NHS
Greater Manchester
Integrated Care

[redacted]

Date: 28 September 2022

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 – James Robert Curry

Thank you for your Regulation 28 Report dated 04/08/22 concerning the sad death of James Robert Curry on 18/11/21. On behalf of NHS Greater Manchester Integrated Care (NHS GM), I would like to begin by offering our sincere condolences to Mr. Curry's family for their loss.

Thank you for highlighting your concerns during Mr. Curry's Inquest which concluded on 30 June 2022. On behalf of NHS GM, I apologise that you have had to bring these matters of concern to our attention but it is also very important to ensure we make the necessary improvements to the quality and safety of future services.

The inquest concluded that James' death was a result of 1a) Bronchopneumonia 1b) Fracture Neck of Left Femur. Following the inquest, you raised concerns in your Regulation 28 Report to NHS GM that there is a risk future deaths will occur unless action is taken.

I hope the response below demonstrates to you and Mr Curry's family that NHS GM has taken the concerns you have raised seriously and will learn from this as a whole system.

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

Concern 1:-
1. The Inquest heard that a lengthy wait for an elderly patient with a hip fracture on a trolley in the Emergency Department will impact their physiological reserves and add to their pain. In Mr Curry's case, the Inquest heard that the prolonged wait was due to a shortage of beds within the Trust.
2. Mr Curry needed an orthopaedic bed to enable him to have the operation. The evidence was that a shortage of beds meant that he could not be placed in one and had to go to AMU. As a consequence, on admission he did not receive the orthogeriatric care envisaged by NICE in their guidance.

The Trust recognise that hip fractures are very common, especially in older people where the impact of a fracture can have a significant impact upon their lives. At Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT), it is recognised that there have been significant challenges throughout the hip fracture pathway. The Trust's response to the Covid pandemic and prolonged increased activity impacted on the service's ability to treat and manage patients within the appropriate processes and timeframes.

At the time of Mr Curry's admission to Tameside Hospital the Trust, like other areas of the country, was

experiencing sustained and significant operational pressures within the Emergenc[redacted] and wider hospital and were responding to continuous Covid challenges and pressures. The Trust had separate areas for Covid positive and non Covid patients as set out in NHS England national planning guidance which contributed to delays in Mr Curry being triaged and subsequently transferred to an appropriate bed.

The Trust has now been able to reinstate previous care pathways due to a decline in the national incidence of Covid positive cases. This means that the bed base of trauma and orthopaedics has been increased to near pre-pandemic levels.

The Surgical and Medical Division have worked closely together to design and implement an enhanced bed allocation process. The process supports those patients with a fractured neck of femur from the moment that the patient has their fracture confirmed in the ED through to admission to a trauma and orthopaedics bed.

The pathway redesign has included both in- and out of hours actions to take by the clinical teams, with support from the Trust's patient flow team. Each Trust bed meeting, which occurs five times per day, highlights any patient within the ED who will require a Trauma and Orthopaedic beds due to a fractured neck of femur.

3. The Inquest heard that the operation should have taken place earlier than it did under the NICE guidance. The Inquest was told that the NICE guidance is based on ensuring the best outcomes for elderly patients with fracture neck of femur and reducing mortality. It did not due to a shortage of capacity in the Trust. The Inquest heard that the Trust was regularly not able to operate in timescales compliant with the NICE guidance.

The Trust recognise that best practice and NICE guidance states that patients that have sustained a hip fracture should have timely surgery to repair the injury within 36 hours of admission, where the patient is clinically stable to undergo surgery. To manage these patients within the appropriate timeframe alongside competing priorities within the trauma and elective services, the Division of Surgery, Women's and Children's services (SWC) have reviewed and strengthened their processes.

The trauma and orthopaedic department run a daily trauma meeting, where all patients with a fractured neck of femur and who are awaiting surgery are identified. Individual plans of care and management are agreed clinically with the on-call orthopaedic consultant and trauma coordination team. An overview of all patients with a fractured neck of femur and who are awaiting surgery is also provided to the surgical bed meeting each morning, including status of patient and current wait time for surgery.

For those patients who can proceed to surgery, this will be scheduled to take place within the 36 hours timeframe to support compliance with NICE guidance. If this is not possible due to a theatre not being available, an urgent review of the entire trauma and elective lists that day will be undertaken. A clinical and operational discussion determines how the patient can be accommodated and a plan devised. The detailed plan is then enacted with the approval of the Divisional Management Team (DMT) and patient scheduled into theatre.

For those patients who are deemed not fit for surgery, the trauma coordination team supports the orthopaedic and anaesthetic clinicians to determine the clinical plan. This plan is discussed at the daily trauma planning meeting. For patients who may require diagnostic tests as part of their pre-operative optimisations, daily tracking of these is also included within the daily planning meeting.

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Where the Trust is not able to meet the 36-hour timeframe for surgery for a patient with a fractured neck of femur, a clinical incident report is submitted. Following the incident, a root cause analysis (RCA) is completed by the trauma coordinators to identify reasons for the delay and opportunities for learning. The RCA investigations are reviewed weekly in the "NOF Review Meeting" for comment, action and approval. This meeting is attended by the Clinical Lead for Neck of Femur, the Matron for Trauma and Orthopaedics and the Directorate Manager. Compliance is monitored through regular internal returns.

The Trust submits data to the National Hip Fracture Database, which specifically looks at care for patients over the age of 60, who undergo surgery following a hip fracture. This includes data to improve care through quality improvement in line with NICE guidelines and the National Falls and Fragility Fracture Audit Programme (FFFAP). Data is submitted by the trauma co-ordinators daily. The Trust have implemented a Divisional fractured neck of femur improvement programme which is reported and monitored daily via the Divisional senior leadership team. Oversight of Divisional compliance with this pathway is also monitored via the Service Quality and Governance Group, which is chaired by the Executive Director of Nursing and Integrated Governance.

Actions taken or being taken to share learning across Greater Manchester.

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

2. 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. NHS GM is committed to improving outcomes for the population of Greater Manchester.

I hope this response demonstrates to you and Mr. Curry's family that NHS GM has taken the concerns you have raised seriously and is committed to work together as a system including our service users, carers and families to improve the care provided.

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

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Deputy Chief Nurse
NHS GM Integrated Care