NHS
Greater Manchester
Integrated Care

[redacted]

Date: 31 October 2022

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

Dear Ms Mutch

Re: Regulation 28 Report to Prevent Future Deaths – James Alan Tice 09/10/21

Thank you for your Regulation 28 Report dated 06/09/22 concerning the sad death of James Alan Tice on 28/04/22. On behalf of NHS Greater Manchester Integrated Care (NHS GM), I would like to begin by offering our sincere condolences to Mr Tice family for their loss.

Thank you for highlighting your concerns during Mr Tice' Inquest which concluded on 31 August 2022. On behalf of NHS GM, I apologise that you have had to bring these matters of concern to our attention but it is also very important to ensure we make the necessary improvements to the quality and safety of future services.

The inquest concluded that Alan's death was a result of 1a) Hypovolemic Shock; 1b) bleeding from deep cuts to both wrists. Following the inquest, you raised concerns in your Regulation 28 Report to NHS GM that there is a risk future deaths will occur unless action is taken.

I hope the response below demonstrates to you and Mr Tice' family that NHS GM has taken the concerns you have raised seriously and will learn from this as a whole system.

This letter addresses the issues that fall within the remit of NHS GM and how we can share the learning from this case.

1) **Availability of beds for patients requiring an informal admission to an older adults mental health ward in the area covered by Pennine Care NHS Foundation Trust.**

Mr Tice was under the Home Intensive Treatment Services (HITS) following his discharge from Beech ward on 7 February 2022. He was referred to the HITS team for short term intensive follow up prior to be handed back to the Older Peoples Community Mental Health Team. Whilst open to the HITS team he started to relapse, therefore they remained involved for a prolonged period. On the 6 April 2022, it was agreed that he required a further planned inpatient admission to review his treatment in a safe environment and a bed request was made. The delay in sourcing a bed was escalated daily through the Bed Flow Priority Meeting and as there are no privately commissioned beds available within the North of the country for older people's psychiatry, a bed needed to be identified within Pennine Care NHS FT (PCFT). It was also recognised that both Mr Tice and his wife wanted him to be admitted back to Beech ward. A bed did not come available until three weeks later, the 28 April 2022.

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On the 28 April 2022 a bed was identified in Stockport. This was on the day of Mr Tice's death. It is not clear if Mr Tice would have accepted admission to Stockport as this is an out of area bed.

2) **Availability of psychotherapy services for older adults in the community whose needs exceed the services available through Thinking Ahead.**

It was recognised by services that Mr Tice benefitted from a psychological approach to his care. Whilst one staff member was able to offer this approach and was allocated to see Mr Tice regularly when on duty, there was no formal psychologist support. It was recognised by the Organisation intervention from a psychologist would have been of benefit. There is no psychologist support in older people's services in Heywood, Middleton and Rochdale. It is also recognised that there is an issue in the recruitment of psychologists nationally.

Actions taken or being taken to share learning across Greater Manchester.

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

2. Shared learning from this and similar cases at Greater Manchester and borough level will be cascaded to professionals through relevant governance and learning forums.

3. Regulation 28 Report and response to be shared with mental health commissioners in Greater Manchester to ensure that a review of older adult inpatient provision is undertaken.

In conclusion, key learning points and recommendations will be monitored to ensure they are embedded within practice. NHS GM is committed to improving outcomes for the population of Greater Manchester.

I hope this response demonstrates to you and Mr Tice family that NHS GM has taken the concerns you have raised seriously and is committed to work together as a system including our service users, carers and families to improve the care provided.

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

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NHS Greater Manchester Integrated Care

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