



# Greater Manchester Mental Health NHS Foundation Trust

## PRIVATE & CONFIDENTIAL

HM Assistant Coroner Mr Christopher Murray  
Manchester South Coroner's Office  
1 Mount Tabor Street  
Stockport  
SK1 3AG

8<sup>th</sup> July 2021

Dear Mr Murray

### Trust Management Offices

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WE ARE SOCIAL



### Re: Stephen Thurm (deceased) Regulation 28 Preventing Future Deaths Response

Thank you for highlighting your concerns during Mr Thurm's Inquest. We are sorry you have had to raise these concerns with us and we have carefully considered them, reflecting on this tragic incident and how we may provide better and safer care in the future. Please see the Trust's response in relation to the concerns below.

#### **1. The inquest heard that information regarding the risk of self-harm to Stephen was passed by his family to his treating clinicians and his care coordinator but this was not taken into account as Stephen denied a recent attempt to take his own life. What steps could be taken to ensure family information is taken into account in the relevant care plan and risk assessments.**

When service users are under the care of Greater Manchester Mental Health NHS Trust (GMMH) there is an expectation that family and carers are identified and involved in assessment and care planning where possible. There are circumstances when service users do not wish for their family to be involved in their care and treatment or may change their decision regarding involving family in their care and treatment. Where service users do not consent to share information with their family about their care and treatment the Trust expects staff to maintain contact with family to ascertain any concerns, they may have in relation to the service user. The Trust would also expect a carers assessment to be carried out with carers who are providing support to service users to enable them to raise any concerns about their care providing role and the impact this may have on their own life and health.

In Stephen's case he initially consented to sharing information with his parents in relation to his care and treatment and then later withdrew this consent. Despite this the multi-disciplinary team continued to engage with Stephens parents to keep them informed about his care and treatment, both through care coordinator contact and outpatient appointments.



Any information that was shared with the staff in relation to risk was acted upon and the Trust acknowledge that the response to the information provided was not always effectively communicated back to Stephen's parents. There was a delicate balance to be maintained between acting on information received whilst keeping Stephen engaged with the service and not alienating him which may have led to further disengagement.

When these situations do arise, they are discussed within the multi-disciplinary team (MDT) to ensure clear plans are in place to support both the service user and any family or carers as well as manage any risks.

Careful consideration needs to be taken when communicating with carers and families as this is often sensitive and decisions need to be made on an individual basis. When Stephen withdrew his consent there was an MDT review of his care and a clear rationale was documented regarding how the team would respond to concerns raised by his parents. This was fed back to Stephens parents verbally and we acknowledge that this was not provided to them in writing. On reflection the Trust could not share Stephen's care plan as was not consenting to this, but a letter explaining this should have been provided to his parents.

GMMH Trust Clinical Risk Assessment Policy has been updated in March 2021 to include circumstances when staff may be required to breach someone's confidentiality in respect of risk to self or others.

*Breaching patient confidentiality is sometimes necessary to prevent suicide or serious harm, family and friends may offer insight into the Service User's state of mind and should be considered a potential source of information and support for the Service User. The staff should assess whether the Service User lacks capacity, at the time, to consent to information about their suicide risk being shared.*

*The Service User should be informed if you are disclosing information without their consent to maintain their safety if it is considered in their best interest to do so.*

The clinical risk policy also outlines to staff that the duty of confidentiality does not mean that staff should not listen to the views of family or friends.

*Even if the Service User does not consent to share information with family or friends, staff should listen, obtain their views and offer them information about what support they can access in their own right.*

Alongside the updated Clinical Risk Policy the Trust wide clinical risk training has also been reviewed and updated in March 2021 to include the need for staff to gather information from other sources and not just the service user when undertaking assessment of risk. The use of professional curiosity is raised within the training and the need not to take things at face value but to corroborate information with other professionals, friends and family. The training makes it clear to staff that you do not require consent from a service user to receive information from others.

All qualified staff across the Trust are required to undertake this mandatory Clinical Risk Assessment Training as a minimum every three years.



To strengthen this message a Trust wide learning event is being held on 16<sup>th</sup> July 2021 to focus on demystifying information governance, information sharing and confidentiality. These events are attended by more than 120 people from across the Trust and learning is shared by attendance by staff from each area of the Trust and this learning is then being taken back to their clinical areas. The learning event is then summarised in a briefing that is circulated to staff through their management structures and shared on the Trust intranet and in the patient safety newsletter.

In March 2021 a Trust wide Carer Engagement Event was held opened by Executive Directors and senior staff attendance from all our district services. This included identified themes from serious incidents and complaints, our current performance in relation to carer contact and what training and resources are available to staff. We then heard a powerful story from one of our carers about his experience of being a carer for someone under the care of GMMH services. Each division developed and submitted a divisional Carer Action Plan to improve carer engagement locally to sit alongside an overarching corporate action plan which is being monitored by the Trust Quarterly Service User and Carer Engagement Forum that feeds into the Trust Quality Improvement Committee.

## **2. The inquest heard that there is no designated gap between service user appointments to allow care coordinators to write up their detailed notes contemporaneously.**

In a Community Mental Health Team (CMHT) the staff work in an agile way. As they are often out visiting service users in their own homes it is usual for more than one visit to be carried out before staff return to the office and write their notes up on the clinical records. Whilst out on service users visits it is usual staff practice to make brief notes contemporaneously (usually in writing) which are then written out in full and input into the clinical record on return to the office. The Trust policy for managing clinical records has a standard that clinical records should be input within 48 hours of a service user contact. Good practice would be for staff to write up their contacts the same day, although on occasions this is not possible due to other priorities – any information relating to an increase in risk would be expected to be communicated the same day.

Following a pilot scheme starting in 2020 the Trust is now using Management and Supervision Tool (MaST) across all CMHT's. MaST is a software platform which analyses data from the Trust's existing clinical records system, Paris, to supplement decision making in CMHT's regarding likely resources required to provide effective mental health care. MaST is routinely used in supervision with staff and highlights activity so that service user contact and the recording of this is monitored.

To underpin this the Trust is undertaking a quality improvement project in relation to the compliance of staff supervision and the quality of supervision being undertaken across the Trust.

## **3. Mr and Mrs Thurm expressed they were both suffering with a severe effect on their mental health but their care needs as the main carers was not built into any long-term plan.**



As outlined in point 1 of this response any involved carers should receive a carers assessment where any concerns about their own health and ability to care could be identified. This should be carried out annually and if any support needs are identified during this process the carers would be signposted to the most appropriate agency.

In Trafford the Clinical Commissioning Group commission the Carers Centre in Trafford to undertake carers assessments and provide this support and signposting. The Trust provide carers with a carer pack, this is provided by the service and includes information about what services are available to support carers and how they can access a carers assessment. The Trust is monitored on this performance and it is recorded in Stephen's clinical record that his parents were provided with this information.

The Trust acknowledge that being a carer can impact on health and wellbeing and have a designated Trust Carer Lead and Local Carer Leads in each division of the Trust. The Trust also has a carer strategy that sets out the vision for engaging, involving and supporting carers the progress of which is monitored through the Quality Governance Committee that reports to the Board.

I hope this response demonstrates that GMMH have taken the concerns you have raised seriously. If you have any further questions in relation to the Trust's response, please do let me know.

Yours Sincerely,



**Medical Director**

