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Date 12 December 2024

Ms Alison Much
Senior Coroner for Greater Manchester South
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

By email only: [redacted]

Dear Ms Mutch

Re: Regulation 28: Report to Prevent Future Deaths
Inquest into the death of Leslie Andrew Swindells

I am writing in response to the Regulation 28 (Coroners and Justice Act 2009) Report to Prevent Future Deaths, issued on 17 October 2024, following the inquest into the death of Leslie Andrew Swindells. In advance of responding to the specific concerns raised in the Report, on behalf of everyone at *gtd Healthcare*, I would like to extend my sincere condolences to Mr Swindells' family and loved ones. We were all deeply saddened by his tragic death.

I take the matters of concern identified in Section Five of your Report in turn and respond to these as follows:

1. **The Inquest heard evidence that the practitioner who saw Mr Swindells had very limited training in mental health and was employed in a role described as a mental health assistant practitioner. The evidence was that there was limited understanding of the scope of their role by GPs and what was covered by the term routine mental health appointments.**

The Practitioner who carried out Mr Swindells' telephone consultation on 23 May 2024 was an Assistant Practitioner in Mental Health, who had been employed by gtd Healthcare ("gtd") in this role at Hattersley Group Practice for two years.

In 2020, as part of the NHS Five Year Forward View for Mental Health, Health Education England (now known as NHS England) developed a two-year higher apprenticeship programme for Assistant Practitioners in Mental Health, with specialist and core modules tailored to mental health training. The Practitioner who carried out Mr Swindells' consultation participated in this apprenticeship programme and graduated from the University of Bolton in 2022, with a distinction in his Foundation Degree in Health and Social Care.

The Royal College of Nursing indicates that Assistant Practitioners should work as part of the wider health and social care team, having direct contact with patients, service users and clients. It is expected that they will operate at a level above that of Health Care Support Workers and have a more in-depth understanding of the factors that influence a patient's health. Following completion of the foundation degree, Assistant Practitioners are able to work as Band 4 non-registered healthcare staff, working within a locally and defined protocols, and escalating to senior clinicians for guidance where necessary.

In accordance with their job description, the roles and responsibilities of Assistant Practitioners in Mental Health include: completion of annual severe mental illness ("SMI") physical health checks, the regular depression reviews arranged following an initial mental health consultation with a registered practitioner and also providing support for completion of ADHD and Autism assessments. When conducting the SMI health checks and depression reviews, Assistant Practitioners are required to complete a gtd template, and escalate any patients who are identified as vulnerable and at high-risk of self-harm or harm to others, to a registered practitioner for further assessment. The scope of the Assistant Practitioner in Mental Health role is limited to non-urgent, low-level mental health reviews. They would not be expected to be responsible for completing assessments for patients presenting with new or deteriorating mental health concerns or symptoms.

We understand the concerns that you have raised about the level of training of gtd's Assistant Practitioners in Mental Health and the understanding of their role within the wider GP practice. In response to your concerns, as an organisation gtd has taken the following steps:

- Following consultation, on 6th November 2024 the Director of Nursing and Allied Health Professionals made the decision that going forward, Assistant Practitioners in Mental Health would not be employed within *gtd*. At present, there are no Assistant Practitioners in Mental Health employed by *gtd*.
- As *gtd* has other Assistant Practitioner roles, we commissioned a review of all non-registered practitioner roles, including their remit and responsibilities, to ensure that that all roles have the required competency and management systems in place for safe practice. This review was completed on the 27 November 2024. The policy and subsequent recommendations will be ratified at the Clinical Quality Improvement Group scheduled for 8th January 2025. The outcome and recommendations from the review will be launched on the week commencing the 12th January 2025.
- As part of the launch of the review and its outcomes, details on the scope and responsibilities of all roles will be shared with all relevant clinical and non-clinical staff (including GPs).

- *gtd's* mental health lead plans to conduct a wholescale review into the organisation's mental health processes and practices. This review will then inform the development of the organisation's mental health processes moving forwards.

2. **In Mr Swindells case the evidence was that he should never have had a review undertaken by someone with such a limited understanding of mental health and that lack of understanding of mental health meant that the practitioner did not recognise the level of risk Mr Swindells posed.**

Please see our response concerning the Assistant Practitioner's level of training and understanding of mental health above. It is agreed that Mr Swindells should not have had an appointment with an Assistant Practitioner in Mental Health after presenting with new symptoms of paranoia, and that unfortunately the level of risk of self-harm posed by Mr Swindells was not identified by the Assistant Practitioner.

At the time of Mr Swindells' death, Assistant Practitioners in Mental Health completed their reviews on electronic templates developed by *gtd* staff. In this instance, the Assistant Practitioner completed the review on the depression review template, which was designed to be used for depression reviews only, and therefore did not include any prompts for the user to check whether the patient was suitable to proceed with a consultation with an Assistant Practitioner, based on their presenting complaint. Unfortunately, the Assistant Practitioner's level of training hindered him from understanding the complexity of Mr Swindells' presenting complaint, and therefore the need to escalate to a more senior clinician or make an urgent referral to mental health services was not recognised. He instead agreed a plan with Mr Swindells to refer him back to mental health services on a non-urgent basis. Following Mr Swindells' death, *gtd* added an additional question to the Assistant Practitioner's mental health template to ask whether the patient is presenting with any new or acute symptoms. If the answer is "**yes**", the Assistant Practitioner was then prompted to escalate the patient to a senior clinician. This escalation was mandatory. The change to the template was successfully implemented on 26th September 2024 and was utilised in SMI health checks and depression reviews until 3rd November 2024, when the role of Assistant Practitioner in Mental Health ceased to exist in *gtd*.

In addition to this, we have emphasised via education sessions and our Clinical hot topics bulletin the need for the question, 'Do you feel like harming yourself or others?' to become a routine question to be asked in all mental health consultations. This will ensure that all our clinicians directly consider the patient's risk of self-harm and/or suicide in each and every appointment, and then escalate to senior clinicians or mental health services, as necessary.

3. **The appointment had been booked via the reception team with no triage by a doctor following a telephone call to the practice. The evidence was that a shortage of trained reception/admin staff meant that an agency worker was screening calls that day and had a limited understanding of how patients need to be allocated.**

Mr Swindells' daughter first contacted Hattersley GP Practice on Tuesday 21 May 2024 and spoke to an agency receptionist about her concerns regarding her father's mental health, in particular his increasing paranoia and concerns about his current medication. The receptionist confirmed their understanding that the requested appointment concerned Mr Swindells' mental health and booked a telephone appointment with the Assistant Practitioner in Mental Health for Thursday 23 May 2024. During this call, appropriate safety netting advice was provided and the receptionist sign-posted Mr Swindells' daughter to Accident and Emergency if his mental health deteriorated further prior to the planned appointment.

It is not unusual for a GP Practice to experience staffing shortages and unfortunately, whilst the regular reception staff are aware of the need to escalate any urgent mental health concerns to the on-call GP, the agency receptionist was not aware of this process. It is accepted that at the time of this incident, the induction process for agency staff did not provide sufficient guidance to ensure that they understood the correct triage and booking in process for patients with acute mental health conditions.

We recognise the importance of the concerns which you have raised regarding the reception triage system and in response to this we have taken the following actions:

- We have reviewed the induction process for agency staff to ensure that they are aware of all key processes within the practice for directing patients to the appropriate clinicians.

- We introduced an interim reception triage template to assist reception staff with their initial data gathering and to ensure that the right type of appointment was booked with an appropriate clinician. This template prompts the receptionist to ask key questions and then guides them to an appropriate outcome, for example, urgent same-day appointments with a registered clinician are recommended in cases where the patient is demonstrating severe mental health problems (including suicidal ideation, new hallucinations, delusions or paranoia). In any cases where they are uncertain about the appropriate outcome or concerned about the patient's symptoms, receptionists are required to discuss the patient with the on-call GP.

- To further ensure that all patients were seen by an appropriate clinician, access was restricted to Assistant Practitioners' appointment books, so that only patients who have been triaged by a registered clinician could be added. As the Assistant Practitioner in Mental Health Role has been dissolved, this action is no longer required.

- We introduced a 'digital front door' at Hattersley Group Practice on the 18th November 2024. This online tool, which has already been successfully launched in other *gtd* practices, requires the patient or a family member to complete an online triage form. This is then reviewed by a doctor or an advanced clinical practitioner to determine the appropriate pathway for the patient to manage their request. Where a patient is unable to access the online forms, they can contact the practice directly and the staff will go through the questions and complete the form on their behalf so that the form can then be processed in the same way as had the patient completed it themselves. Forms are reviewed daily and the system is integrated with the Electronic Patient Record, EMIS, so that requests are saved directly to the patient's record with one click. The reviewing clinician triages patients following the Primary Care Streaming Protocol and the patient will then be booked for an appointment with an appropriate clinician, within the required timeframe.

  Standard Operative Procedures are in place for the management of the digital front door and all requests are reviewed by a clinician prior to any further action such as booking an appointment is taken. In practice, this means that receptionists will not be involved in the process for allocating appointments, thus removing the need for training of locum receptionists to identify the correct pathway for patients. By implementing this tool, *gtd* will ensure that the patient is seen by the right person, at the right time, in the right place.

4. The evidence was that where GP practices chose to deploy staff with such limited qualifications to see those who needed treatment for their mental health it was essential that all those in the practice understood the limitations of the role and that there was close supervision of the practitioner.

As discussed above in our response to Section One, the Assistant Practitioners in Mental Health operating with *gtd,* who worked as Band D (Band 4 equivalent) practitioners are no longer employed in the organisation.

These Assistant Practitioners were able to work independently of direct supervision for routine mental health reviews, however they were unable to see any new presentations or make any clinical decisions or plans without the agreement of a senior clinician. Therefore, a supervisor had to be readily available and within close proximity to the Assistant Practitioner to provide support. In each practice, *gtd* ensures that there is always access to a GP or Advanced Clinical Practitioner, should an Assistant Practitioner need to escalate any concerns about a patient.

The regular salaried GP, who worked on the same day as the Assistant Practitioner, spoke with him at the end of his clinics to ensure that he had no issues or concerns with regards to the patients he had reviewed. Whilst the Assistant Practitioner in Mental Health felt that he was able to escalate concerns to the GP, in this instance his limited knowledge of the management of paranoia meant he did not appreciate that this consultation should have been discussed with the GP.

5. **Further information is needed about how the supervision worked at the time of the incident/how it works now.**

To support staff with limited qualifications, as well as GPs and Advanced Clinical Practitioners who supervise the Assistant Practitioners, *gtd* is strengthening its programme of clinical audits. We are currently in the process of developing a web-based audit tool ("Clinical Guardian") currently used in our urgent care services to be used in primary care and will support with the audit of clinical and non-clinical staff. The contract has been signed with the audit software supplier, and training will take place during December, with the intention of starting a 3-month pilot of the new process from the 2nd January 2025.

4. **The Inquest heard that it was envisaged by the practice that the GP on duty would have a supervisory role. However, it was unclear how this operated other than by the mental health assistant escalating a concern to the duty GP.**

Please see our response concerning GP supervision of the Assistant Practitioners at Section Four above.

5. **The assessment was carried out by telephone. The inquest was told that approximately 80% of the practitioner's mental health reviews took place in this way although it was accepted in evidence that it was far more challenging to assess an individual's mental health via telephone than face to face. During the conversation the practitioner did not identify their role or their qualifications to Mr Swindells.**

In agreement with Mr Swindells' daughter, a telephone appointment was booked for him to discuss his mental health on 23 May 2024. You heard in evidence at the Inquest from a GP at Hattersley Practice, who was well known to Mr Swindells, that he was not keen on attending mental health appointments and tended to miss these pre-booked appointments. It is acknowledged that it can be more challenging to assess an individual's mental health via telephone rather than face-to-face. In circumstances such as Mr Swindells' however, where the patient has been reluctant to attend appointments in person, and has a history of missing appointments, a telephone consultation enables clinicians to ensure that they are at least able to speak to the patient. Unfortunately, on this occasion, it appears that although the type of appointment was suitable given Mr Swindells' history of non-attendance, the level

of clinician was inappropriate, and therefore the telephone consultation was not as effective as it would have been with a more senior clinician.

Telephone reviews are an accepted practice for routine two-week mental health reviews as the purpose is to ensure that the patient has collected, is compliant with taking their medication, and that there are no side effects. A face-to-face consultation is not deemed necessary for this type of review, but a referral to GP/ACP would be initiated if any concerns were identified and face to face appointment booked in.

As part of the learning to be shared following this case, we will emphasise the need for clinical staff to ensure they have explored all opportunities to see new presentations of mental health conditions as a face-to-face consultation rather than via telephone.

During the appointment, the Assistant Practitioner introduced himself by name, however it is accepted that he did not identify his specific role, qualifications or clarify that he was not a GP. Following this incident, we have produced guidance for staff on *gtd's* expectations of how they introduce themselves to patients to ensure that patients understand who is providing their care. We have also developed posters to put up in our practices that will also be available on the practices' web pages to ensure that patients are able to recognise the different clinicians involved in their care.

6. **The documentation of the practitioner was poor and did not reflect the content of the conversation which had been recorded and was available to the inquest.**

It is accepted that there were shortcomings in the documentation completed by the Assistant Practitioner in Mental Health and that the documentation was not reflective of the conversation between him and Mr Swindells.

You heard in evidence from the Assistant Practitioner that at the time of Mr Swindells' appointment, the usual template utilised by Assistant Practitioners in Mental Health to record their appointments and referrals, was experiencing technical issues. The Assistant Practitioner then attempted to use a different template; however, this was impacted by the same technical problems. To test the template before further inputting details about Mr Swindells' appointment, the Assistant Practitioner selected random boxes and this information then saved. Unfortunately, once he was able to complete the template, the Assistant Practitioner did not remember to remove the inaccurate information and proceeded to enter the appointment details. It was the Assistant Practitioner's evidence that although inaccurate information remained on the template, the critical information reflecting Mr Swindells' perceived condition at the time of the appointment was all accurately recorded on this document. On the evening of 23 May 2024, the Assistant Practitioner realised his error and remembered that the inaccuracies remained on the template and attempted to log

into the patient's record from home to rectify the records. Two attempts were made to log into the record; however, the Assistant Practitioner was unable to amend the records.

We recognise the concerns that you have raised into the documentation concerning Mr Swindells' appointment with the Assistant Practitioner. We have outlined at Section Two above the changes which were introduced to the standard templates utilised by Assistant Practitioners in their mental health and depression reviews. In addition to this, to ensure that accurate contemporaneous records are kept of all appointments with patients, clinicians have also been provided with hard copies of the templates to be used if they are unable to access the clinical system templates due to IT issues.

7. Practitioners such as the one who saw Mr Swindells are not part of a professional/supervisory body.

We agree that Assistant Practitioners are not regulated by any professional or supervisory body. As discussed above, given that Assistant Practitioners are not accountable to any regulatory body, they are unable to see any new presentations or make any clinical decisions or plans without the agreement of a registered clinician. All patients who attend appointments with Assistant Practitioners must first have been seen or triaged by a regulated clinician, such as a GP or an Advanced Clinical Practitioner. We have outlined at Section Three above the safeguards which we have implemented to ensure that appointments can no longer be booked without the patient first being triaged by a registered clinician.

Finally, I would like to take the opportunity to assure you that *gtd* seeks to learn from all untoward incidents and absolutely recognises that Mr Swindells' death was the most serious type of such incidents. As outlined above and in the evidence of the Head of Nursing and Allied Health Professionals during the inquest, *gtd* has already taken learning from Mr Swindells' sad death and will continue to do so. We are committed to sharing our learning from this case through our training academy and with our staff to prevent any potential reoccurrence of the tragic circumstances in which Mr Swindells died.

Yours sincerely

[redacted]

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Director of Governance