

Greater Manchester Health and Social Care Partnership
By Email

E: [REDACTED]

12 November 2020

Ref: [REDACTED]

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

Dear Ms Mutch

Re: Regulation 28 Report to Prevent Future Deaths – Samuel Garner, date of death: 19th October 2019

Thank you for your Regulation 28 Report concerning the death of Samuel Garner on 19th October 2019. Firstly, I would like to express my deep condolences to Mr Garner's family.

The regulation 28 report concludes Samuel Garner's death was a result of 1a) Bronchopneumonia; 1b) Traumatic pneumohaemothorax; 1c) Right rib fracture; and II) Vascular dementia, Frailty.

Following the inquest you raised concerns in your Regulation 28 Report to NHS England regarding:

1. The inquest heard evidence that on admission to Stepping Hill Hospital the Emergency Department was extremely busy due to the volume of patients in the department. This had been typical of the picture in both the preceding and following weeks due to winter pressures/demands.
2. As a result of the lack of appropriate space Mr Garner an elderly and vulnerable patient was treated in the corridor for periods during his stay in the ED. This included whilst he was being given antibiotics intravenously - he scored on the sepsis pathway on arrival. He was also moved in and out of bays depending on varying prioritisation of need.

3. He waited a number of hours for his chest to be drained (after it was identified that was what was required) due to competing demands on clinical staff. He was in significant distress whilst waiting.
4. It was identified at an early stage that he would need a surgical bed and his care would be optimised in such a setting. There was a significant delay in moving him from the Emergency Department to a surgical ward due to lack of bed capacity within the Trust.

I have responded to each of your individual points below.

Point 1 high levels of demand and Emergency Department capacity

The national and local pressures on the urgent and emergency care system have been well publicised during the course of the last year, with Greater Manchester experiencing significantly higher levels of attendances during the winter months. Attendances were, on average, 9% higher than the previous year which is about an extra 9000 attendances per month across Greater Manchester. This also resulted in a higher number of patients requiring admission to acute hospital beds and therefore crowding and delays within Emergency Departments.

As a result of this, the Greater Manchester Urgent and Emergency Care Transformation Board agreed a revised transformation plan in early January this year with two principle ambitions:

- To reduce attendances to Emergency Departments by improving access to, and utilisation of, primary and community-based services by rapidly developing and testing a GM 'UEC by Appointment' model
- By April 2022, we will reduce:
 - o Ambulance attendances by 100 per day across GM
 - o ED walk in attendances by 300 per day across GM

The onset of the COVID 19 crisis delayed the transformation programme until more recently where we have refreshed our planning work and agreed to rapidly implement new models of care during September and October this year (ahead of winter). The new approach will incorporate two elements:

- Implementation of the new national NHS 111 First Initiative, which will ask patients to call 111 prior to attending an Emergency Department
- A new pre-Emergency Department triage and streaming system

Both of these will help ensure patients are streamed or referred to the most appropriate service for their needs. This will include a wide range of community and acute-based services and will ensure only patients who need an Emergency Department go to an Emergency Department. A large proportion of patients will receive early, local clinical assessment prior to being referred which will help ensure safety. We estimate that the new models of care will reduce Emergency Department attendances by around 900 per day across Greater Manchester.

I can confirm that all localities within GM have now gone live during the last 3 weeks with their services. A new national campaign to promote 111 First will be launched in early December which will encourage patients to call 111 before deciding to attend an emergency department.

It is also worth noting that GMHSCP also has a Greater Manchester Urgent and Emergency Care Operational Hub, which is designed to provide real time support to local systems by monitoring and managing patient flow. The hub has a near to real time data feed from all acute hospital sites, which it uses to support decision making around deflection of ambulances to alternative destinations, when a hospital emergency department is showing signs of pressure. The hub also supports the management of discharges from hospital and repatriations between hospital sites (in and out of the GM area). The hub is under constant development and is working closely with systems to develop more sophisticated methods of managing demand to reduce the likelihood of emergency department crowding even further and proactively managing flow to prevent blockages.

Point 2 – Corridor care within the emergency department

As highlighted above, crowding within emergency departments results in patients having to be cared for in non-designated areas within the department. This can include corridor spaces. This is not something that is supported but, is often the result of both high levels of attendances and reduced flow out of the emergency department. The work described in points 1 and 4 of this response will help to reduce the risk of crowding and therefore corridor care.

It should be noted that all of the acute trusts in Greater Manchester now utilise a patient safety checklist in their Emergency Departments. These checklists are time-based frameworks that outline clinical tasks that need completing for each patient in the first hours of their admittance to an ED. It ensures that assessments and tests happen in a timely way in order to help mitigate some of the risks associated with corridor care. These have been adopted from the national checklist template which was published in 2017 and which has been proven to improve clinical processes and reduce harm and serious incidents from unrecognised patient deterioration.

Point 3 – delay in completing a chest drain

It is not possible for the GMHSCP to comment on this specific aspect of care. I have contacted Stockport NHS Foundation Trust and I have been advised as follows:

Mr Garner sustained the injury on the 23/09/19 and he attended the Emergency Department the following day. He had a NEWS2 score of 0, normal CXR and pelvis/R hip XR and so he was discharged after FRESH assessment with safety netting advice.

He returned unwell on 11/10/19 at 1242hrs with NEWS2=11 (T 35.8, BP 149/77, HR 101, RR 32, SaO2 98% (on 12L O2). He had developed an oxygen requirement with shortness of breath. He had been at home with daughter and son-in-law with carers 4X/day but had been in respite for the previous 2/52. He had apparently lost 18kg in weight and had had abdominal pain. He had required a buprenorphine patch for pain

relief. His blood gas showed pO₂ of only 15.2 on 12L oxygen. 2 consultants were involved in his care in rapid assessment and seen by an FY1 at 1417hrs. He had IV antibiotics and fluids prescribed and a chest x-ray was requested at 1352hrs which was performed at 1608hrs.

The x-ray showed a moderate to large right-sided hydropneumothorax on review by a middle-grade doctor with the attending FY1. The chest injury protocol would suggest a CT scan at this point for further imaging, and also to further investigate the nature of the fluid in the pleural cavity, particularly 18 days after the injury. The CT thorax, abdomen and pelvis scan was requested at 1727hrs, but there was a delay as the first biochemistry blood sample was haemolysed and so had to be repeated. The eGFR must be known by the radiologist before they authorise a contrast CT scan due to the theoretical risk of contrast-induced nephropathy. The eGFR result went onto the system at 1755hrs but the CT scan was done at 1918hrs and then reported at 2010hrs. This showed it to be a likely haemothorax with almost complete collapse/consolidation of the underlying lung. There were slightly displaced fractures of right 10th-12th ribs with fractures in 2 places on the 10th and 11th ribs radiologically. This is not clinically so significant as the 11th and 12th ribs are floating and so the fact that these lower ribs may not move in a co-ordinated fashion, it would not really affect ventilation. The important feature was the massive haemothorax, but as it was 18 days old he was discussed with cardiothoracics in Wythenshawe. They suggested a chest drain and local admission under the general surgeons. The patient had been handed over by the FY1 doctor to an ST1 doctor. The ST1 doctor has long since rotated on but records suggest that she asked the surgical registrar to insert the chest drain, but then a middle grade documents that by 2210hrs he had inserted a chest drain and 1200ml blood had drained out. The check CXR was done at 2225hrs that shows it to be in place.

Therefore, the decision to insert the chest drain was made at 2030hrs when the ST1 documents the advice from cardiothoracics. The drain had been inserted no more than 100 minutes later. Mr Garner was moved from cubicle 13 to resus bed 2 at 2054hrs which would imply no actual delay, as he needed to be in the right place and such a procedure requires equipment and personnel to be assembled, and then the procedure takes some time. The attending doctor records it to have been an uncomplicated procedure. Oramorph was given at 1823hrs and IV paracetamol after the drain was inserted, and often significant amounts of analgesia are necessary to facilitate the drain insertion, but that was not required. There are multiple nursing entries that do not suggest him to be in pain or discomfort. His oxygen requirement improved dramatically after the drain.

It was a complicated journey to the drain being inserted, as the requirement for it was not apparent until he had been seen by the FY1. The delays were due to clinical need; the haemolysed bloods delayed the CT and a further delay to ensure Mr Garner was in the right place for the drain to be inserted.

Point 4 – hospital bed capacity and the discharge of patients

As part of the initial COVID 19 response, Greater Manchester localities worked to rapidly develop updated Discharge to Assess Pathway Guidance, which were formally approved in late April and have now been adopted across all localities within

Greater Manchester. The purpose of the guidance is improve the flow of all patients being discharged from acute care and to help ensure patients needs are assessed in the home or usual place of residence. The guidance is also designed to improve consistency across organisational and geographical boundaries thereby, minimising unnecessary delays for patients. To help improve the consistency and operation of the pathways at the interface between different organisations, it has been agreed that the following elements of the guidance are required to be implemented by all localities:

- Adoption of a single GM Discharge to Assess Referral Form
- Triage of discharge to assess referrals within 30mins
- Adherence to the guidance for COVID 19 testing for discharge and PPE requirements
- The supply of 2 weeks medication supplies at the point of discharge from an acute hospital
- Operation of a next day follow up process following discharge (localities to determine how this is delivered)

The guidance is fully aligned with national policy and guidance and there has been significant additional community-based capacity created to support this. Whilst we saw some initial improvements from this work, the second COVID wave is adding further pressure on acute hospital beds due to increased admissions and reduced bed availability as a result of infection, prevention control and staffing issues. Further work is underway to review community-based capacity to support discharges and to review elective care activity within hospitals. Reducing or suspending elective care work will help to provide additional capacity for patients, such as Samuel Garner, who have urgent care needs.

I hope this response is satisfactory and provides sufficient assurance on the work we have undertaken to help mitigate the risk of future deaths.

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



Dr [REDACTED]
Chair of GM Medical Executive, GMHSCP