NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

[redacted]
Chief Executive Officer
Silver Springs
Fountain Street
Ashton-under-Lyne
Lancashire
OL6 9RW

Telephone: [redacted]
Email: [redacted]@tgh.nhs.uk
PA: [redacted]@tgh.nhs.uk

10th July 2020

Mr Adrian Farrow
HM Assistant Coroner
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Mr Farrow,

Regulation 28: Report to prevent future deaths, following the Inquest touching upon the death of Mr Gordon Fenton

I am writing to you in respect of your letter dated 23rd April 2020, by way of a Regulation 28 Report issued following the Inquest touching upon the death of Mr. Gordon Fenton, which concluded on 6th March 2020. I hope to be able to address the concerns raised in your report and set out below my response which has been compiled further to joint working between Tameside and Glossop Integrated Care NHS Trust (TGICFT) and Pennine Care Foundation Trust (PCFT).

Concern 1:

The inquest heard that there was a particular tension in relation to shared care between Pennine Care NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Trust for patients who are subject to psychiatric care, who have acute medical problems.

I am very sorry if this was the impression projected to you, the jury and Mr Fenton's family at inquest. I hope that you will accept that both TGICFT and PCFT are committed to working together to improve the safety of all patients requiring psychiatric care, who also have acute medical problems.

As you may already be aware, TGICFT have obtained a copy of the court recording. This has been reviewed by the Trust and has identified areas of learning in terms of providing evidence at Coroner's Court and the importance of continuity, even where there may be a difference of opinion as to the expectations of each service.

Please note that TGICFT are not commissioned by the Clinical Commissioning Group to provide in-reach services to Mental Health Wards, it is accepted that at the of time of Mr Fenton's care, there were existing processes that required improvement in terms of shared physical and mental health care, which have been detailed below.

Concerns 2 and 3:

There does not appear to be a reliable and consistent method of sharing medical records and information between the two Trusts.

There does not appear to be a formalised decision-making process in place involving both Trusts to review the treatment plan to determine the optimum medical and psychiatric care to suit the particular patient's needs.

As part of our investigation into your concerns, extensive discussions have taken place between the Associate Director and Mental Health Quality Lead at PCFT, Head of Assurance & Governance for TGICFT and Lead Nurse for Mental Health & Learning Disabilities at TGICFT in relation to ongoing improvements in shared service, specifically in relation to creating a formal standard operating procedure and enhancing services we offer.

I understand it was discussed in evidence that we have been working towards creating a joint Standard Operating Procedure (SOP) for older patients receiving mental health care and treatment from PCFT who require medical input. It is recognised that these patients will often have the most complex comorbid physical and mental health needs, therefore it is extremely important that there must be a shared responsibility between mental health services and acute services to ensure all patients have timely access to specialist advice and are provided with safe and effective care.

The joint SOP which is scheduled to be trialled in August 2020 will apply to all patients within PCFT's older peoples' mental health inpatient wards. Both organisations will continue to work in partnership to identify, agree and establish working parameters for the Digital Health Team at TGH to support the physical health needs of older people receiving mental health care and treatment on Summers & Hague wards, of which Mr Fenton was a patient. The offering of Digital Health services will be conducted as a pilot in the first instance for 8 weeks, which will then be reviewed to establish a more formal offer and outcomes. It is hoped that if this procedure is successful that similar processes will be developed for all of our patients requiring shared input.

A number of joint pathways have also been created with regards to Mental Health Inpatient Transfers of Care and Return Inpatient Transfers of Care. In terms of transfers of care, the process will be split into three categories;

1. Patients with an acute deterioration of their physical health,
2. Patients with a chronic long-term condition who may be deteriorating or for ongoing management advice and;
3. Gathering of required information either at the point of admission or transfer back from TGICFT.

I understand that the process will include PCFT performing baseline physical observations and calculating the National Early Warning Score (NEWS), following which, if deemed necessary they will refer the patient to PCFT's medical team/on call Doctor and handover clinical presentation. At this time, PCFT will assess whether further assistance is required from the Digital Health Services to coordinate access to specialist services for review to agree an appropriate management plan. If the patient does need immediate on-going physical health support, the Nurse in Charge will contact Digital Health to complete a full physical and mental health assessment to determine whether the patient requires admission to a medical ward. The Digital Health Team will be responsible for coordinating direct admission to a medical bed, however if an attendance to the Emergency Department (ED) is required, Digital Health will liaise directly with the ED Team Leader and complete a 'Situation, Background, Analysis and Recommendation' (SBAR) handover. PCFT will be responsible for informing the Mental Health Liaison Team of patient transfer to TGH.

Once a patient is deemed medically fit for discharge, our Ward Team will contact PCFT MH Liaison Team to provide a full handover of nursing care and agree patient outcomes, including on-going care and treatment. Included in this handover are bloods completed within the preceding 24 hours. The appropriate PCFT Junior Doctor will then be asked to attend the medical ward as a matter of urgency to assess the patient's suitability for transfer back to PCFT and arrangements made by PCFT MH Liaison Team to transfer the patient to Summers or Hague Ward.

I am confident that the new joint SOP will support PCFT clinical teams in early identification of patients who may be experiencing an acute physical health deterioration and early intervention and prevent any unnecessary attendance for those patients at the Emergency Department (ED), or multiple moves for those older people currently an in-patient on Summers and Hague Ward. It is also anticipated that this will support signposting, including ongoing care and treatment of patients with chronic long-term conditions who require specialist services, as well as assisting with planned transfer of patients returning to PCFT following a period of care and treatment within our inpatient services.

Once the new SOP is approved by both Trusts, self-directed training will be carried out by all staff to which the SOP is relevant and this training documented in their training record. I understand that in the meantime PCFT are using our Digital Health Team for advice and guidance with regards to mental health patients requiring medical input.

It is planned that the updated process and outcome of Mr Fenton's inquest will be presented at our Divisional Governance Meetings and also reported to the Service Quality &

Operational Governance Group (SQOGG), with any subsequent actions to be closely monitored.

Both Trusts are confident that following communications and implementation of the new joint SOP will address the concerns raised and minimise the likelihood of similar occurrences taking place and to enable both Trusts to provide safe and effective care to all our patients.

I hope your concerns have been addressed, however should you have any queries arising from the content of this letter or require further information or clarification, please do not hesitate to contact me.

Yours sincerely

[redacted]
Director of Nursing and Integrated Governance
In the absence of the Chief Executive