Alison Mutch

HM Coroner South Manchester
Coroners Court
1 Mount Tabor Street
Stockport
SK1 3AG

National Medical Director
NHS England & NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

16th June 2022

Dear Ms Mutch,

Re: Regulation 28 Report to Prevent Future Deaths – Norma Rushworth 14th October 2020

Thank you for your Regulation 28 Report dated 13th May 2021 concerning the death of Norma Rushworth on 14th October 2020. Firstly, I would like to express my deep condolences to Norma Rushworth's family.

Please accept our apologies for the length of time this response has taken to complete.

The regulation 28 report concludes Norma Rushworth's death was a result of complications of emergency surgery following a previous surgical procedure that had resulted in an abdominal dehiscence due in part to a wound infection not identified prior to the abdominal dehiscence.

With the medical cause of death as 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 NHS England.

The matters of concern are as follows:

1. The inquest heard that due to the pandemic and restrictions Mrs Rushworth was not supported as she would usually have been at outpatient appointments. The inquest heard that this impacted significantly on the quality of the history available to clinicians; support for a vulnerable patient and her decision making.

2. The inquest heard that following her discharge back into the community after surgery, support and monitoring was limited notwithstanding how vulnerable she was; the complexity of her surgery and the risk she presented. Advice re management of a patient such as her in the community and risks and management of them was not conveyed clearly enough to the community health professionals and to her family. Covid restrictions meant that communication had been difficult, and the written documentation did not cover the challenges this caused. Her deteriorating health in the community was not as a result, recognised at an early stage.

In response to the first query I refer to the Greater Manchester Health and Social Care Partnership (GMHCSP) response which stated that at the time of Mrs Rushworth's death, the national guidance around attendance at hospital settings "*Visiting healthcare settings during COVID-19 pandemic"* 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 for information: Coronavirus » Visiting healthcare inpatient settings during the COVID-19 pandemic (england.nhs.uk). The visiting guidance was reviewed regularly during the pandemic.

With regards the second matter of concern In terms of national discharge policy in place in October 2020, this included a clear set of agreed criteria to reside, which provide a framework to guide clinical staff as to whether a person is fit to be discharged or should remain in hospital for further treatment. The guidance advises that patients are reviewed against these criteria on a daily basis.

The guidance also provided information on how health and social care staff should engage with patients and carers ahead of discharge. Section 6 of the current version of the guidance summarises the actions and support that should be provided.

Hospital discharge service guidance - GOV.UK (www.gov.uk)

As the cause of death documented in the report also refers to wound infection, we would also like to highlight to you that in 2018 NHSEI commissioned The National Wound Care Strategy Programme, a long-term commitment to improving wound care. The aim of the England-wide strategy is to improve the quality of chronic wound care through innovative solutions that will improve wound healing and prevent harm in line with the commitments set out in the NHS Long Term Plan. The Programme aims to standardise wound care by developing clinical recommendations which support excellence in preventing, assessing, and treating people with wounds to optimise healing and minimise the burden of wounds for patients, carers and health and care providers.

The recommendations of the National Wound Care Strategy Programme are available online and have been widely publicised to the clinical community. In addition, the Programme and Health Education England (HEE) have published free to access, online education on a number of wound care topics, and continue to develop further wound care education resources. These resources are aimed

primarily at registered clinicians and experienced health and care support staff but the NWCSP is also contributing to the work of the NHS England and Improvement Enhancing Health in Care Homes team which is developing similar resources for novice health and care support staff. Work is also underway to support Higher Education Institutions that provide pre-registration clinical education in providing wound care education of an appropriate standard and range in their pre-registration programmes.

The learning from the PFD has been shared with all NHS England and Improvement regions.

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,

National Medical Director