Pennine Care
NHS Foundation Trust

Corporate Services
Trust Headquarters
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Ashton Under Lyne
Lancashire
OL6 7SF

[redacted]

11th July 2023

Private & Confidential
Anna Morris
HM Assistant Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Morris

I write in response to your Regulation 28 report dated 16th May 2023, and in respect of the concerns you have highlighted after hearing evidence at the Inquest of Carl Thompson on the 17th February 2023.

Your Matters of Concern below have been reviewed and Pennine Care's response is outlined below.

Point 1
I am concerned that the jury have found that the risk assessments and risk planning for Carl's s.17 leave in March 2022 was inadequate. This issue was not addressed in the Trusts' internal investigation conducted by Sophie Marshall, and I have not received any evidence that there have been reflections or changes following Carl's death on this issue to reassure me that there is not a continuing risk of future deaths.

The Trust policy CL019 Clinical Risk Assessment and Management V9 identified that a risk assessment should be reviewed for inpatients at the point of:

- Admission.
- When granting leave or discharging from a Section.
- Following an incident.
- When information changes that significantly impacts on the risk status.

It is recognised that clinical risk assessment and management of the assessed risk is a dynamic and continual process and risk formulation is pivotal to understanding a person's risk form a professional, service user and carer perspective.

Decisions involving clinical risk always involve balancing the health and safety of service users and others with service users' quality of life, their personal growth, and their right to exercise choice and autonomy in the care they receive. It is

acknowledged that achieving this balance is often complex and absolute safety can never be guaranteed.

Pennine Care supports the clinical position of positive risk taking or therapeutic risk taking by clinicians with service users and a shared accountability with service users where clinically appropriate.

Pennine Care has an approved Trust Risk Assessment Tool within the PARIS electronic patient records (EPR). The risk assessment format for adult acute inpatient services is more formulaic in approach and provides opportunity to give greater narrative to sharing information about risk, the identification of the presenting risk which drives a clearer formulation of the risk factors for the service user.

Regular multidisciplinary discussions with the patient and their loved ones in relation to risk assessment and management are frequently held in weekly ward rounds, this includes future planning and possible leave planning and safety panning.

To address this point, the steps the service has taken so far are:

- Shared learning for the staff team, this has been shared via supervision and the Care Hub Quality Learning forum.
[redacted]consultant team, this has been shared via the lead [redacted]tant meeting to support the importance of well-[redacted]cumented risk assessments.
[redacted]trust, this has been shared as trust wide learning for [redacted]in the footprint to be aware of and learn from.
- Continued commitment to booking staff on the Clinical Risk Formulation [redacted] STORM (suicide prevention skills) training; ward manager and service manager will monitor uptake and compliance with essential to role training.

Further action:

- Inpatient Learning forums have been agreed to be held in addition to training [redacted]meetings to reflect on shared learning points. The learning from this case is going to be shared in a learning forum on 30/06/2023.

[redacted]

<u>Point 2</u>
I am concerned that the Trust's own internal review found that whilst Carl was on leave from the 7th March, the clinical team were made aware of an increase in Carl's risk factors when contacted by his mother who outlined her concerns.

This point is being addressed in conjunction with point 1 (risk assessment) and point 5 (escalation process). Clinical risk training supports practitioners to understand and act on concerns raised by families for patients on leave.

Point 3
The review concluded that this represented a missed opportunity for the clinical team to understand how several factors may be combining to increase the risk for Carl, including his use of non-prescription medication and illicit substance misuse.

This point and action links to point 1 in relation to good assessment and management of risk.

Further to this and in relation to point 6, consideration has been given to raising awareness of substance use within the inpatient service user group.

There is a growing body of literature and focus on mental health and drug use, and a shift in strategy nationally around more collaborative approaches to empower people to lead lives they want to lead and keep themselves and their families healthy 'and how practitioners on the front line can best be supported to deliver what matters to servicer users within an ethos that maintains dignity and respect' (HM Government – No Health without Mental health).

The Department of Health's Refocusing the Care Programme Approach identifies [redacted]key users of secondary mental health services. The [redacted] whole systems approach to their care, involving a [redacted]ations working together.

[redacted]st Drug and Alcohol service is supporting their Intervention and Development worker to commence providing General Drug [redacted]cohol brief intervention training for inpatient ward staff.

Point 4
The Trust's own review concluded that the clinical team could have sought to understand these risk factors through direct contact with Carl.

[redacted]dent Investigation commissioned by Pennine Care Foundation Trust recognised that the inpatient staff could have sought to contact Carl directly following discussion with the family. [redacted]

This was identified as an action within the Investigation detailed 'Where there are concerns expressed whilst a patient is on leave – consider making attempts to contact the patient to assess the situation.

The action identified included:

- Share learning around this case including raising awareness of making attempts to contact patients on leave where concerns are raised.

Update:

- This has been discussed within individual supervision sessions.
- Group reflective discussion in relation this point to be facilitated in Inpatient Learning Forum on 30/06/23.

Point 5

The Trusts own review concluded that following such direct contact, consultation could have been sought with others within a legal framework to ask Carl to return to the ward with support from services or family. The review concluded that the nursing team could have escalated this information via the on-call system for further medical support.

This point was identified as a recommendation for learning within the Serious Incident Investigation commissioned by Pennine Care Foundation Trust.

The recommendation detailed: Inpatient services to escalate concerns out of hours through appropriate out of hours support – e.g., night manager, consultant on call.

Action:

- Raise awareness with inpatient staff regarding escalation processes out of hours for support. Appendix 1.

Update:

- This has been completed, this point has been raised in individual supervision with inpatient staff.
- This issue has been shared as a trust wide piece of learning and the trust [redacted] and Clinical Effectiveness has developed a 'When [redacted] rns' poster, this has been shared across all inpatient [redacted] e team involved and is displayed in clinical offices to [redacted] g.

Point 6 [redacted]

The review concluded that a risk to Carl's physical health was present especially in view of research and evidence for substance misusers starting to use again after periods of abstaining.

Linked with point 1 (risk assessment) and point 3 – raising awareness around [redacted] – General Drug Awareness session.

- Shared learning with p[redacted]ssionals involved.
- Shared learning with wider teams
- Raising awareness in supervision with ward staff
- Inpatient Learning Forum for reflective discussion in relation to this point.
- Drug and Alcohol team to provide some awareness sessions for inpatient staff

Point 7

I am concerned that on the 9th March, Carl should have been seen face to face by the CMHT, in line with Trust Policy. Instead, he only received a telephone call from a duty worker who had never met him.

For a patient on Section 17 leave for whom a referral has been made to the CMHT, and for whom an allocated worker has been identified it would be good practice for that allocated worker to support a person on leave through home visits and to complete an up-to-date risk assessment. In Carl's case he had been referred to

CMHT but not yet allocated a care coordinator. A phone call from the duty officer was part of their practice for unallocated CMHT patients.

It is recognised that it may not always possible for a patient to be seen by a care coordinator that they are known to. They may be new to the service, there may have been staff changes since they were last care coordinated. However, where this is felt to be essential to a person's care, there is now a regular process in place to ensure weekly communication between the inpatient wards and CMHT where this can be raised and reviewed.

Point 8
I am concerned that prior to his commencing leave on the 7th March, Carl had not been allocated a CMHT Care Coordinator, despite being an inpatient for over 3 months, since 31st December 2021.

The investigation recognised that during the time period of CT's death, CMHT was on the Trust Risk Register in relation to staffing vacancies and patients awaiting allocation. The current position is more positive with an improved staffing establishment, a reduced waiting list and CMHT is no longer on risk register.

[redacted]re now attending ward meetings on both acute [redacted]Stockport at least weekly to promote discussion and [redacted]he discharge pathway. This allows clinical decision [redacted] of patients who may benefit from allocation of a care [redacted] discharge, for example to allow the therapeutic relationship to commence prior to discharge.

[redacted]
Even if a patient is not allocated before discharge, the CMHT duty worker will attend the ward rounds if the person is approaching discharge, to support from a community perspective, this need is also able to be identified through the ward meetings.

Point 9
[redacted] *gave evidence that although the Trust Review had identified a number of missed opportunities, the Trust Action plan, which contained 6 Action points was still "In progress".* [redacted] *was not able to identify a single action point that had been completed to date.*

IR authors required to give evidence will be supported and be prepared to give evidence against the action plan demonstrating improvements in service. To this end, local support has been revisited for Investigation authors, to support active review of action plans with the Investigation author and the services involved.

Support for Investigation authors has been raised as an area for further development within the Trust.

- The Trust has re-established the Just Culture trust wide meeting in June 2023, this is chaired by the Executive Director of Nursing, Professional Leadership and & Quality Governance.

- The trust is considering an updated training offer for authors of investigations with a compassionate, just culture approach.
- The Trust has a new PSIRF (Patient Safety Incident Response Framework) implementation group, this was established in February 2023 following a PSIRF trust wide Implementation planning away day. This is looking at the new framework, planning for implementation including updated Investigation templates and support for staff completing these.
- Patients Safety training is now available online for all staff to complete. As part of the new PSIRF framework additional training on supporting authors approaching investigations has been offered to staff virtually through 2023.
- The Quality team have also planned to share learning slides around preparation for Coroner's Inquests with staff identified as Investigation authors.

I trust this response assures you that the Trust has taken your concerns seriously and has thoroughly reviewed the issues raised.

Yours sincerely

[redacted]

[redacted]
Acting Executive Director of Quality, Nursing & Allied Healthcare Professionals
Director of Infection Prevention and Control

Enc. Appendix 1 (When should I escalate concerns)

[redacted]