NHS
Greater Manchester

4th Floor
3 Piccadilly Place
London Road
Manchester
M1 3BN

Date: 08 December 2023

Ms A Mutch
HM Senior Coroner
South Manchester

Dear Ms Mutch,

Re: Regulation 28 Report to Prevent Future Deaths

Thank you for your Regulation 28 Report dated 17th October 2023 concerning the sad death of Terrence Davenport on 24th September 2023. On behalf of NHS Greater Manchester Integrated Care (NHS GM), We would like to begin by offering our sincere condolences to Mr Davenport's family for their loss.

Thank you for highlighting your concerns during Mr Davenport's Inquest which concluded on 23rd August 2023. On behalf of NHS GM, we apologise that you have had to bring these matters of concern to our attention. We recognise it is very important to ensure we make the necessary improvements to the quality and safety of future services.

Following the inquest, you raised concerns in your Regulation 28 Report to NHS GM that there is a risk a future death will occur unless action is taken. The medical cause of death was 1a) Pneumonia on the background of the fractured left neck of femur (operated); II) Dementia (mixed type), ischaemic heart disease.

I hope the response below demonstrates to you and Mr Davenport's 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.

The inquest heard evidence that the acute hospital setting was difficult for Mr Davenport due to his dementia and created risks to his health once he was medically optimised. He had to remain there due to a lack of suitable care/nursing beds. This meant that he was in an unsuitable care setting and that a bed that could have been utilised for an acute patient was not available.

Ensuring acute capacity is available in our hospitals is an ongoing and significant challenge across Greater Manchester. In Tameside, there is a Home Finder Team based in the Integrated Urgent Care Team (IUCT) at Tameside Integrated Care Foundation Trust who work with patients and families to facilitate a timely and appropriate discharge for medically optimised patients so acute beds can be made available.

We know that Mr Davenport was assessed by the Multi-Disciplinary Team (MDT) as requiring a general nursing bed and the Home Finders Team contacted several community providers of general nursing care in both Tameside and in the Greater Manchester footprint to identify an appropriate discharge.

Unfortunately in Mr Davenport's case, additional issues including dependency levels of existing residents and workforce issues meant that none of the providers identified to provide the support were able to safely accept Mr Davenport into their care. The situation was also impacted as Mr Davenport's assessments fluctuated between him being medically fit for discharge and requiring ongoing treatment. We acknowledge that these factors unfortunately impacted the ability to discharge Mr Davenport in a timely manner to an appropriate community placement.

In respect of Mr Davenport's support whilst he was in hospital I understand a number of different mechanisms were put in place to support Mr Davenport whilst he was awaiting appropriate placement. In addition to the Ward supporting with his care and support needs he received additional input from dietetics, the complex discharge team, and the physiotherapist. He was also reviewed by the specialist dementia team and Admiral nurses and I understand that Mr Davenport was moved to a bed nearer to a window and specialised equipment (RITA) enabled Mr Davenport to watch Western Movies which he enjoyed.

The need for timely discharge whilst ensuring appropriate placements is recognised as an ongoing challenge in Tameside (and more widely). In order to support acute bed capacity the following processes have been put in to place:

1. Home Finders Team (as described above) that are focussed specifically on supporting timely and appropriate placements for patients ready for discharge. This Team work closely with patients, families and providers to facilitate a supportive discharge.
2. Tameside locality partners meet weekly in an Executive Length Of Stay meeting to consider any barriers to discharging patients with "No Criteria to Reside"[1] (NCTR) and work together to identify and remove any barriers to appropriate discharge. The number of patients with NCTR are monitored continuously both locally and at GM level to inform understanding of the capacity of the system to meet ongoing needs of the population.
3. Tameside Digital Health Team (based at Tameside ICFT) provide a face to face digital service directly with Residential and Nursing Homes to support residents to remain in the Care Sector with support wherever possible. They will also support in working with Residential and Nursing Homes to support residents in the Home once they have been discharged.
4. The Integrated Urgent Care Team is Tameside's urgent response team; they provide rapid assessments for people in the community, with an aim to keeping people in their own homes and preventing hospital admission. They have a combination of health and social care staff to provide a holistic assessment. They also provide physio support for people in 24-hour care to help improve mobility following an acute health issue or fall.

In addition to the above there is a significant focus in Tameside on the quality of care provided across the locality. Tameside have a specialist Quality Improvement Team in place who work with providers to improve the quality of care they provide to residents. This includes a specialist Quality Improvement Nurse whose work is focussed on Nursing Home provision in the borough. Additionally, our contractual performance documentation is heavily focussed on ensuring personalised good quality care.

[1] The phrase "No Criteria to Reside" is used in the context of discharging patients from a hospital. According to national guidelines, patients are discharged when they no longer meet the 'Criteria to Reside'. This means that patients who are 'medically optimised' but require ongoing health and/or social care input should be transferred to a non-acute setting

System-wide market risks across GM have been escalating over the past 9-12 months, with the highest in the nursing care market. Impact on residents and the workforce continues to be minimised by system leaders and providers when nursing homes exit the market either by de-registering/ownership or closure. We anticipate that there will be more closures over the coming months, and that these will continue to be managed locally with as least impact as possible. A system-wide mitigation plan focussing on workforce and market development has been developed to support providers to remain resilient over Winter and into the medium-term.

The inquest was told that resident who pushed Mr Davenport was not suitable for placement at the care home where the incident happened. The care home where previous incidents had occurred was out of area. The inquest was told that lack of information sharing between two GM local authorities, the care homes involved and GMP meant that the safeguarding issue was not recognised. It was unclear if this was due to an effective information sharing protocol not existing between local authorities/care homes/GMP in Greater Manchester or it not being adhered to. However, the impact was that the risk of harm was not understood, and staff and residents were put at risk.

As part of movement across settings robust information sharing particularly around any risk elements is vital for patient safety. With regards to processes in place for new residents (and specifically in regard to people moving between care homes), there should be three sources of information that support identification of risks and appropriate placement and subsequent care planning.

1. The assessment from the original care home – this should include robust information about the person, including risk assessments, behaviours, etc. Where the patient has been the subject of a safeguarding, the care plan should have been updated to reflect potential risks.
2. The support plan from the placing authority – which should clearly identify the assessed needs, risks, etc. Similarly, where the patient has been the subject of a safeguarding, the support plan should have been updated to reflect this.
3. The pre-admission form used by care homes to gather information to assess suitability – this should identify basic need information as well as gathering additional information on behaviours to help inform risk assessments, which will help determine if the care home can meet the patient's needs alongside the existing residents' needs.

Whilst processes are in place for information sharing both within and between localities, we recognise that information sharing between partners (as described above) is not always as robust as it should be. Additionally, it is recognised that current system pressures requiring patients to be moved to a community setting quickly may impact the quality of information being provided.

We acknowledge that although there are processes in place there is a need for services to use these processes robustly to support future safety of residents and support appropriate placements of residents.

With a focus on learning from this Prevention of Future Deaths Report the following actions are being taken locally via Tameside locality to work to support this:

1) In Tameside part of our contractual and quality management oversight is around ensuring that there are robust pre-admission assessments undertaken and subsequent care planning is undertaken in line with assessment or risk. A separate communication will be sent to providers to include learning from Mr Davenport's case, highlighting to Homes the importance of robust pre-admission risk assessments and subsequent personalised care planning around a resident's needs whilst factoring wider impact i.e., environmental and impact on other residents, families, and staff.

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Additionally learning from this report will be presented to Tameside Care Home Managers in December 2023; the learning will focus on sharing risk information across settings as well as completing robust pre-admission risk assessments. An additional face to face session will take place in February; this will be attended by ICFT Trust Colleagues with a focus on issues around discharge and transfer between community and acute settings.

2) Learning from this case will also be taken via Tameside System Quality Group which is attended by Senior colleagues from both TMBC and Tameside Integrated Care Foundation Trust. The focus will be on partnership working and managing risk across settings, and there will be a decision taken around the need for any additional work required to support safe discharges and facilitate partnership working to mitigate risks particularly within the current pressured position.

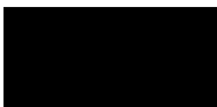
3) Wider Learning via NHS Greater Manchester – learning will be shared via the GM System Quality around ensuring robust information being shared when patients are moving across settings and localities, this is particularly important currently due to current pressures on discharge.

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.

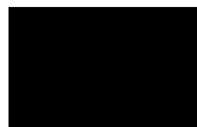
We hope this response demonstrates to you and Mr. Davenport's family that NHS GM has taken the concerns you have raised seriously and is committed to working together as a system including our service users, carers and families to improve the care provided.

Thank you for bringing these important patient safety issues to our attention and please do not hesitate to contact me should you need any further information.

Yours sincerely



Chief Nursing Officer
NHS Greater Manchester



Place Base Lead
NHS Greater Manchester - Tameside