigan and the apparent ineffectiveness of the team in dealing with referrals appropriately; this included the numbers of referrals being received by the Team, concerns regarding the staffing levels and the unpredictable nature of the volume of referrals.

You were particularly concerned with whom within the team identified the priority for the referral and whether this was the role of an administrative team member. You also sought assurances about whether the team could action all referrals in line with agreed timescales, as detailed in our Assessment Service Operational Guidance. You were also concerned to know what actions were taken by Practitioners when a service user was not contactable and how this was handed over to the following shift to ensure appropriate action was taken.

Taking your points in turn, I can confirm the Trust have completed the following:

1 Matters of concern:

I. It is the referrer and not an administrator who categorises referrals. A system is in place whereby administration staff place referrals in an appropriate tray based on the referral priority provided by the referrer, who is usually a general practitioner. Where no priority has been identified by the referrer this is now brought to the immediate attention of the senior nurse practitioner on duty who will review the referral and assign the appropriate clinical priority within a maximum of 30 minutes of receipt.

II. The referral priority is identified on the referral form initially by the referrer. This is placed in the appropriate tray by administrative staff as detailed above. The senior nurse practitioner on duty is alerted to the receipt of the referral and takes action to clinically review the information provided in order to allocate an appropriate response time in accordance with the agreed operational guidance. This action occurs within a maximum of 30 minutes of receipt of referral. A number of options are available to the duty staff upon review of the referral. This includes allocation of an emergency assessment if deemed appropriate or a response time within the urgent or routine categories. The electronic patient information system, Otter, is available to all staff both clinical and administrative.

III. The service user information system, Otter, already records the date and time of referral in addition to the referred and assigned priority. This information is available to all staff in the assessment team and I apologise if this was not made clear during the course of the inquest.

IV. The work of the assessment team can be unpredictable due to the unplanned nature of referrals. I can confirm that whilst at the time of the incident, the team had gaps in staffing due to sickness and vacancies; the team is now fully established. Sickness continues to be proactively managed at a local level and monitored across the entire business stream in line with Trust policy. Staff work to a rota that ensures maximum coverage across the 24 hour period.

V. There is a system in place where the referral/case notes will stay in the referral tray until at least three telephone calls have been made to the service user within a maximum of a 24 hour time frame. The purpose of the telephone calls to the service user is to enable further information gathering to assist with the prioritisation of the referral and to arrange a mutually agreed appointment date and time. A further system is in place which indicates that after this time, a face to face unplanned visit will be arranged for urgent referrals which will take place at the address provided by the referrer.

In the case of referrals considered to be of a routine nature, they are discussed the next day in the morning meeting and a decision taken as to whether the cases need to be reprioritised. A multi-disciplinary team decision is taken on the next action required, which can include an increase in referral priority or further discussions with the referrer on the appropriate course of action.

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VI. A formal written handover takes place at the start of each shift. As per number V above, the morning meeting reviews all cases for the previous day where no contact has been made and decides on an appropriate course of action. This is recorded on the Otter information system which is available to all staff and as previously stated I apologise if this was not made clear to you during the course of the inquest.

2 I have concerns with regard to the 5 Boroughs Partnership NHS Foundation Trust, particularly the Gateway Team, in relation to:

I. Please refer to 1. I above.

II. Please refer to 1. II above.

III. Please refer to 1. V above.

IV. Please refer to 1. III above.

V. Please refer to 1. V above.

VI. Please refer to 1. IV above. In addition, all vacancies within the assessment service have been recruited to. There is no waiting list for referrals to be seen.

VII. The Trust are currently undertaking a review of the entire Acute Care Pathway (ACP) which includes a review of staffing levels and skill mix across all teams and the effectiveness of pathways between services. This is due to be reported at the end of February 2014. The team manager receives regular management supervision where the concerns you have raised have been discussed and action taken.

VIII. Training in the form of 'lessons learned' took place on 22 January 2014 and included an update of guidance and systems currently in place within the team. This has been cascaded across the other assessment teams and will be shared at the Quality and Governance Meeting in February 2014.

I can assure you that as a Trust we take the management of referrals very seriously and I can confirm that the management of referrals within the Assessment Team has been reviewed. Whilst it was never the role of the administrative staff to assign a referral priority, the assessment team does has a robust system in place to ensure all referrals accepted by the team, are reviewed by a senior clinical member of staff without any undue delay. A system has been introduced whereby the team have a daily recorded morning meeting in which referrals are identified and actions or responsibilities for the shift are delegated.

In terms of wider learning from serious untoward incidents, the three Assessment Teams managed by the Trust meet together in formal minuted meetings. This forum is used as a vehicle to learn lessons and share good practice. All changes to systems have been discussed and shared with the steering group and the implementation of the changes is monitored by the local management teams. This is

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to ensure consistency across the teams and that any changes made support and link-in with the pathways into other services and teams.

Further to the Serious Untoward Incident (SUI) Report being completed, an action plan was developed by the local Business Manager for the Trust to deliver, all of which linked into the recommendations set out by yourself. I can also confirm that all the recommendations made in relation to this case, have now been completed.

If I can be of any further assistance or you require further information about the steps we have taken, please do not hesitate to contact me.

Yours sincerely

S J Barber

Simon Barber
Chief Executive Officer

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