NHS
Greater Manchester
Integrated Care

[redacted]

Date: 5 September 2025

Private & Confidential
Ms. Alison Mutch
Senior Coroner for the area of Manchester South
Manchester City Coroner's Office & Court
Exchange Floor
The Royal Exchange Building
Cross Street
Manchester M2 7EF

[redacted]

Dear Ms. Mutch

Re: Regulation 28 Report to Prevent Future Deaths – Janet Alison Anderson

Thank you for your Regulation 28 Report dated 9 May 2025 regarding the sad death of Janet Alison Anderson. On behalf of NHS Greater Manchester Integrated Care (NHS GM), We would like to begin by offering our sincere condolences to Janet's family for their loss.

Thank you for highlighting your concerns during the inquest which concluded on the 14 April 2025. 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.

During the inquest you identified the following cause for concern: -

1. **The inquest heard evidence that the prolonged hospital stay and lack of progress in finding a suitable place in the community significantly contributed to her decline. She had been suitable for discharge from 20th May and there was no clear strategy to progress her discharge or for the two different trusts to work together to ensure a speedy and safe discharge.**
   The evidence before the inquest indicated a lack of joined up working between the two trusts that meant that despite the clinical concerns about the impact of her prolonged hospital stay she remained in an acute setting.
2. **The GMMH documentation was of a poor quality and did not capture key discussions/decisions including in relation to medication. As a consequence, trust staff were not fully sighted on earlier decisions and her needs.**
3. **The lack of progress in discharge meant that an acute hospital bed was not available to other patients who needed care in an acute setting.**

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I note that your report has been shared with Manchester University Hospitals NHS Foundation Trust (MFT) and Greater Manchester Mental Health NHS Foundation Trust (GMMH) and trust they will respond to the issues specially relating to Ms. Anderson's care. I have responded to the issues you raise in light of the work undertaken by NHS GM as commissioner responsible for health and social care..

As a Greater Manchester (GM) system. we have committed to reducing the number of Clinically Ready for Discharge (CRFD) bed days by 25% and reducing the Length of Stay (LoS) for Mental Health Adult acute, older adults and Psychiatric Intensive Care Unit (PICU) inpatients wards by end March 2026. A trajectory has been set and is monitored through a single source data set to ensure alignment and a comprehensive dashboard for monitoring is available system wide.

To support the reduction, NHS GM localities have committed to and submitted Improvement Plans. These show that barriers to discharge remain, particularly in relation to accommodation pathways and individuals with complex needs. Localities are addressing these barriers through focused actions around step-up/step-down provision, targeted escalation approaches for complex patients, urgent and emergency care integration schemes, and coordinated planning for cross-border discharges. Manchester locality remains the locality with the highest number of Out of Area Placements (OAPs), Long Stay Patients (LSP's), and CRFD cases. However, significant work has been undertaken and, as an example of progress to date, we have seen a 38% reduction in the Manchester locality, giving us confidence that our plans and actions are having an impact.

GMMH have worked closely with NHS GM and Manchester commissioners to understand internal causes of delay, identify resource priorities, and explore immediate opportunities within existing services to reduce flow pressures. This work includes:

- A comprehensive review of Multi Agency Discharge Event processes (MADE) (governance, attendance, decision-making, data capture)
- Improved CRFD escalation through a newly implemented senior system MADE forum
- Realignment of community support resources with a focus on housing and forensic step-down
- Active matching of patients to the new local provider framework schemes
- Weekly review of Manchester trajectories through Locality Assurance and Provider Collaborative governance

In addition, a series of extraordinary MADE events have taken place, reviewing every CRFD case and identifying both individual and system-level blockers. One of the key actions agreed is the development of a consistent, end-to-end brokerage and funding pathway. This will define clear responsibilities, time standards at each stage, and introduce a formal protocol for cases that depend on external provider responses. In these cases, delays will be logged and monitored but not attributed to statutory agencies.

As part of this transformation work to address OAPs, CRFD, LoS and LSP's there are several system wide actions to support the localities achieving their CRFD reduction targets:

- Additional patient flow capacity and gatekeeping roles have been funded and recruited to ensure robust admissions and additional focus on weekends and out of hours.
- Additional Voluntary Community and Social Enterprise (VCSE) capacity in Manchester locality to support prevention of avoidable admissions and ensure timely discharge following inpatient admissions
- Bespoke work in Bury to review support accommodation barriers – learning to shared system wide
- Review across GM of community-based alternatives to admission
- Implementation risk / gain share with MH trusts

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- Home First model to be embedded in localities

As well as the actions and improvements listed above, an escalation policy for Mental Health patients who are CRFD is due to be rolled out system wide by quarter 3. This escalation process could be applied to the case of a patient who is CRFD in a medical bed but waiting for a package of care through a MH provider. The process, which is currently being piloted, provides a system aligned to 4 levels of escalation, levels 1-4. Any case where a mental health patient is CRFD with an identified barrier to discharge can be escalated. The process prescribes actions and maximum timescales to be followed at each level to ensure that all options have been considered to provide the patient with the safest and most appropriate option, if multi-agency leads meetings between providers and place colleagues cannot resolve the barriers then a level 3 escalation safety huddle will be convened by the clinical director for mental health at the ICB, followed by robust monitoring of actions set to resolve the barriers. Level 4 escalation can be made to region if required. The pilot has received positive feedback from across the system.

I hope that this response addresses your concerns. Please contact me if I can be of further help.

Best wishes

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Interim Deputy Chief Executive Officer and Chief Nursing Officer
NHS Greater Manchester

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