HEALTHIER PEOPLE,
BETTER FUTURE

Heywood, Middleton and Rochdale
Clinical Commissioning Group

Your Ref: 54658-2014

26 April 2016

Mrs L J Hashmi
Area Coroner
The Phoenix Centre
L/Cpl Stephen Shaw Way
Heywood OL10 1LR

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Dear Mrs Hashmi,

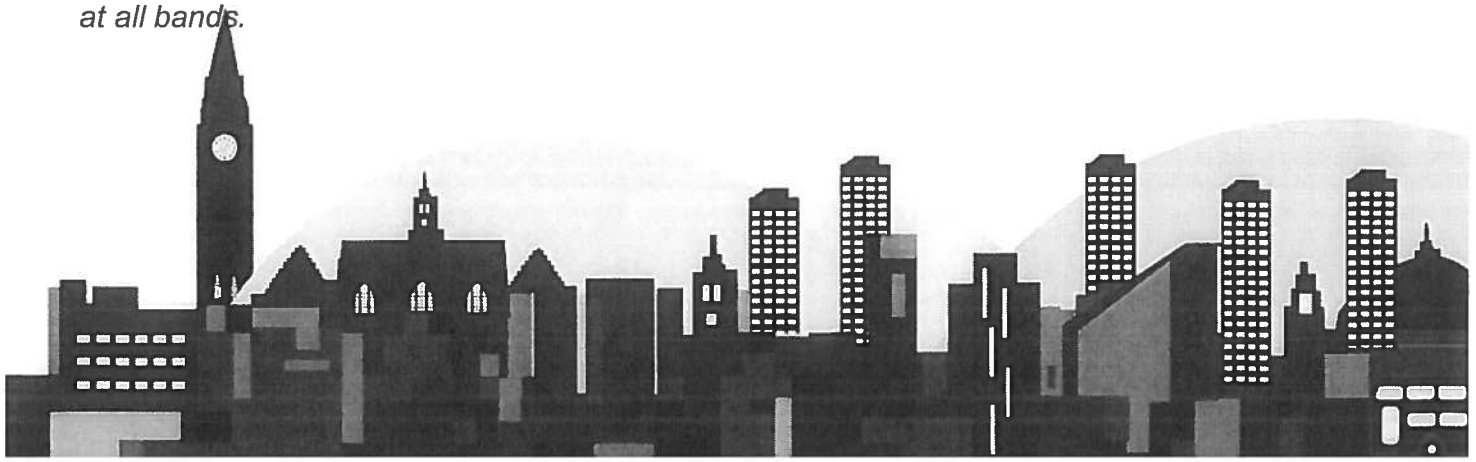
Re: Regulation 28 Letter – Inquest into the Death of Susan George held on 15 February 2016

On 2 March 2016, as HM Coroner for Greater Manchester North, you issued a Regulation 28 Form to the Director of Commissioning at Heywood Middleton and Rochdale CCG ("HMR CCG"). The Regulation 28 Form was worded as follows:

'There is no inpatient Clinical Psychologist service available within PCFT. This is a second (possibly third) PFD form on the same issue. The Trust maintains this is a result of commissioning issues. Without inpatient clinical psychology there is a marked service gap that puts patients such as Susan at risk.'

In developing this joint response to the above, the CCG and Pennine Care NHS Foundation Trust ("PCFT") have liaised closely regarding this matter. The position advised by PCFT is as follows:

'To support the required response from the commissioners, the Trust would like to inform them that whilst we acknowledge there is no dedicated Clinical Psychologist available to the In-patient unit on a full time basis, and that this is due, in part, to the level of funding available to the service, a session is available on both wards on a weekly basis for the staff to utilise. These sessions are designed to discuss formulation, difficult cases, to use as reflection and support and to supervise practice. This is greatly welcomed by all staff and well engaged with at all bands.

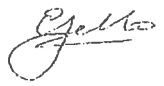


In addition, since the case in question, the wards at Birch Hill are now a recognised learning placement for psychology students and benefit from regular input from this perspective.
The Trust would welcome further investment in psychological input into its in-patient unit and is working with the CCG on a programme of Transformation for the whole acute care pathway that will include re-design of the service and a review of skills required with a corresponding action plan to realise the aspiration.'

The CCG recognises the requirement to support a Transformation programme for the acute care pathway, including community services, and has committed investment in 2016/17 to progress this workstream. This Transformation programme will be co-produced between the CCG and PCFT. The CCG welcomes the clarification from PCFT that psychology input is available as part of the inpatient service, as described above. The CCG will continue to work closely with PCFT in order to implement the local Transformation programme, in line with the CCG's vision for Mental Health Services, as described in both the Rochdale Borough Mental Health and Wellbeing Commissioning Strategy (2014-17) and the Rochdale Borough Locality Plan.

I hope that this response addresses the issue raised by the Regulation 28 Form, but should HM Coroner wish to discuss this response or require further information she should not hesitate to contact Ian Mello, Director of Commissioning and Provider Management at HMR CCG on 0161 655 1324.

Yours faithfully,



Ian Mello
Director of Commissioning and Provider Management

Pennine Care NHS
NHS Foundation Trust

Trust Headquarters
225 Old Street
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Lancashire
OL6 7SR

20th April 2016

Ms L Hashmi
Area Coroner, Manchester North
Phoenix Centre
L/Cpl Stephen Shaw Way
Heywood
OL10 1LR

Our Ref: KB/ELD
Department: Trust Headquarters

Dear Ms Hashmi,

Re: SUSAN GEORGE (Deceased)

Thank you for your Regulation 28 Report, dated 29th February 2016, and for bringing to my attention the concerns that you had after hearing all the evidence. Your concerns have been reviewed in line with the stipulated timescales. I list below the Trust response to the nine points you raised.

1. No review of the decision to discharge was sought or conducted when it became apparent that there had been a material change in Susan's presentation on the 10th November 2014. Had a review taken place then it is likely that the discharge would have been deferred or cancelled.

Response:

The issues raised in points 1, 2 and 3 can be considered together.
It is acknowledged that should staff have sought a review at the point of SG ringing the police, expressing her concerns to Access and Crisis, then a different outcome may have been agreed as regards her discharge that night.

The ward has appointed a substantive Ward Manager since this case and the development of a more robust discharge process has now been implemented.

The discharge assessment document is prepared prior to planned discharges and is then completed on the day of discharge by the discharge nurse. The final page of this document is the 'Discharge Plan' which contains the emergency contact numbers and a crisis contingency plan. A copy of this is handed to the patient upon discharge.

The discharge nurse obtains the date and time of the 7 day follow up prior to the patient leaving and informs the patient of this appointment.

All relevant parties are informed of the planned discharge with the patients' consent. This is also in line with the revised Mental Health Act Code of Practice 2015. We are also undertaking a pilot of shift pattern for nurses which means the 'meetings' nurse will work 08:30 –to 16:00 in order to ensure full completion of discharge documentation by the same staff member and thus avoids this task being handed over to a nurse who may not have been involved in the discharge meeting. This is supported with the development of the Triangle of Care initiatives, in which the involvement of family members providing information regarding the patient, even if the service user does not give consent to share information, is still included in the information that informs the discharge process.

The current discharge protocol will be reviewed to ensure it is still reflective of all required processes and add a note of guidance to staff should they be faced with a similar situation.

The guidance will be updated through the Trust Acute Care Forum and ratified through Governance process for implementation in all areas.

2. The discharge process was disjointed, lacked co-ordination and did not involve SGs primary/associate nurse.

Response:

As above.

3. The discharge policy was perfunctory and staff failed to follow it in any event.

Response:

As above.

4. Poor record keeping, predominantly on the part of the nursing staff

Response:

The Trust acknowledges that the record keeping evident in this case at times fell below the expected Trust and professional bodies' standard.

Since this case the ward has now appointed a substantive ward manager and has fully implemented the Standard of Record Keeping audit on the ward. This process includes each set of notes being audited on a monthly basis with individual results being feedback to each named nurse/qualified nurse during their supervision with any performance issues being addressed and monitored through this process. This

has led to a significant improvement in the quality of record keeping within the ward. To continue to undertake this monthly process to take into account changes in documentation as the services develop and evolve. The results to be fed through the ward benchmarking processes and the monthly ward manager's forum managed and chaired by the In Patient Services Manager for the North Division.

This process is further assured by an annual Trust wide record keeping audit and the ward has shown continued high compliance rates within this audit in the last 12 months. There is an annual Integrated Quality Matrix (IQM) conducted on each ward and as part of this matrix, documentation is scrutinised. The audit conducted in September 2015 on Moorside has shown an improvement in identifying and liaising with patients' carers' and also in care planning and risk management. The ward staff have also implemented a written weekend handover, which is read out in Mondays' board round, detailing how each patient has been, any incidents and their mental state over the weekend.

5. There is no protocol/guidance on what steps to be taken when an inpatient contacts the emergency services (e.g. police via 999). This is important as it goes to risk assessment and management.

Response:

To develop an agreed protocol/guidance for staff to utilise if a service user contacts the emergency services via 999, including review of risks and appropriate action to take to safeguard the service user and support the staff response.

6. Unprofessional staff attitudes towards patient/care provision- two qualified nurses involved in Susan's care used inappropriate language and demonstrated negative ways of thinking during both conversations with colleagues and the police communications operator. Prevailing attitudes such as this, particularly towards vulnerable adults, puts care standards at risk.

Response:

There have been some specific actions taken as regards the two nurses identified via the coroner. Although of course we cannot divulge the full details of this action it is appropriate to the allegations highlighted and being managed through the Trusts Conduct and Disciplinary processes and the NMC Fitness to Practice processes. In relation to the overall culture and attitudes on the ward, as previously mentioned the ward now has a substantive ward manager who has instilled a more proactive and positive culture but it is recognised that ward environments have many challenges, with difficult cases to manage safely, staffing levels and acuity challenges and the need to have a stabilised ward team to foster a positive culture led by senior clinical leaders who are excellent role models and instil expectations

into every level of the team. This is being addressed through a targeted organisational development review of the team as a supportive measure to help foster further embedding of a positive culture and build on the work already undertaken.

The safer staffing work and transformation plans for the next 12 months led jointly by PCFT and the CCG will further enable the development of this on the ward through investment and transformation plans.

All adult wards, including Moorside are implementing safe wards initiative. When giving handover staff should say something positive about what each patient has been doing during the shift, or draw attention to some positive quality they have, or if this is not possible something positive about the way in which staff supported the patient (positive appreciation). In addition, if any difficult or disruptive behaviour is reported, a possible psychological understanding of the patient's behaviour must be offered.

In addition to this and in order to promote a positive milieu on the ward Moorside are implementing a 'positive quote of the day' This would be displayed for both staff and patients.

7. Poor advocacy on the part of the nursing staff whose decisions appear to have been clouded by the rigidity of the medical decision to discharge.

Response:

Point 7 and 8 can be taken together.

To re-iterate to staff the fact they are responsible and accountable for their own decision making. If they are unhappy or not clear in what they have been directed to undertake then to utilise the escalation process in place through the ward manager, In patient service manager on on-call system if required.

To develop a briefing on guidelines for staff to follow on how service users can access support if they are unhappy with the decision made about their care.

These guidelines will include the use of advocacy, the principles in the Triangle of Care and the engagement of the full MDT and how the nursing staff can support this process in the best interests of the service user.

8. Staff were unaware of how to support and advise patients on the issue of obtaining a second medical opinion where the patient disagrees with the first doctor's decision (in this case, to proceed to discharge).

Response:

As above.

PCFT and HMR CCG:

9. There is no inpatient Clinical Psychologist service available within PCFT. This is a second (possibly third) PFD form on the same issue. The Trust maintains this is a result of commissioning issues. Without inpatient clinical psychology there is a marked service gap that puts patients such as SG at risk.

Response:

PCFT acknowledges there is no dedicated Clinical Psychologist available to the inpatient unit on a full time basis. This is due in part to the level of funding available to the service.

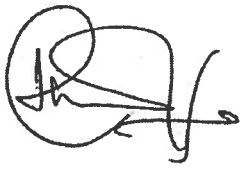
There is a session available on both wards on a weekly basis for the staff to utilise to discuss formulation, difficult cases, use as reflection and support and supervise practice. This is greatly welcomed by all staff and well engaged with.

In addition, since the case in question, the wards at Birch Hill are now a recognised learning placement for psychology students and benefit not from regular input from this perspective.

The Trust would welcome further investment in psychological input into its in-patient unit and is working with the CCG on a programme of Transformation for the whole acute care pathway that will include re-design of the service and a review of skills required with a corresponding action plan to realise the aspiration.

I hope this response assures you that the Trust takes seriously any concerns that you raised.

Yours sincerely



Dr Henry Ticehurst
Medical Director

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