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Date: 26 March 2015

PRIVATE AND CONFIDENTIAL

Mr Nigel Meadows
HM Coroner
Coroner's Office
Manchester City Area
PO Box 532
Manchester Town Hall
Albert Square
Manchester, M60 2LA

Dear Mr Meadows

Re: Kimberley Lindfield (deceased) Inquest hearing concluded 30 January 2015. Regulation 28: Report to Prevent Future Deaths

Thank you for your Regulation 28 Report of 2 February 2015 following the Inquest Hearing at Manchester Town Hall into the death of Kimberley Lindfield.

I acknowledge that your concerns also have regional and national implications and that you will be receiving responses from the other organisations listed in your report.

Firstly, before I respond to your report I wish to highlight Manchester Mental Health and Social Care Trust's (MMHSCT) concern that paragraph 21 of your letter suggests that you heard evidence at inquest that members of MMHSCT staff were not aware of the new policy instigated after the death of Paul Dean or the Trust's expectations in respect of a mental health referral and were attaching an incorrect interpretation to the term "medically fit". No member of MMHSCT staff gave such evidence and the University Hospital of South Manchester accepted that no referral was made to this Trust, thus MMHSCT's response to referral on that occasion was not tested. You did hear direct evidence from [REDACTED] Consultant Psychiatrist MMHSCT, as to the training given to the Trust's clinical staff at the time of Ms Lindfield's death and the fact that MMHSCT staff were being trained at that time to respond to any referral made, regardless of the fitness of the patient. [REDACTED] Medical Director of MMHSCT, also confirmed in his statement that this is the regime currently in place at MMHSCT and provided you with copies of the Trust's training material confirming this.

In response to your concerns highlighted in your report, of the five areas identified, only the first of these (i.e. audit of mental health referrals) refers to MMHSCT as well as the University Hospital of

Where People Matter Most

South Manchester (UHSM) and Greater Manchester West (GMW).

A meeting, chaired by [REDACTED] (Interim Medical Director, UHSM), was held on 17 February 2015 to consider the actions necessary in response to the Regulation 28 letter. There were representatives from UHSM, GMW, Manchester and Trafford commissioners, as well as from MMHSCT at the meeting.

In responding to your recommendations for better and more integrated mental health and physical health care, I wish to make the following observations:

The liaison arrangements at UHSM is highly complex and MMHSCT can only take responsibility for those areas in which we have been commissioned to provide a service. At present, MMHSCT is commissioned to provide A&E Liaison for Manchester residents aged 16 and over. Unfortunately, Ms Lindfield was not referred to MMHSCT services whilst in A&E or on A10.

I appreciate your wish to see a timelier referral to mental health services and, as our services are primarily for A&E, we have set target response times which are closely monitored by UHSM, our Trust and Commissioners. There is regular scrutiny of our performance in A&E at several fora, including Executive to Executive meetings with the Manchester Clinical Commissioning Groups, System Resilience Groups and locally with senior managers at UHSM.

In respect of an audited process regarding referrals to mental health liaison teams, we will of course cooperate fully with our colleagues across the local health economy to help develop this. However, since A&E associated ward liaison is provided by MMHSCT, but most other ward liaison services are commissioned from Greater Manchester West (GMW) Foundation Trust's RAID team, it would seem appropriate that this piece of work is led by UHSM, with the involvement of the two mental health provider organisations.

The Trust accepts that you are rightly concerned to ensure that patients are seen depending on their need and that there should be no exclusion by team members undertaking assessments on the basis that a patient is not 'medically fit'. MMHSCT has given you an assurance that this has not been the case for some time, and that our induction training for junior medical staff, incorporate this advice and guidance. In addition, revised Urgent Care Standard Operating Procedures are currently being finalised and we have ensured that this point is clear within them. As we have not seen any evidence to suggest that a referral has been turned down on the basis of medical unfitness, we are unable to agree, as stated earlier in my response, that your pronouncement on this is in keeping with our clinical practice.

The Interim Medical Director (UHSM) and their Chief Operating Officer arranged a meeting on 3rd March 2015, which was attended by MMHSCT's Medical Director and Deputy Director of Operations, where there was a wider discussion on the Regulation 28 action plan. This included informing all UHSM staff on referring patients when it was appropriate rather than on the basis of medical fitness. This information will be widely disseminated by UHSM who will also carry out an audit in the future to ensure that there is evidence of this as good practice. A group will be established to scope and devise the audit, with representation from all partners.

In respect of the other concerns raised in your report, MMHSCT has agreed to provide UHSM with advice in respect of their development of a self-harm policy and also with their development of guidance and protocols on observation of patients at risk. MMHSCT has suggested that they may wish to build on our existing observation policy.

A training plan is to be put in place to meet the Training Needs Assessment undertaken by UHSM. Although MMHSCT has been involved in discussions about training over a long time, UHSM have asked GMW to provide training to their staff.

The partners have agreed to establish regular liaison meetings between UHSM, MMHSCT and GMW at which the actions described above will be monitored.

I hope this response provides you with assurance that the Trust has taken action in response to your Regulation 28 Report.

Yours sincerely



Michele Moran
Chief Executive