Pennine Care
NHS Foundation Trust

15 January 2024

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[redacted]

Private & Confidential
MS Joanne Kearsley
HM Senior Coroner
HM Coroner's Court
Floors 2 & 3, Newgate House,
Newgate
Rochdale
OL16 1AT

Dear Ms Kearsley

Ref: Inquest touching on the death of Ms Teresa Chmielek

I write in response to your Regulation 28 report dated 24 November 2023, and in respect of the concerns you have highlighted after hearing evidence at the Inquest of Ms Teresa Chmielek on 23 November 2023.

I was sorry to learn that following witness evidence, you had concerns which had not been addressed. Your concerns have been reviewed and I understand that this prompted a deep dive into the service and processes used, facilitated by our Network Director of Quality for the North. This process has informed our response and I have summarised the main points of this here for assurance.

The Deep Dive used a process mapping approach and as a result, a number of changes to the Single Point of Entry (SPoE) function in Oldham. I am advised that to provide some objectivity to the process, an external lens was applied by a subject matter expert in relation to the SPoE function in Old Age care, with representatives from the team, members of the leadership team, medical staff and quality representation.

We have recognised that the SPoE function needs greater integration into the wider Old Age provision, rather than as a separate function. This is now in place. The SPoE function is an integral part of the Home Intensive Treatment Team (HITTS) to ensure that this is activity undertaken by the team and not an individual function. Alongside this, the Multidisciplinary Team (MDT) meeting has been reviewed and processes have been introduced to administer this meeting, with all decisions recorded on our electronic patient record, with an audit function to support. This should ensure that the process is more robust.

A standard operating procedure (SOP) has also been introduced, which is now at the stage of final draft, and this covers all processes required, including the administration of a referral, gaining additional information, speaking to the patient / family (when this needs to be face to face), the role of the meeting and outcome letters to GPs and families.

Finally, as a result of your concerns and the findings from the deep dive, the Trust have commissioned a fact-finding investigation under the Trusts Disciplinary Policy in relation to actions taken or not taken by the SPoE Nurse. This process is currently ongoing. While this continues, steps have also been taken to ensure the correct support is in place for all team members and the supervision of staff has been reviewed. To reflect the integration of this function, there is capacity for regular review of individual cases within the supervision sessions. We hope that this should also further strengthen our internal system of controls and assurances, but also minimise the possibility of other patients experiencing the concerns that you have shared with us.

[redacted]**cern:**

1) **The notes made by the SPoE Nurse for use during discussion at the [redacted]ning MDT meeting did not include any reference to the report of a recent suicide attempt and the Court was not satisfied that the risk of suicide had been identified or recognised by the SPoE Nurse.**

As mentioned earlier in this response, we have developed a SOP which outlines processes to be followed in Oldham to ensure the administration of the referral, assessment of the patient and engagement with families is all presented at the MDT Meeting. Decisions and outcomes are recorded on the electronic patient record. The SPoE function in Oldham is now integrated into the wider HITTs team and the MDT meeting has been reviewed, to ensure wider representation with clarity of roles participating and format of the meeting. Full referral details and outcomes of assessments/ discussion with families are shared in the MDT Meeting.

It is anticipated that these changes should minimise the opportunity for important information or risk factors, such as those outlined, to be omitted. This learning will be shared with other teams within the Network and across the Trust to ensure that any transferable learning from these events and changes are understood.

2) **The Court heard that the practice at the screening MDT meeting was for the SPoE Nurse to read out the contents of the referral to the Psychiatrist who would then advise on next steps. There was no evidence to show that any form of meaningful multi-team discussion took place at the screening MDT meeting.**

Our review of the MDT meeting has changed the format of the joint meeting. The SPoE function is integrated into the wider HITTs team and the representation at the MDT has been extended. The Trust SOP now articulates expectations at the MDT meeting, and all decisions will be documented on the electronic patient record, along with a record of the discussion. It is regrettable that this was not in place at

the time of the inquest, but it is considered that this should provide an auditable means of demonstrating the quality of our care.

3) **There was no direct contact between the mental health team and the Deceased (either by telephone or in person) before the decision to reject the referral was made.**

As reflected in the introduction to our response, the deep dive review conducted identified a number of recommendations for change and the SOP reflects those improvements. The administration of the referral is covered in the SOP with clear guidance on how to obtain further information on the patient's presenting condition. This includes a discussion with the patient and their families where appropriate, prior to the MDT discussion. All discussions, decisions and assessments will be on the electronic patient record. These changes will be shared with the team by the service manager.

4) **The Consultant Psychiatrist present at the MDT meeting has no recollection of discussing the referral and whilst the evidence was that a letter to the GP practice explaining the reason for rejecting the referral was generated, there is no record of this letter on the Trust's electronic systems or having been received by the GP practice.**

As part of our review process, a number of changes have been made to the MDT meeting, including wider representation. A process to support the meeting has been reviewed and all discussion and decisions are recorded on the electronic patient record. The SOP includes instructions relating to outcome letters to GP, patients and families. The electronic patient record can be audited to understand and monitor compliance with this requirement, allowing for action to be taken by the leadership and quality teams where good or poor practice is identified. Now the function is integrated into the wider team, supervision arrangements are in place which allow space and time for discussion of specific cases.

5) **The evidence was that there is no member of staff allocated to deal with referrals when the SPoE Nurse is absent from work which means that during their absence, urgent referrals are not being reviewed.**

Further to the evidence heard at inquest, the deep dive highlighted that any arrangements in place to cover absence or leave were not robust. As you are now aware from our response, the function is no longer a stand-alone role and therefore as part of a wider team, cover for absences can be planned, increasing resilience.

6) **There is currently no Standard Operating Procedure on how referrals into the SPoE Older Adults should be managed.**

While not in place at the time of the inquest, a Standard Operating Procedure has been drafted, with input from operational staff and is currently under final review. Once this has been ratified, this will be shared with teams by the service manager with communication of our expectations for use.

7) **There is currently no system by which the management of referrals into the SPoE and related decision-making are audited. As such there is a risk that poor quality decision-making is going unchecked.**

As outlined in response to the earlier points, all decisions and discussion can be entered onto the electronic system, which can be audited. The decision to integrate the function into the team allows for case-by-case supervision for practitioners which should add additional support for staff and oversight.

I am sorry that you had cause to raise concerns with us directly at the conclusion of Ms Chmielek's inquest and I trust this response assures you that we have taken your concerns seriously and have thoroughly reviewed the issues raised.

Yours sincerely

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Executive Director of Quality, Nursing & Healthcare Professionals/Deputy CEO