NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

Integrated Governance Unit
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Fountain Street
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15th September 2022

Private and confidential
To be opened by the addressee only
HM Coroner, Miss Mutch
Via Email

Dear Miss Mutch

I am writing further to the inquest touching upon the death of Mr James Robert Curry (who died on 13th November 2021) which concluded on 30th June 2022 and the subsequent Regulation 28 Notice issued to the Trust. I hope to be able to build upon the issued raises within your report, and set out below my response in terms of what we already are doing and what we plan to do. I have outlined these in order of the concerns raised.

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), I acknowledge that there have been significant challenges throughout the hip fracture pathway. The Trust's response to the Covid pandemic and increased sustained activity have impacted on the service's ability to treat or manage patients within the appropriate processes and timeframes.

At the time of Mr Curry's admission to Tameside Hospital the Trust were experiencing sustained and significant operational pressures within the Emergency Department and wider hospital and were responding to continuous Covid challenges and pressures. The need for the Trust to have segregated areas for Covid positive and non Covid positive patients also contributed to Mr Curry's additional waiting time in the Emergency Department and ultimate transfer to the most appropriate bed.

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For those patients are not deemed 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 then daily tracking of these is also included within the daily planning meeting.

Where the Trust are not able to meet the 36 hour timeframe for surgery for patient with a fracture neck of femur a clinical incident report is submitted. Following the incident a root cause analysis is completed by the Trauma Coordinators to identify reasons for the delay and opportunities for learning. The root cause analysis investigations are then 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 Manger.

For assurance of performance with the National Institute for Health and Care Excellence (NICE) Clinical guidance the Surgery, Women's and Children's Division are monitoring compliance on an ongoing basis. 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.

I hope that this response has provided assurance that the Trust has taken your comments and concerns seriously and taken action to minimise the risk of such event occurring again. Should you require any further information, please do not hesitate to contact me through the Legal Services Team on 0161 922 5020.

Yours sincerely,

Executive Director of Nursing and Integrated Governance

For and on behalf of Karen James OBE, Chief Executive Officer

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