NHS
Manchester University
NHS Foundation Trust

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27 June 2025

Alison Mutch OBE
HM Senior Coroner
HM Coroner's Office
1 Mount Tabor Street
Stockport SK1 3AG

Sent via email only to [redacted]

Dear Ms Mutch

The late Janet Anderson, 11 June 1958 – 28 October 2024: Response to Prevention of Future Deaths Report

I am grateful to you for giving us the opportunity to respond to the concerns which arose during the Inquest into this lady's death that *"the prolonged hospital stay and lack of progress in finding a suitable place in the community significantly contributed to her decline. The evidence before the Inquest indicated a lack of joint working between the two Trusts that meant despite the clinical concerns about the impact of her prolonged hospital stay, she remained in an acute setting."*

In order to understand the specific issues you raise in Mrs Anderson's management, it is relevant to include some background information which may not have been provided to you in evidence in quite so much detail.

Mrs Anderson was admitted from her Nursing Home to Manchester Royal Infirmary on 21 April 2024 with a urinary tract infection but was subsequently also treated for an exacerbation of chronic obstructive pulmonary disease, during which she was found to have been infected with COVID. Following initial treatment, she developed a further urinary tract infection which responded to antibiotic treatment, following which she was deemed to be medically optimised for discharge by the end of May.

At this stage it became apparent that the family had concerns about her previous care at Gorton Parks Nursing Home and had requested alternative accommodation outside the local authority area which was being sourced by the Community Mental Health team (CMHT). However, there was difficulty in identifying accommodation acceptable to Mrs Anderson's family, which was at a cost acceptable to the CMHT.

Her case had been discussed at the Patient Transfer List (PTL) meeting which is held to consider the ongoing management of patients who no longer have medical need to remain in

hospital but for whom there are other obstacles to discharge. This meeting is held daily and attended by representatives of the hospital, the Local Care Organisation (also part of MFT) and other relevant stakeholders including GMMH and the local authority.

Although Mrs Anderson's case was discussed with colleagues from the CMHT at the PTL on many occasions during her admission, the problem of identifying suitable accommodation which was acceptable to Mrs Anderson and her family, whilst being affordable to the CMHT, could not be resolved. As a result of this it was not possible to identify a safe discharge destination for Mrs Anderson which was acceptable to her and her family, and as a result she had to remain in hospital whilst this continued to be explored. Unfortunately, in hospital her condition gradually deteriorated and following a series of recurrent infections she died on 28 October 2024.

Actions taken by MFT

MFT accept that the established escalation processes through the PTL meeting did not achieve timely discharge for Mrs Anderson. This was largely a result of the specific circumstances of her case, particularly the requirement for her to be accommodated outside her current local authority area. However, as a result of her case, discussions have been held with colleagues in GMMH to provide a more robust escalation process where discharge being organised by the CMHT is taking longer than expected.

Following these discussions, GMMH are in the process of appointing a new Manager for Community Flow who will provide a coordination role between the Community and Inpatient Services. This should enable discharge planning to be commenced earlier in a patient's hospital journey where discharge coordination is being led by the CMHT. In addition, a clearer pathway of escalation for patients in whom discharge has been delayed has been developed between GMMH and MFT. There is now a process in place, over and above the PTL meeting, which brings the GMMH Senior Leadership Team's attention to patients whose discharge is being managed by Mental Health Services where discharge plans are not progressing to enable a date to be confirmed for discharge from hospital.

I trust that this reply has assured you that MFT has taken your concerns seriously and have learned from the events which contributed to Mrs Anderson's death. On behalf of Manchester University NHS Foundation Trust, I would like to once again offer Mrs Anderson's family condolences on their loss.

Should you have any further questions, please do not hesitate to get in touch.

Yours sincerely

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[redacted]

Joint Chief Medical Officer / Caldicott Guardian