GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Health and Social Care Partnership
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T: [redacted]
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Date: 15 October 2021

Ms A Mutch
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Re: Regulation 28 Report to Prevent Future Deaths – Norma Rushworth 10/10/20

Thank you for your Regulation 28 Report dated 23/08/21 concerning the sad death of Norma Rushworth on 10/10/20. Firstly, I would like to express my deep condolences to Norma Rushworth's family.

The inquest concluded that Norma's death was a result of 1a Bronchopneumonia, 1b Immobilisation following surgery for Diverticulitis, 1c II Ischaemic Heart Disease, Aortic Valve Disease, Hypertensive disease.

Following the inquest you raised concerns in your Regulation 28 Report to Greater Manchester Health and Social Care Partnership (GMHSCP) that there is a risk future deaths will occur unless action is taken.

This letter addresses the issues that fall within the remit of GMHSCP and how we can share the learning from this case.

Point 1 – support for vulnerable patients at appointments during the pandemic. At the time of Mrs Rushworth's death, hospital trusts were constrained by the national guidance around attendance at hospital settings "*Visiting healthcare settings during COVID-19 pandemic.*" The guidance restricted patients from attending appointments with a person to support them. In March 2021 this guidance was updated to advise that patients attending outpatients, diagnostic service and Emergency Departments are now allowed to be accompanied by one person to support them with making complex/difficult decisions. A link to the full guidance is included below for information:

Coronavirus » Visiting healthcare inpatient settings during the COVID-19 pandemic (england.nhs.uk)

Point 2. Communication between acute and community settings on risk and patient management.

Mrs Rushworth was discharged from the acute trust on 9th September following good post-operative recovery. District nurses attended Mrs Rushworth the day after her discharge from the acute trust. They then attended on 3 additional days, with the final attendance being to remove her stitches on 16th September, with this date being scheduled by the consultant.

Mrs Rushworth's attended A&E on the 17th September after the wound reopened.

Actions taken or being taken to prevent reoccurrence across Greater Manchester.

1. Learning to be presented/shared with the Greater Manchester Quality Board. This meeting is attended by commissioners, including commissioners of specialist services, regulators, Healthwatch and NICE.

2. Communication to all relevant providers to share appropriate advice and guidance and increase staff awareness regarding the range of materials that are already available.

3. Shared learning from this and similar cases at Greater Manchester and borough level will be cascaded to professionals through relevant governance and learning forums.

In conclusion, key learning points and recommendations will be monitored to ensure they are embedded within practice. GMHSCP is committed to improving outcomes for the population of Greater Manchester.

I hope this response provides the relevant assurances you require. Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely

[redacted]

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Chair of GM Medical Executive, GMHSCP