Date: 23 June 2020
Your Ref:
Our Ref:

Bolton Council

Chief Executive's Office
Town Hall
Bolton
BL1 1RU

Tel: 01204 331001
www.bolton.gov.uk

Mrs A Mutch
HM Senior Coroner Manchester South
HM Coroner's Office
1 Mount Tabor Street
Stockport. SK1 3AG

Dear Mrs Mutch

Barry Preston
Regulation 28 Report to Prevent Future Deaths

I am writing in response to your Regulation 28 Report to Prevent Future Deaths, issued following the Inquest touching the death of Barry Preston on 19 and 20 February 2020.

Following receipt of the Regulation 28 Report, I requested that that the statutory Director for Adult Services review the concerns that related to Bolton Council and I am now in a position to provide a response.

Bolton Council has liaised closely with Bolton Foundation Trust (BNFT) and Greater Manchester Mental Health Foundation Trust (GMMHFT) in order to fully ensure that a collaborative approach was taken to respond to the concerns and I am now in a position to respond to the points as outlined in Section 5.

On behalf of Bolton Council, BNFT and GMMHFT it is clear that there was lack of coordination in Mr Preston's care and for that please accept our sincere apologies.

Section 5 (3) ***The inquest heard that he had a care coordinator in the community. However, the care coordinator did not take a lead in ensuring he was being supported in the acute settings or that best interest meetings were taking place. There was a lack of understanding between agencies of role and responsibilities under the integrated care model.***

The point regarding care coordinator responsibilities is addressed in point (4) by GMMH. However, with regard to the lack of understanding of roles and responsibilities under the integrated care model, we have made some changes following the inquest which should provide assurance.

The Integrated Discharge Team (IDT) is a multidisciplinary team consisting of health and social care professionals from BNFT and Bolton Council. The team is responsible for the coordination of the discharge planning process for those inpatients with an identified health and/or social care need that

will need meeting on discharge. At the time of this incident, the IDT also had a social worker seconded into the service from GMMHFT.

It became clear throughout the inquest that the role of the mental health practitioner within the Integrated Discharge Team was fragmented, and that only certain wards within the acute trust made referrals to the IDT which resulted in a lack of communication during Mr Preston's various transitions between Royal Bolton Hospital wards, Laburnum Lodge and Trafford General Hospital.

A review of the mental health practitioner role within the IDT had commenced prior to the death of Mr Preston, however following a subsequent review with the Local Authority and BNFT, taking into consideration the concerns noted within the inquest, the decision has been taken to end the secondment of the mental health social worker and return the postholder to Greater Manchester Mental Health. There is now one point of contact, which is the care coordinator, who will in-reach into the hospital when any service user they are involved with is admitted.

Section 5 (4) ***The inquest heard that whilst he was being treated in acute settings there was no coordination or ownership of his care. It was unclear as to who was making decisions and assessing suitability of placement.***

During the period of time that Mr Preston was an inpatient he was seen by multiple teams including the Home First Team, inpatient therapy services and the IDT. Since this incident it has been recognised that there were multiple handovers between teams and these teams have now been brought together under a single management structure in order to provide improved communication between staff groups and lead to better patient experience.

At the time of this incident the IDT did not provide a comprehensive service to inpatient assessment areas such as ward D2, operating an in reach model which was reliant on other professionals identify those patients who had existing social care needs prior to admission to hospital . The team has been reconfigured to ensure that patients with complex health and social needs are identified through the same multi-disciplinary team process that has been in place on base ward areas. Since May 2020, all assessment wards as well as the Emergency Department are provided a full service and a lead care coordinator is assigned to oversee the coordination of the discharge planning process from admission to discharge.

As a combined service it has been identified that there are a number of skills and competencies which all members of the team will need to have in order to identify those patients with complex onward needs. The development is underway but has not been finalised due to the COVID-19 Response. Additional training of existing staff is being undertaken and will be completed by the end of August 2020.

The IDT has identified that the role of a seconded mental health role within the team was a key omission in the management of Mr Preston's Journey. The use of different organisation's case recording systems also resulted in the failure to identify that the patient already had a care coordinator in the community and the needs to identify an IMCA to represent the patient's best interest. Since this incident the IDT has in conjunction with GMMHFT, removed this role from the service in order to provide a single care coordinator (this will either be a social worker or discharge nurse) for each patient who is hospital based and will liaise with other organisations where needed. All input will be recorded in the patient's electronic patient record and social services case recording systems.

Section 5 (6) The inquest heard that whilst an inpatient he was served a pudding that was hot that, while eating it unsupervised, he dropped it on himself and suffered a burn. The burn did not contribute to his death but did cause significant additional discomfort.

Mr Preston sustained a first degree burn to his chest whilst in the care of Trafford General Hospital after he was served a pudding that was too hot. This incident was investigated by Manchester Foundation Trust and steps have been taken to improve safety measures in relation to the temperature of food and how this is served to patients including supervisory arrangements.

Whilst the Manchester Foundation Trust completed its own internal root cause analysis it is not clear whether they referred this incident to Trafford Council for a section 42 Safeguarding Investigation under the Care Act 2014 .As the host authority, Trafford Council would have been responsible for undertaking the investigation had it been referred to them by the hospital but they would have notified Bolton Council if this was the case as Bolton was the authority where Mr Preston was ordinarily resident.

This has been checked with Bolton Safeguarding Adults Team and there is no evidence that Trafford contacted to advise of a safeguarding investigation under the multi - agency safeguarding procedures.

Section 5 (7) ***His placement at Laburnum Lodge was made without clear understanding of his needs. He fell twice within 24 hours sustaining a further bleed to his brain and readmission to the acute hospital.***

It was clear from the evidence heard at the inquest that Mr Preston's needs were very different to those prior to admission to hospital. Mr Preston required the assistance of two carers for all transfers and needed assistance with personal care and eating and drinking. The decision to transfer Mr Preston to Laburnum Lodge was made by the occupational therapist in the Home First Team which is managed by the community division of Bolton Foundation Trust. The occupational therapist deemed Mr Preston suitable for transfer to this intermediate care facility primarily related to his mobility needs and recommended occupational therapy and physiotherapy input.

The occupational therapist sent the referral to Laburnum Lodge and the registered manager made the judgement that they could meet Mr Preston's needs in the unit, based on the documentation provided. It was highlighted that Mr Preston was at risk of falls therefore a falls assessment was completed by care staff on admission to the unit and he scored 13 which is high risk. A bed sensor was put in place and he was nursed in bed to try and mitigate the risk of further falls.

It became evident at the inquest that Mr Preston was receiving enhanced care at level 3 which is 1:1 supervision whilst on the ward but he was downgraded to level 2 by ward staff just prior to transfer.

With hindsight, he should not have been downgraded to level 2. The level of supervision required was a crucial factor in minimising the risk of further falls and Laburnum Lodge agreeing that they could meet his needs. Had he remained at level 3 enhanced care then Laburnum Lodge would not have deemed him suitable as they are not staffed or equipped to provide 1:1 supervision

Actions taken by Bolton Council and BNFT

- All wards have been advised by Bolton Foundation Trust that the decision to reduce the level of enhanced care should not be undertaken by ward staff without a full multi - disciplinary meeting
- Ward Managers have been instructed that any patient with complex needs should be escalated to the integrated discharge team by the ward for a full MDT meeting where any transfer of care is being considered.
- Development of a skills and competency framework.

I hope that the coordinated responses of Bolton NHS Foundation Trust, Bolton Council and Greater Manchester Mental Health Trust have provided you with the assurance that all organisations have taken appropriate action to mitigate the risk of future deaths.

Please do not hesitate to contact me in the event you require any further assistance.

Yours sincerely

[redacted]
Chief Executive