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Date: 19 February 2021

Ms A Mutch OBE
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Re: Regulation 28 Report to Prevent Future Deaths – Anthony Slack 13.04.2020

Thank you for your Regulation 28 Report dated 1 December 2020 concerning the death of Anthony Slack on 13 April 2020. Firstly, I would like to express my deep condolences to Anthony Slack's family.

The inquest concluded that Anthony Salck's death was a result of 1a) Community acquired pneumonia; 1b) COVID 19; 2) Dementia, chronic obstructive pulmonary disease, asbestos related pulmonary fibrosis, pleural plaques, type 2 diabetes.

Following the inquest you raised concerns in your Regulation 28 Report to Greater Manchester Health and Social Care Partnership regarding the quality of observations and availability of documentation from the care home, the lack of risk assessments for new admissions to the care home, a lack of clarity around PPE guidance for care home staff at the time and the availability of ambulances in the area.

I have noted that your Regulation 28 letter has also been sent to The Vicarage Residential Care Home, Public Health England and NHS England. Whilst I may summarise some of the actions taken by these organisations, I will leave it to the named respondents to address the specific concerns relevant to them which you have expressed. My letter therefore addresses the issues that fall within the remit of GMHSCP.

Summary of actions taken or being taken by the organisation involved.

The Care Home confirmed that;

1. The Provider/Registered Manager is speaking to staff individually to reiterate the need for thorough record keeping in relation to falls but also generally. A documentation awareness training offer has been made to the Provider/Registered Manager by Tameside and Glossop CCG Quality Improvement Team. This has been accepted and sessions will take place in February via Microsoft Teams. The Local Authority require all providers to comply with good record keeping standards as required by their CQC registration.

2. There is a Digital Health service for care homes in the borough and the CCG Contacts Performance and Quality Improvement teams have spoken to the provider and re-emphasised the need to seek advice from the Digital Health team, both following a fall but also in the event that there is some visible deterioration in a resident.

3. At the time of Mr Slack's death there was no way of ascertaining how Covid-19 entered the home. Whilst the home had been 'locked down' they were still accepting patients from the acute trust who had to create beds for the increasing numbers of covid-19 in-patients they had. Furthermore at that time there was no routine testing of care home staff or residents. Staff are now PCR tested weekly and have twice weekly lateral flow tests and residents are PCR tested monthly and any symptomatic resident has access to lateral flow testing also. The majority of residents and several staff have now had the first vaccine. The Provider/Registered Manager confirmed that the visitor's policy has been updated for professionals and relatives (ensuring testing). They have also updated the admission procedure with regards to covid-19 and risk assessment (require negative test on admission)

4. Local Population Health colleagues provide written guidance on infection prevention and PPE every time there is a policy change. The CCG and ICFT now provide infection prevention webinars to support the care home sector and The Vicarage have positively engaged with these webinars, enabling several of their staff to access them. The local authority ensure no providers have been without PPE. The Provider/Registered Manager assured the CCG that there is clear guidance up in the home around PPE . Regular IPC audits are in place by IPC teams.

5. Throughout March 2020, operational teams at NWAS liaised with local Emergency Departments to establish cleaning teams to assist ambulance crews with the additional cleaning required following each handover. This partnered service meant that once a patient had left the ambulance, a cleaner would enter the saloon of the vehicle and clean the ambulance on the crews' behalf whilst they completed handover, in order to improve 'handover to clear' time. The roll-out of this initiative was initially challenging due to the differing structural setups of local Emergency Departments, however as part of an initial roll out, the first Emergency Department went live 6 April 2020 with a

two shift system operating from 06:00-14:00 and 14:00-22:00 with two person per shift. The initiative was rolled out to seven other Emergency Departments in the North West. Following the initial roll out, a feasibility review was undertaken which highlighted periods of inactivity between 06:00-08:00 and 19:00-22:00. As suce, the cleaning service has been revised and is now offered between 08:00-19:00 at each location. In response to the increasing pressure on the NWAS service, the cleaning service was extended further and NWAS crews are now supported by on-site cleaning crews at sixteen Emergency Departments across the North West. The cleaning service was not in place at Tameside Hospital at the time of Mr Slack's attendance, though it has been confirmed that such a service is now provided there. Should an NWAS crew attend an Emergency Department at a time or location where the on-site cleaning crew is not in operation, ambulance crews are advised to complete onboard cleaning themselves, in the usual way.

Actions taken or being taken to prevent reoccurrence across Greater Manchester.

1. Learning to be presented/shared with the Greater Manchester Quality Board. This meeting is attended by commissioners, including commissioners of specialist services, regulators, Healthwatch and NICE.

2. A Greater Manchester Infection Prevention and Control Care Home Cell has been established to interpret guidance and ensure a clear and consistent message to the care homes across Greater Manchester.

3. A monthly webinar has been organised, attended by over 100 care homes, to explain the science that supports the guidance, the interpretation of the guidance and to share best practice. The 5th Webinar is to be broadcast on 23rd February. This webinar and all the previous webinars are available to view on YouTube.

4. Tameside Local Authority, CCG and the care home have been invited to share the learning from this event at a quality improvement meeting on the 15th March 2021. The Quality Improvement Group meet monthly to share best practice and lessons learned. This group is attended by all 10 CCGs and LAs from across GM along with care home providers and key stakeholders

The Greater Manchester Health and Social Care Partnership (GMHSCP) is committed to improving outcomes for the population of Greater Manchester. In conclusion key learning points and recommendations will be monitored to ensure they are embedded within practice.

I hope this response provides the relevant assurances you require. Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely

[redacted]
Chair of GM Medical Executive, GMHSCP