Greater Manchester Health and Social Care Partnership
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Manchester M1 3BN

[redacted]

Date: 14th June 2021

Alison 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 – Alan Massam 24/10/2019

Thank you for your Regulation 28 Report dated 26/04/2021 concerning the sad death of Alan Massam on 24/10/2019. Firstly, I would like to express my deep condolences to Alan Massam's family.

The inquest concluded that Alan's death was a result of 1a Lower respiratory tract infection; 1b Multiple rib fractures; 1c Falls; II Acute on sub-acute subdural haematoma, advanced dementia, frailty.

Following the inquest you raised concerns in your Regulation 28 Report to Greater Manchester Health and Social Care Partnership (GMHSCP) that there is a risk future deaths will occur unless action is taken.

This letter addresses the issues that fall within the remit of GMHSCP and how we can share the learning from this case. This includes actions specific to the Stockport locality.

Point 1 – communication between organisations involved in discharge of complex and vulnerable patients.

Stockport CCG has confirmed that communication between the hospital, GP and wider Community Services has improved by the use of a common system allowing the various organisations to see each other's work. This is reliant on patient consent but works well in practice as it allows information regarding changes in a patient's circumstances to be updated and immediately accessible to other health and care colleagues. The expectation is that care needs are assessed in a timely manner and information shared to ensure that all involved are acting in the best interest of the

patient, based on the most current information and that transfers between care providers are managed effectively.

Stockport CCG works closely with Local Authority colleagues and care home staff to deliver a high standard of service. Work is undertaken on the basis of a joint approach to consistently improve the quality of care and to gain an understanding of the various roles. This includes the CCG having recruited a Care Home Matron to drive the quality agenda and to support care home colleagues.

Point 2 – protocol around safe discharge planning.

It is not the acute trust's usual policy to transfer a patient back to the care home if no contact has been made with the home. On this occasion as there had not been any response from the care home despite several attempts, the decision for Mr Massam to return to his home was made following consultation with the Consultant, the FRESH assessor and with his daughter. As the contact attempts had been unsuccessful the trust were not aware of any concerns on the part of the home prior to the patient returning to them. The trust did make every effort to engage directly with the care home team before Mr Massam left the hospital and that when multiple attempts to communicate with the home failed, there was appropriate escalation within the hospital to approve the discharge.

Stockport established the Discharge Concerns Panel in October 2020 due to several discharge concerns being raised with the Head of Discharge Services and Stockport NHS Foundation Trust Adult Safeguarding Team from external partners and providers. To compound the situation further, the number of discharge concerns increased following the implementation of the National Guidance regarding Discharge. The intention of the Panel is around finding practical solutions aimed at improving discharge outcomes for patients and reducing discharge concerns across the Trust. There was some delay in the full implementation of the panel due to the second wave of COVID-19 and the subsequent increased workload on teams to support timely discharge from hospital, despite which a number of achievements have been made. These include;

- A review of the D2A document has been undertaken with associated audit.
- A review and update of the transfer document used by ward staff when discharging patients back to an established placement, or a new placement, has been undertaken.
- Engagement with the ward staff to better understand specific themes and identify actions to improve.
- A review and update has been undertaken with regard to the Rapid Discharge checklist (End of life Discharge).
- A Task and Finish Group has been established with out of area colleagues to improve relationships, understand their discharge offers and improve the discharge journey for patients.

Future actions will include the implementation of Trusted Assessment training for all staff.

Point 3 – escalation process in care homes for patients refusing medication.

In any situation where a patient is not accepting prescribed medication and is declining fluid intake then contact should be made to the patient's GP so that a decision can be

made in relation to next steps. GP services can be accessed 24 hours day either via the patient's local GP or via Mastercall Out of Hours primary care provision.

Point 4 – suitability of placements against patient need.

Our aim is to ensure that all patients are able to access the care they need, when they need it and in the environment best able to deliver the care they need. The CCG works with colleagues in the Local Authority, Adult Social Care to ensure that care needs are appropriately assessed and met. In circumstances where care needs change there is a process of re-assessment and review and once it is identified that a patient's needs have changed families are supported in the task of identifying alternative accommodation.

For the wider Greater Manchester (GM) footprint, GMHSCP is working across the whole system to look at safe and appropriate discharges for people with complex needs. The Partnership is looking at longer term support as part of the GM Discharge Programme and the Adult Social Care Transformation Programme. There is a programme of work underway to review this in detail and we are working with the 10 GM localities on this agenda.

Additionally there is a Learning Disabilities Complex Needs programme which has been underway for 18 months and will continue for another year. As part of this programme of work, complex needs and discharge scoping is underway.

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. Learning to be shared with the Greater Manchester commissioners of services to consider the findings of the investigation within the context of the services they commission.

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

Dr [redacted]
Chair of GM Medical Executive, GMHSCP