NHS
Greater Manchester
Integrated Care

[redacted]

Date: 11 October 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 – Philip Jones 09/10/21

Thank you for your Regulation 28 Report dated 17/08/22 concerning the sad death of Philip Jones on 09/10/21. On behalf of NHS Greater Manchester Integrated Care (NHS GM), I would like to begin by offering our sincere condolences to Mr Jones family for their loss.

Thank you for highlighting your concerns during Mr Jones Inquest which concluded on 30 May 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 Philip's death was a result of 1a) Bronchopneumonia; 1b) Motor Neurone Disease. 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 Jones 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.

Matter 1. The Inquest heard evidence that there were significant backlogs in appointments to see a neurologist due to a national shortage of clinicians and appointments. *In Mr Jones' case this had not impacted the overall outcome but the Inquest heard evidence that this would not necessarily be the case in all patients. The Inquest heard that pre-pandemic, there was a backlog in existence at 3,500 patients waiting for a neurology appointment. The figure at the time of the Inquest was appro x. 7,000;*

Following the COVID 19 pandemic the waiting list for a new appointment in Neurology has significantly grown to in excess of 10,000 patients waiting across GM with a wait time of 52 weeks for a routine appointment. Neurology do however have a robust triage process in place for all referrals into the service and any deemed as clinically urgent are being prioritised and booked within a 4-6 weeks. Pre-pandemic the waiting list for Neurology on average stood between 3000-4000 patients with a wait time of 12-18 weeks for routine appointments, this however was heavily reliant on Locum consultants holding super clinics each weekend along with additional WLI consultant clinics.

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Following government guidelines all face to face activity during the pandemic was stood down and appointments converted to telephone consultations, this resulted in the locum clinics ceasing and a backlog of patients who needed reviewing post telephone appointment for examination impacting on the available clinic capacity remaining. We were also impacted by loss of clinic room capacity as a result of social distancing guidelines which continues to be an issue for us as a service.

The Neurology service has always had more referral demand than capacity, our current capacity modelling reflects an approx. deficit of 1500 new patient slots per month. A comprehensive action plan detailing the steps being taken as a service to bring down the current waiting list to acceptable levels (attached) has been developed and the current situation is scoring highly on the trust risk register. (Copy attached).

Recruitment of substantive clinicians is ongoing along with reinstating the use of locum capacity.

Neurology Waiting List Action Plan.docx

Risk Register 7167.pdf

Matter 2. The Inquest heard evidence that incompatible/different IT systems at the District General Hospital and Tertiary Centre made communication and information sharing in relation to patients more difficult. This impacted the holistic view that clinicians needed of an individual patient. Whilst images could be shared there was no ability for notes for one Trust to be visible to a clinician at another Trust;

Consultant Neurologists hold clinics across GM and have access to both the Salford IT systems and the District General Hospital IT systems where they are based. There are occasions where patients choose the site in which they have their outpatient appointments, and this may not be the site most local to them. This can result in information not being available to the consultant at the time of consultation.

The facility to share clinical records between separate NHS Trusts is not unique to this organisation and the tertiary centre. The Trust is proactively working towards transfer to an electronic patient record as outlined within the NHS Long Term Plan, with the oversight of their Chief Clinical Information Officer. The digitisation of patient clinical records will provide an opportunity for sharing of information between organisations and the Trust is committed to progression of the digitisation agenda in line with national ambition.

Matter 3. The Inquest heard that there were delays in communications from consultants to other clinicians e.g. GPs and patients following appointments/assessments due to a shortage of administrative support for consultants. This meant that important diagnostic/treatment [redacted]ut patients was not shared expeditiously.

[redacted]sed Booking and Scheduling and Secretarial and Administration department at [redacted]re robust management measures in place to ensure that possible delays are identified [redacted]anagement team, which is part of our Clinical Support Services Division, oversee and coordinate the booking and scheduling of theatres and endoscopy procedures, secretarial and administration of all clinical typing, to ensure that patients treatment and communications are not delayed and the patient is retained our central focus.

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Current typing standards (Key performance indicator) is for 95% of clinical letters to be typed within five days of the appointment. The review confirmed that this target was met in Mr Jones' care. Secretarial and administration managers review typing performance and administration work daily and the coordinated approach taken by the Trust allows for the transfer of resource to cover areas such as absence. Any risks are identified with appropriate plans made with divisional escalation. Further to this, daily management meetings are held to undertake a continuous review of performance, workload and any emerging concerns or risks relating to staffing, including absences. With a centralised team there is the ability to move colleagues to areas as needed to close any gaps or to support in additional workload to resolve any risks or provide cover in times of additional need or surge. Any vacancies are discussed in these daily meetings to ensure that they are advertised without delay to minimise service disruption and maximise patient safety and experience. Performance relating to their communication with external partners such as GP's, other Trust's or care providers and patients is overseen through divisional mechanisms, with any exceptions or delivery challenges shared at Operational Board and considered through the lens of quality, safety and Experience through the Trust Service Quality and Assurance Group.

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 Jones 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

[redacted]

Chief Nursing Officer
NHS Greater Manchester Integrated Care

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