NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

Tameside and Glossop Integrated Care NHSFT
Fountain Street
Ashton Under Lyne
Tameside
OL6 9RW

[redacted]

Integrated Governance Unit
Silver Springs
Tameside and Glossop Integrated Care NHSFT
Ashton Under Lyne
OL6 9RW

[redacted]

9th September 2022

Mr C Morris
HM Senior Coroner
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Mr Morris,

I am writing further to the inquest touching upon the death of Kathleen Stewart which concluded on 28th June 2022 and the subsequent Regulation 28 Report issued to this Trust. I hope to be able to build upon the issued raises within your report, and set out below my response. I have outlined these in order of the concerns raised.

Concern 1

The court heard evidence that, whilst the Middle Grade doctor who treated Mrs Stewart in the Emergency Department did not identify any bony injury, a Radiographer who formally reported on the pelvic X-Ray the following day identified a minimally displaced fracture of the right superior pubic ramus; It is a matter of concern that this X-Ray report was not acted upon, and as such Mrs Stewart did not receive the indicated follow up of analgesia and referral for physiotherapy.

To support results governance the Trust has an established safety workstream, overseen by the Executive Medical Director. The workstream was established a number of years ago to specifically put in place and monitor improvements and risk involved in results requesting and acknowledgment. The group reports directly into the Service Quality and Assurance Group chaired by myself as the Executive Director of Nursing and Integrated Governance, which in itself is overseen by the Quality and Governance Committee, chaired by a Non-Executive Director.

disability confident EMPLOYER

[redacted]

Everyone Matters

The Trust has in place a system whereby a Radiologist or Reporting Radiographer reviews and reports on all X-Rays which have been requested from the Emergency Department. Where the request for an X-Ray is made by a member of the Emergency Department Team, the report is shared for Emergency Department Consultant review and, where appropriate, further action is undertaken. At the time Mrs Stewart was treated in the Emergency Department there were reports within the Emergency Department awaiting Consultant review, which was contributed to by the increased activity seen in the Emergency Department as a result of the operational response to Covid-19.

Whilst the Trust has current safety net procedures in place, we are working to introduce a system whereby a Radiologist or Reporting Radiographer will be able to immediately assign a level of priority to each report in the Radiology reporting system, CRIS. This will be completed using a using a Red-Amber-Green (RAG) rating.

Where critical or unexpected findings are identified within the radiological images these will be RAG rated Red, and an immediate alert will be shared with the Emergency Department Team for prompt action by the Consultant-on-call. The alert will appear automatically on the patient's electronic casualty card. Where image findings are positive but expected these will be RAG rated Amber and notified to the Emergency Department for action on a daily basis. Where there are no significant findings, these will be notified to the Emergency Department for action on a weekly basis. The software to support this electronic and automated function is under development and is due to be completed by the end of September 2022. A pilot of the system in the Emergency Department with full testing and safety sign-off is due to be completed by Monday 10th October 2022. Once the system is live this will provide real time alerting to critical radiology findings.

A Standard Operating Procedure (SOP) has been developed to support the roll out of this new electronic capability, which provides an explanation of the reporting and escalation process and outlines the clinical responsibilities of both Radiology and Emergency Department colleagues. The SOP includes monitoring and oversight arrangements to ensure compliance with the process. The SOP also provides clear guidance on the need to record action taken in relation to any abnormal results identified after the patient has left the Department, this will be recorded in the patient's electronic notes. The automated alerting system will also have the capability to escalate any un-read or un-acknowledged radiology findings to operational and clinical leads for action.

Implementation of the new process, and its outcomes, will be overseen by the Medicine and Urgent Care Quality and Safety Board in conjunction with the Clinical Support Services Quality and Safety Board. Divisional updates will be provided monthly to the Trust's Service Quality and Assurance Group, chaired by myself as Executive Director of Nursing and Integrated Governance, until the new process is fully embedded.

In the interim, to mitigate risk Emergency Department Consultant reviews of all radiology reports received within the Department is being prioritised and is being monitored on an daily basis by the Urgent Care Clinical Director and Associate Divisional Director, overseen by the Medicine and Urgent Care Divisional Quality and Safety Board. For those radiology reports where an action is required the Emergency Department Consultants work with the Urgent Care

disability confident EMPLOYER
[redacted]
Everyone Matters

Administration Team who will process the required action. This process is completed electronically to ensure reports are acknowledged by the recipient.

In the specific context of this case, I am aware that that fractured pubic rami is treated non-surgically. However, I appreciate that Mrs Stewart's pain may have been addressed more effectively had the X-Ray report been acted upon. The steps outlined within this letter are intended to minimise risks to other patients with a focus on safety, quality and experience.

Concern 2

The Trust does not appear to have undertaken any specific investigation as to why this was the case. As such, the Trust has not taken the opportunity to:-
a) Identify what went wrong in Mrs Stewart's case and ascertain what learning can be derived from the incident;
b) Ascertain whether this was an isolated incident or whether there was (or is) a broader problem in relation to acting on abnormal reports of clinical imaging (and if so, the nature and extent of any such problem); or
c) Consider the fitness for purpose of the system in place within the Emergency Department for acting on abnormal reports of clinical imaging.

I would like to begin by conveying my sincere apologies that this matter had not been investigated or identified at the time of Mrs Stewart's care.

As a result of your concerns outlined above, the Trust has undertaken a retrospective concise investigation into Mrs Stewart's case in the form of an Multi Disciplinary Team (MDT) learning review involving Urgent Care and Radiology.

The MDT learning review noted the initial actions undertaken in the Emergency Department following the inquest; to confirm the number of reports awaiting review, introduce a process to manage these and for future review. It was highlighted that capacity had been made to ensure that this important work was being prioritised. As is outlined above, this is being monitored on an ongoing basis by the Urgent Care Clinical Director and Associate Divisional Director, overseen by the Medicine and Urgent Care Divisional Quality and Safety Board.

The investigation was informed by an audit of radiology findings, using a large random sample from June 2022. In respect of Emergency Department clinicians identifying fractures, the audit found that the Trust scored favourably when compared to the National average (3.1%, compared to 3.7% Nationally). The audit also identified that the small number of fractures not identified by Emergency Department clinicians were all acted upon appropriately when the report was received from a Radiologist or Reporting Radiographer.

The audit will be used to inform future teaching sessions for junior doctors; providing additional education in respect of pubic rami, lumbar spine and thoracic spine X-Rays. These X-Rays will also be reviewed by a Consultant on the day of performance where received by the Emergency Department prior to 22:00 hours. This is intended to reduce the occasions on which injuries are not identified by doctors within the Emergency Department.

disability confident EMPLOYER
[redacted]
Everyone Matters

The review also highlighted progress made in relation to the introduction of a new process to assign a priority to radiology reports, the development of the electronic alerting system and the associated SOP (as outlined in relation to concern 1 that the X-Ray report was not acted upon).

It is our intention to repeat this audit on a six month rolling programme and this will include standards to measure compliance with the new SOP as detailed in the section one of this response. This specific audit has also been added to the Trust Audit plan which is overseen at the Service Quality and Assurance Group and the Quality and Governance Committee.

As a result of your concerns outlined above in relation to incidents, the Trust's incident trigger lists have been circulated widely throughout the organisation with a reiteration of the importance of incident reporting. Emergency Department Consultants have been specifically reminded of the need to report as an incident any missed abnormal results.

In addition to this, a planned monthly focus on incident reporting is currently underway across the organisation and being led by the Assistant Director of Integrated Governance throughout September, culminating in the Trust's Patient Safety Conference on October 6th 2022. This programme of events and activities seeks to engage staff at all levels and focusses on identification of incidents or near misses, incident reporting, acting on and learning from incidents.

The MDT learning panel noted that a review of Mrs Stewart's care by the Learning from Deaths Team was undertaken in December 2021. The Learning from Deaths Team identified concerns that the family and care home had not been informed of the fractured pubic rami and an incident form was completed, in accordance with Trust guidelines. At that time, work was ongoing to improve results governance within the organisation; with collaboration between Urgent Care, Radiology and the Clinical Information Team. There was a risk on the Urgent Care Risk Register in relation to results governance, with mitigation and further action recorded. Following a discussion with the Emergency Department's Clinical Director, the incident was closed, with no further action identified. It is apparent that operational pressures as a result of our Covid-19 response impacted upon our oversight of this.

It is considered that this could have been handled differently, with improved triangulation. Detailed actions to improve this have been outlined to you in my letter of 11th August 2022 and you are aware that the Trust's Incident Reporting, and Incident and Complaint Investigation Policy is currently being reviewed alongside the NHS England Patient Safety Framework to ensure that this aligns. The policy will outline the process for identifying, reporting, managing, investigating and learning from patient safety incidents. The purpose of this review of policy is to support a systematic, compassionate and effective response to patient safety incidents; with a clear focus on learning and continuous improvement. This work will ensure accountability, compassion, openness and ownership of improvement and will provide a basis for local training and development. This policy will describe in detail the approach in place to ensure that the Trust is prepared for patient safety incidents so that staff understand what to do and how to behave when an incident happens. This will also include the Trust, Divisional and Directorate governance arrangements (including key organisational roles and responsibilities) to ensure an effective response.

disability confident EMPLOYER
[redacted]
Everyone Matters

I hope that this provides you with assurance that this matter has been taken seriously with a commitment to improve and learn from these events. In addition to this, in September 2022, Mrs Stewart's case will form part of a multidisciplinary learning event being held by the Trust. We will seek to share the learning from Mrs Stewart's case in order to prevent harm to, and improve the experience of, future patients. Inevitably, this will include a focus on incident reporting, which supports our aims outlined earlier in this letter.

I hope you will feel that the Trust has taken appropriate action as a result of your findings, however should you wish to discuss any aspect of this or seek further assurance please do not hesitate to contact me through the Legal Services Team on [redacted]

Yours sincerely

[redacted]

Executive Director of Nursing and Integrated Governance

disability confident EMPLOYER

Everyone Matters

[redacted]