Greater Manchester Mental Health
NHS Foundation Trust

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PRIVATE AND CONFIDENTIAL

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

1st July 2025

Dear Ms Mutch

Re: Janet Anderson (deceased) Regulation 28 Preventing Future Deaths Response

Thank you for highlighting your concerns following Ms Anderson's inquest which concluded on 14th April 2025. On behalf of Greater Manchester Mental Health NHS Trust (GMMH), I would like to offer Ms Anderson's family our sincere condolences for their loss.

The Inquest evidence heard that both GMMH and Manchester Foundation Trusts (MFT) had treated Ms Anderson's death as expected, therefore neither Trust had carried out an internal investigation, which would have reviewed the systems in place for patient flow and the working relationship between the Trusts. Following Ms Anderson's inquest, staff from GMMH and MFT have met to discuss areas of improvement, better communication and collaboration.

MFT hold a daily Patient Transfer List meeting (PTL), attended by GMMH and the local authority. The purpose of the meeting is to discuss the patients that are medically fit for discharge that remain in MFT due to housing and onward placement difficulties. This forum allows for interagency communication and joint understanding of the issues delaying discharge for each patient. It is accepted that the PTL did not work for Ms Anderson, therefore both Trusts have discussed what additional changes can be made to strengthen the process.

Both Trusts have agreed to the opportunity to internally review Ms Anderson's patient journey, GMMH will hold a Learning Multi-Disciplinary Team Meeting, with the following invitees:

- GMMH Mental Health Liaison Team (MHLT)
- GMMH Community Mental Health Team (CMHT)

- MFT
- Northwest Bed Bureau
- Manchester City Council

The purpose of this event is to work further with agencies to identify the key pathway issues in improving the patient flow journey. MFT have confirmed their attendance. The LMDT will also allow for the teams to reflect on when a Best Interest decision should be considered when there are limited options available which align with the wishes of patients/carers and there are risks of harm that may be caused by a prolonged hospital stay.

Since April 2025 GMMH have established a weekly Executive led Mortality Review Huddle where all patients who have died whilst under the care of GMMH the previous week are reviewed under the Learning from Deaths Framework. As the Medical Director I lead this huddle which includes clinical staff and the Patient Safety Team. Each patient death is reviewed to identify any learning for the Trust and requirement for any further investigation.

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 trusts that meant that despite the clinical concerns about the impact of her prolonged hospital stayed, she remained in an acute setting.**

   The lack of progress in discharge meant that an acute hospital bed was not available for other patients who needed care in an acute setting.

There are internal processes within GMMH which bring all patients who are identified as being 'clinically ready for discharge' (CRFD) into daily meetings to track progress in discharge planning and drive plans forward. From May 2024 Ms Anderson's case and attempts to assess and identify a placement picked up in pace and focus as a result, but this should have been commenced earlier. There should be a focus on identifying barriers to discharge and making discharge planning the focus from the first day of admission; in many instances this is the case but clearly not in the instance of Ms Anderson where this only occurred once hitting CRFD. To rectify this, GMMH has developed a new post in the CMHT's of a full time Operational Manager for Community Flow who will commence in post on 23 June 2025. This new role is being undertaken by a senior social worker who has experience working in older adults' mental health provision and is familiar with the intricacies of patient flow and working with the local authority, funding panels and families. They will have responsibilities for reviewing all new admissions to both mental health and acute beds each week and ensuring the purpose for the admission is clear and shared, any potential barriers to discharge are identified with clear corresponding plans and timescales which will then be tracked. This is additional investment and senior capacity.

Under the CMHT Standard Operating Procedure (SOP), a patient who is on the Care Programme Approach (CPA) pathway, should had contact with their care co-ordinator/a member of the CMHT every 28 days as a minimum when in an acute hospital. It is expected that the care co-ordinator will attend the ward and introduce themselves to the treating acute team, so they have a named contact.

It is accepted by GMMH that the lines of communication between MFT and GMMH were not clear or robust. To support this the newly created Operational Manager for Community Flow role will also coordinate and be the link between GMMH and MFT at a senior level, offering a named contact and improving the visibility of GMMH within MFT. It is expected that this individual will attend the weekly PTL meeting to represent GMMH and feedback to the CMHT.

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 decision and her needs.**

Any discussions or inquiries undertaken between the acute trust staff relating to an inpatient and the MHLT will be documented in GMMH electronic patient record Paris, even if the patient isn't under the care of the team, to ensure all communication is captured. This has been communicated to the team involved in Ms Anderson's care and will be included in the Trust wide Standard Operating Procedure for MHLT's that is currently in draft format with a plan to be in operation across all MHLT's by 1st September 2025. This will ensure consistency across all MHLT's working across the different acute Trusts within the GMMH footprint.

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.**

GMMH intend to move to a more proactive approach to discharge and will review all admissions of CMHT patients ensuring discharge planning is considered from admission. The role of the Operational Manager for Community Flow is to have oversight and coordinate actions to start discharge planning on a patient's arrival into the acute setting, rather than waiting for a patient to be deemed medically fit for discharge. This approach should in essence mean that views of the patient and family, and any restrictions on placements are identified and discussed at the earliest possible opportunity to enable timely discharge.

Yours Sincerely

Medical Director for Recovery
Greater Manchester Mental Health NHS Foundation Trust

Please contact us if you require support with this information including other language, audiotape, Braille or larger print.