PRIORY
Part of MEDIAN

7 October 2024

Ms Joanne Kearsley
Senior Coroner
Manchester North Coroners

Via email: [redacted]

Private and Confidential

Dear Ms Kearsley

Mr David Thompson - Response to Regulation 28 report

I write to you in response to the Regulation 28 report Priory received dated 12 August 2024. The report was issued following the Inquest touching the death of Mr David Thompson, which was heard on 31 July 2024.

You raised three areas of concern. The first was regarding Priory Hospital Dorking:

1. *The incident review of his admission to the Priory Dorking indicated that there was no My Safety Plan commenced on admission or complete prior to his discharge.*
2. *There was no engagement prior to discharge with the local Home Based Treatment Team.*
3. *There was no consultation with the Consultants who had treated Mr Thompson at the Priory in Altrincham only a few weeks earlier.*
4. *There was no 48-hour follow up call to Mr Thompson following his discharge.*
5. *A discharge clinical entry and discharge risk assessment was not completed and there was no evidence of crisis information having been provided.*
6. *There was no evidence that the four standard care plans had been opened during Mr Thompson's inpatient stay.*
7. *When conducting the internal review no members of the nursing staff were spoken to, to consider why the matters highlighted above had not been carried out. There was therefore a lack of understanding as to whether this was an individual failing or error or a cultural / system failure. Nor was consideration given to whether any individuals should be reported to their regulatory body.*

The second area of concern you raised was regarding Priory Hospital Altrincham:

1. *On the outpatient appointment in January 2024, the fact that Mr Thompson had been an inpatient in the Priory in Dorking following his discharge from the Priory Altrincham was not known. There was a lack of awareness as to how to access certain parts of the medical records, which would have shown this information. Mr Thompson did not volunteer this information so there was no discussion with him as to why he had relapsed so quickly.*
2. *At the time of his appointment in January 2024, Mr Thompson was not under the care of any NHS community services such as the home based treatment team. This was not recognised or known when formulating his ongoing plan.*
3. *No internal review was undertaken of Mr Thompson's admission within the Priory Altrincham to consider whether there was any learning.*

The third area of concern you raised was addressed to Priory, Greater Manchester Integrated Care Board and Pennine Care NHS Foundation Trust:

1. *There was a complete absence of any Consultant to Consultant discussion or communication, given this patient was receiving care from both the NHS and privately.*

Response to your concerns regarding Priory Hospital Dorking

Matters of concern 1, 2, 3, 5 and 6

These were all identified by Priory as part of the internal Team Incident Review (TIR) that was undertaken in the days following Mr Thompson's death. The TIR report was shared with the court ahead of the inquest. It is the purpose of such a review to understand what happened and identify any areas of learning. Action was already being taken to address the learning points identified in accordance with our usual processes. As these were all learnings Priory had already highlighted and were addressing, we were surprised and disappointed that these were listed as matters of concern in the Regulation 28 report, particularly as "It is acknowledged that in the case of Mr Thompson there was no evidence any of these concerns caused or contributed to his death". A detailed action plan (**see appendix 1**) offers assurance that these learning points have been taken forward and recent audits have evidenced improvements at Priory Hospital Dorking.

Matter of concern 4 - 48 hour follow up call

In accordance with Priory policy H02 Admission, Transfer and Discharge, a follow up call within 48 hours of discharge is not required if a patient has a confirmed appointment with an NHS community service within 72 hours of their discharge, as was the case for Mr Thompson. This is made clear in the TIR report and therefore this is not a matter that requires further attention.

Matter of concern 7 - limitations of internal review

It was recognised that Mr Thompson had been a recent patient at both Priory Hospital Altrincham and Priory Hospital Dorking and hence why it was considered at the time that inviting representatives from both services to attend a joint TIR was good practice. On reflection, we conclude that we should have hosted a separate TIR at each service, inviting those involved in the care and treatment of the patient (to include nursing colleagues), and thereafter brought together the key findings at a joint meeting attended by the senior managers, to identify any areas for cross service learning. This learning point has since been reiterated to Priory's Director of Quality and our regional Associate Directors of Nursing and Quality who are responsible for the commissioning and quality review of TIR's.

Consideration was given at the time (and subsequently as the investigation progressed) as to whether any individuals involved in the care of Mr Thompson should be reported to their regulatory body. Reference was made to The Just Culture Guide, as promoted by NHS England in the Patient Safety Incident Response Framework. This states that it is rarely appropriate to blame or single out individuals (save for instances of wilful harm or neglect), but instead consider how learning can be implemented on a wider platform. The fair treatment of staff supports a culture of fairness, openness and learning by ensuring staff feel confident to speak up when things go wrong, rather than fearing blame. With that in mind and in light of the facts, Priory considers there is no requirement to refer any individual to their regulatory body in this instance.

Response to your concerns regarding Priory Hospital Altrincham

Matter of concern 1 - accessing Dorking and Altrincham records

This concern was addressed in the action plan that was embedded within the TIR report and this was shared with the court ahead of the inquest. For this reason, we did not expect this to be a matter of concern listed in the Regulation 28 report. To summarise, when any user opens a patient's record on CareNotes (Priory's electronic patient records platform), the system defaults to show only active documents. This is intended to ensure only records relevant to the current episode of care are present. To view records relating to any previous episodes of care, an 'Entire Record' tab is to be selected. A reminder of the presence of this function has since been circulated to all Priory colleagues and a prompt to select 'entire record' will be added to the admission checklist.

Matter of concern 2 - no reference to NHS community home treatment services

This also relates to the third matter of concern you raised regarding communications between private and NHS services: please see further below for Priory's response to that concern.

Matter of concern 3 - internal review following incident

A review was undertaken of Mr Thompson's inpatient admission to Priory Hospital Altrincham and this is recorded within the TIR report that was shared with the court ahead of the inquest, with a detailed timeline embedded and a summary of this period of care. The conclusion of this review was that Mr Thompson received adequate inpatient care and treatment during his inpatient admission to Priory Hospital Altrincham, and he was discharged appropriately into the care of the Home Treatment Team.

Response to your concerns regarding communication between Private and NHS services

Matter of concern 1 - communications between NHS and private services

Priory expect that when a consultant psychiatrist or doctor is gathering background psychiatric information from a patient at the point of their first assessment, professional curiosity should guide the conversation to ascertain whether the patient is currently receiving care or treatment from any other care provider (NHS or private services). Despite recognising this, patients may not wish to disclose the facts of previous or current episodes of treatment for a number of reasons. This is their right.

However, in order to aid consideration and exploration of this by those undertaking the initial admission assessment, the inpatient admission template on CareNotes has recently been amended, and now includes a field specific to 'Any current NHS or private service involvement in care'. Inclusion of this field will act as a prompt to encourage discussion with the patient to establish the arrangements and details of any other current care providers involved in the patient's care.

To ensure a similar question is asked at the first point of contact for Priory outpatients, a question has now been added to the referral form in use by Priory's central customer service contact centre, 'Are you under the care of any other service?'. This information gathered at first contact is shared with the allocated consultant for their review and to aid discussion during the first outpatient assessment.

Upon receipt of details about any external services involved in a patient's care, it may be appropriate to make contact with these organisations but this will be dependent on the detail of the information made available and whether the patient consents to such contact being made.

To ensure this learning point is reiterated to all consultants across Priory, the importance of identification and liaison (where appropriate) with external organisations involved in the care and treatment of a patient was raised at:

- Priory's Acute service network meeting on 25 September 2024; and
- The Private and Wellbeing service network meeting on 1 October 2024

These meetings are chaired by the Network Clinical Directors (senior doctors within the organisation) for discussion and noting by all in attendance (including Hospital Directors, Consultant Psychiatrists, Directors of Clinical Services, Ward Managers, Senior Nurses and other healthcare professionals). Minutes of the meeting are thereafter circulated to all relevant colleagues for onward sharing as required.

This learning point has also been included in a learning cascade that was issued to all site leaders and thereafter disseminated to all hospital colleagues on 12 September 2024.

It is important to mention that whilst Priory have made advances to the systems and process in place to gather these details and encourage our multi-disciplinary teams to facilitate such contact (with patient consent), all correspondence relating to a patient's admission, discharge and outpatient care is shared with a patient's GP (with patient consent). The patient's GP remains the central coordinator of a patient's care. Other care services involved in a patient's care and treatment can request access to this information via the GP. Should an external service (whether private or NHS) seek additional detail to the information held by the GP, Priory clinicians will make themselves available, at short notice if required, to engage in discussions about a patient's care and treatment.

We will carefully review the responses submitted by Greater Manchester Integrated Care Board and Pennine Care NHS Foundation Trust to this Regulation 28 report to ensure our approaches align.

I trust that the actions outlined above will provide the assurances you seek in respect of this matter.

Yours sincerely,

[redacted]

[redacted]
Chief Executive Officer
Priory

PRIORY

Patient Safety Incident - Action Plan

Reference: 499948	**Date of patient safety incident:** 18.03.2024	**Division and Site:** Healthcare, Priory Hospital Dorking

Summary of the patient safety incident	**Manager(s) responsible for implementation**
DT had an NHS funded inpatient admission to Priory Hospital Dorking between 27.10.2023 and 08.11.2023. He was diagnosed with Bipolar Affective Disorder. DT was discharged into the care of the Home Treatment Team and resumed outpatient care at Priory Hospital Altrincham. DT later came by his death on 03.03.2024.	[redacted], Hospital Director [redacted], Director of Clinical Services (DoCS) [redacted], Medical Director
	Manager signing off final action plan
	[redacted], Hospital Director

Implementation categories:

Score	Implementation category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action complete, tested and embedded

Area for improvement 1: Ensure a My Safety Plan is completed for all patients requiring one					
Implementation actions	Person responsible	Evidence of actions taken	Details of how implementation will be/has been tested	Implementation category and target date for completion	Completion
Issue a reminder to all staff of the requirement to complete a My Safety Plan, and to outline the circumstances when a My Safety Plan is required.	[redacted]	An email was sent by the DoCS on 11.09.2024 reminding all staff to complete a My Safety Plan for all patients with a current or historic risk of suicide and self-harm. Guidance including a video about how to complete a My Safety Plan was also shared:  Area of Improvement 7 - My This email has been followed up with staff during safety huddles and discussion during the daily flash meetings to ensure it reaches and is understood by all relevant staff.	Patient's requiring completion of a My Safety Plan are highlighted on the CareNotes clinical dashboard which is reviewed daily during the morning flash meeting. Where review does not evidence 100% compliance, this is allocated to a specific member of staff for immediate action, and reviewed again the following day to ensure completion. Flash Meeting minutes for 13.09.2024 reflect that all patients requiring a My Safety Plan had one in place (*meeting minutes available if required*).	4 - Complete	01/10/2024 (audit will continue)

Area for improvement 2: Ensure engagement with a patient's Community Mental Health Team (CMHT) (where involved) prior to inpatient discharge					
Implementation actions	Person responsible	Evidence of actions taken	Details of how implementation will be/has been tested	Implementation category and target date for completion	Completion
Issue a reminder to all staff regarding the expectation that referrals to a patient's community team are to be clearly confirmed and documented on CareNotes prior to a patient's discharge.	[redacted]	An email was sent by the DoCS on 29.08.2024 reminding all staff to ensure that once a discharge date has been confirmed and there is a need for a community team's involvement, a referral is to be made by the nurse in charge to the relevant community mental health team. The time and date of the confirmed follow up appointment and contact details for the CMHT are to be recorded on CareNotes:  Area of Improvement 5 -Doc A follow up email was sent by the DoCS on 12.09.2024, re-sharing Priory's Admission, Transfer and Discharge policy, which makes clear the expected discharge processes and the requirement to engage with a patient's community team prior to their discharge:  Area of Improvement 5 - Adı These emails have been followed up with staff during safety huddles and discussion during the daily flash	A sample of five patient records were audited by the DoCS on 10.09.2024, and evidenced 100% compliance of engagement with a patient's CMHT and documentation of the time and date of follow up:  Area of Improvement 3, 5 & Monthly audits will continue for a minimum of three months, until assurance is gained that this practice is embedded. The outcomes of the monthly audits will be shared with the MDT as part of the monthly Clinical Governance report from October 2024.	4 - Complete	01/10/2024 (audit will continue)

		meetings to ensure it reaches and is understood by all relevant staff. The DoCS completed a monthly clinical governance report on 17.09.2024, which was further discussed in the clinical governance meeting on 20.09.2024 focusing on the areas of improvement identified following review of this patient's care:  Director of Clinical Services CG Report S			
Area for improvement 3: Ensure staff gain an understanding of a patient's background history at the point of admission					
Implementation actions	Person responsible	Evidence of actions taken	Details of how implementation will be/has been tested	Implementation category and target date for completion	Completion
Issue a reminder to all staff regarding the expectation that a patient's background history is gained and understood at the point of admission.	[redacted] Medical Director	An email was sent to all responsible clinicians by the Medical Director on 17.09.2024 reminding colleagues to ensure a patient's background information is gained and understood on a patients admission, and where other services are or have previously been involved, consider whether contact with them is required (with patient consent):  Area of Improvement 9 - Col This email has been followed up with staff during safety huddles and	A sample of five patient records were audited by the DoCS on 27.09.2024 and reflected that where required, background clinical information, current and previous treatment community team involvement and GP details were obtained at the point of admission. One patient had a previous admission at another Priory service	4 - Complete	01/10/2024 (audit will continue)

		discussion during the daily flash meetings to ensure it reaches and is understood by all relevant staff.	in 2022. The consultant had access to all details on CareNotes and thus no direct contact was required.  Area Of Improvement - Audit Tool Evidencin Monthly audits will continue for a minimum of three months, until assurance is gained that this practice is embedded. The outcomes of the monthly audits will be shared with the MDT as part of the monthly Clinical Governance report from October 2024.		
Area for improvement 4: Discharge documentation is to be completed in accordance with Priory policy					
Implementation actions	Person responsible	Evidence of actions taken	Details of how implementation will be/has been tested	Implementation category and target date for completion	Completion
Priory Hospital Dorking are to evidence safe discharge planning in accordance with Priory policy H02 Admission, Transfer and Discharge - to include completion of a clinical entry, updated risk assessment on discharge and issue all patients with a crisis card with	[redacted] DoCS	An email was sent by the DoCS on 11.09.2024, reminding all staff to complete a discharge checklist, a discharge risk assessment, a discharge clinical entry and provide the patient with a crisis card with contact details of services they can contact in a crisis at the point of a patient's discharge. Guidance was also provided on how to	An audit of five recently discharged patient records was conducted by the DoCS on 10.09.2024. All expected areas of discharge were completed, save for the issuing of crisis cards	4 - Complete	01/10/2024 (audit will continue)

contact details of services they can contact in a crisis.		complete a detailed discharge entry on CareNotes:  Area of Improvement 3 -Dis This email has been followed up with staff during safety huddles and discussion during the daily flash meetings to ensure it reaches and is understood by all relevant staff.	(crisis cards have since been ordered as none were in stock). Whilst awaiting delivery, this is mitigated by the patients being provided with crisis numbers either written on paper or storing them in their phones prior to discharge:  Area of Improvement 3, 5 & Monthly audits will continue for a minimum of three months, until assurance is gained that this practice is embedded. The outcomes of the monthly audits will be shared with the MDT as part of the monthly Clinical Governance report from October 2024.		

Area for improvement 5: Ensure all patients have four core care plans in place during their admission					
Implementation actions	Person responsible	Evidence of actions taken	Details of how implementation will be/has been tested	Implementation category and target date for completion	Completion
Issue a reminder to all staff regarding the expectation that all patients have the four core care plans in place throughout the hospital admission.	[redacted] DoCS	An email sent by the DoCS on 11.09.2024 shares with all staff guidance on creating the four standard care plans as well reminding staff of the expectation for weekly care plan reviews:  Area of Improvement 8 - The This email has been followed up with staff during safety huddles and discussion during the daily flash meetings to ensure it reaches and is understood by all relevant staff.	A sample of five patient records were audited by the DoCS on 30.09.2024, and evidenced 100% compliance, with all having the four core care plans in place:  Area Of Improvement 8 - Mo Completion of the four core care plans is now also reviewed daily during the morning flash meeting (via review of the CareNotes dashboard). Where reporting does not evidence 100% compliance, this is allocated to a specific member of staff for immediate action, and reviewed the following day to ensure completion. Monthly audits will continue for a minimum	4 - Complete	01/10/2024 (audit will continue)

			of three months, until assurance is gained that this practice is embedded. The outcomes of the monthly audits will be shared with the MDT as part of the monthly Clinical Governance report from October 2024.		
Area for improvement 6: MDT documentation is to be completed in full and with adequate detail					
Implementation actions	Person responsible	Evidence of actions taken	Details of how implementation will be/has been tested	Implementation category and target date for completion	Completion
Issue a reminder to all staff regarding the expectations about the quality and completeness of Multi-Disciplinary Team (MDT) documentation, to include the requirement to complete: • The MDT feedback • A clear and accurate record of the discussion had • Evidence of mental state examination • Patients views • Family/career/external professional feedback • A clear plan following the MDT Discharge planning is to be documented	[redacted] DoCS	An email was sent to the MDT by the DoCS on 29.08.2024 outlining expected standards and quality of completing MDT forms during the ward round, covering all aspects reflected in the implementation actions column:  Area of Improvement 2 - Qu This email has been followed up with staff during safety huddles and discussion during the daily flash meetings to ensure it reaches and is understood by all relevant staff.	An audit of five patient records was conducted by the DoCS on 05.09.2024, which evidenced 100% compliance in respect of complete and good quality MDT documentation:  Area Of Improvement 2, 3 8 Monthly audits will continue for a minimum of three months, until assurance is gained that this practice is embedded. The	4 - Complete	01/10/2024 (audit will continue)

			outcomes of the monthly audits will be shared with the MDT as part of the monthly Clinical Governance report from October 2024.		
Area for improvement 7: Ensure that a patient's family and carers are involved in discharge planning					
Implementation actions	Person responsible	Evidence of actions taken	Details of how implementation will be/has been tested	Implementation category and target date for completion	Completion
Issue a reminder to all staff regarding the expectations about involving a patient's family/carer in discharge planning (with patient consent).	[redacted], DoCS	An email was sent by the DoCS on 11.09.2024 reminding all staff to ensure that a patient's family and carers are involved in a patient's care, by routinely inviting them to the patient's MDT meeting (with patient consent) where discussions regarding discharge planning are had:  Areas of Improvement 4- The This email has been followed up with staff during safety huddles and discussion during the daily flash meetings to ensure it reaches and is understood by all relevant staff.	A sample of five patient records were audited by the DoCS on 10.09.2024. In all cases, the patient's family/carer had been invited to participate in the MDT meeting:  Area of Improvement 3, 5 & Monthly audits will continue for a minimum of three months, until assurance is gained that this practice is embedded. The outcomes of the monthly audits will be shared with the MDT as part of the monthly	4 - Complete	01/10/2024 (audit will continue)

			Clinical Governance report from October 2024.		
Area for improvement 8: All patient referral information is to be uploaded to CareNotes					
Implementation actions	Implementation actions	Implementation actions	Implementation actions	Implementation actions	Implementation actions
Issue a reminder to all administration staff of the Priory requirement to ensure all referral information is uploaded to CareNotes.	[redacted] Ward Clerk	An email was sent to all administration staff by the DoCS on 11.09.2024 to remind the team that all referral information is to be uploaded onto CareNotes within 72 hours of admission:  Area of Improvement 1- R This email has been followed up with staff during safety huddles and discussion during the daily flash meetings to ensure it reaches and is understood by all relevant staff.	A sample of three patient records were audited by the DoCS in September 2024. In all cases, the referral notes had been uploaded to CareNotes:  Area of Improvement 1 - Pric Monthly audits will continue for a minimum of three months, until assurance is gained that this practice is embedded. The outcomes of the monthly audits will be shared with the MDT as part of the monthly Clinical Governance report from October 2024.	4 - Complete	01/10/2024 (audit will continue)