Walsall Healthcare NHS
NHS Trust

[redacted]

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Website: www.walsallhealthcare.nhs.uk

Date: 14 September 2021

Mr Siddique
Black Country Coroners Court
Jack Judge House
Halesowen Street
Oldbury
West Midlands
B69 3AJ

Dear Mr Siddique

Re: Mrs Tripta Bhanote (Deceased)
Date of Death: 9th May 2020
Date of Inquest: 2nd – 4th August 2021

Following the Inquest touching the death of Tripta Bhanote on 2nd to 4th August 2021 and in view of your intention to make a Regulation 28 report to Walsall Healthcare NHST Trust (the Trust), to assist you in arriving at your decision, I have undertaken an investigation into policy and guidance provided to Walsall care homes about the pathways in place to assist poorly or deteriorating residents both pre and during the first wave of the COVID 19 pandemic. As an organisation, the Trust approaches the safety of people using its services with the utmost seriousness and we are keen to take steps to ensure any concerns are addressed as soon as possible after they have been identified.

It was unfortunate that until disclosure of [redacted] formal witness statement on 28th July (para 25), I was not aware that any instructions had been given or that there may be guidance or policies in place with regard to seeking help when residents in care homes become ill. With the short timescale between this disclosure and the Inquest, I was unable to provide policy documents for the Hearing, however I am now in receipt of a range of documents and evidence which would have assisted you and which I hope both Mrs Bhanote's family and yourself will find reassuring.

As per [redacted] report, Enhanced Support, via the Care Home Case management team, has been provided to care homes in the Borough for a number of years and certainly prior to the escalating situation which emerged during the first wave last Spring.

In addition, the Trust's Rapid Response team, made up of medical and advanced practitioner colleagues has been supporting admission avoidance for vulnerable people both at home and in care facilities for several years. This is a separate team from the Care Home Case Management team and District Nursing teams as per the escalation guide provided to care homes (enc1).

We also have a Quality in Care Team (QiCT) who, during the pandemic phoned each home in the borough on a daily basis to identify any potential homes that required immediate support.

However, I have discovered that the Trust is not the lead organisation responsible for the initiatives that have been introduced to assist care homes with recognising deterioration, escalation and hospital admission avoidance in high risk people during the last few years (the Trust has a supporting function), this lies with the Clinical Commissioning Group (previously Walsall, now the merged Black Country and West Birmingham (BCWB) CCG).

I have been made aware of significant programmes of support provided to the care homes in Walsall over the last 3 years by the CCG. These include education and training packages on deterioration and

escalation (enc 2), written guidance and flowcharts around support pathways (also enc 1) and a specialist nursing resource.

At the beginning of the pandemic, the CCG, the Trust and Walsall Council stepped up the support and additional guidance was provided including the attached Department of Health policy document related to care homes (Enc 3 - Admission and Care of Residents during COVID-19 Incident in a Care Home).

On 24th March 2020, the West Midlands Integrated Urgent and Emergency Care Transformation Directorate made a 'call for action' to all CCGs across the West Midlands in relation to DNACPR and Ceiling of Care work in care homes. This call was then communicated to local services and care homes in Walsall via the CCG. The CCG had a dedicated nursing role to support the dissemination of packs and information.

Subsequently an additional resource was made available to the care homes in Walsall, this was the BCWB STP Care Homes 'App' (enc 4) which was developed to include resources and information (Stop and Watch, SBAR and escalation of deterioration).

The packs and resources were supported by the Trust's Care Home Case Management team as described in [redacted] witness statement.

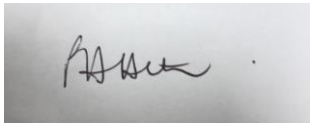
It is clear from the records that the guidelines for DNAR/ceiling of care were followed in Mrs Bhanote's case, albeit she was for full escalation and at Inquest this was found to be poorly communicated within the care home team.

It would also seem from Dr [redacted] entry in Mrs Bhanote's records on 30th April 2020 (referred to at para 49 of [redacted] statement), that he followed the correct pathway as per guidance that had previously been communicated to the home, that was to call the Rapid Response team rather than the ambulance service in relation to her blood sugar results.

Following the Inquest, we have advised the BCWB CCG that not all carers at Anson Court, despite the resource and guidance physically put into the home, were fully aware of the escalation arrangements. I have been advised that since Mrs Bhanote's death, there has been a comprehensive approach to care home education, using the FREED framework. FREED (enc 5) is a collection of tools which support staff to recognise deterioration and escalate appropriately. There has been education and training across the BCWB for the last year and half which has been led by BCWB CCG. Anson Court received this training on 20th November 2020.

On behalf of the Trust, I hope you find this information both useful and reassuring and would finally like to take the opportunity to reiterate our condolences for the loss of Mrs Bhanote to her family and also apologise for not being able to provide this evidence during the Inquest.

Yours sincerely



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Legal Services Manager