Alison Mutch
HM Senior Coroner
Coroner's Court
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National Medical Director
NHS England
Wellington House
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18 January 2023

Dear Ms Mutch,

Re: Regulation 28 Report to Prevent Future Deaths – Maureen Harrop who died on 21 January 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 14 September 2022 concerning the death of Maureen Harrop on 21 January 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Maureen's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Maureen's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise to the family for the delay.

Following the inquest, you raised concerns in your Report regarding Maureen's prolonged stay in the Emergency Department at the Hospital because of lack of bed capacity, as well as the delayed surgery (exceeding the 36 hour timeframe recommended by NICE guidance) due to a lack of theatre capacity, and the significant impact this prolonged wait will have had on Maureen's overall physiological reserves.

NHS England has engaged with the Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT) in order to respond to this Report, and appreciates their helpful input.

The Trust recognises that hip fractures are very common, especially in older people where fractures can have a significant impact upon their overall health and lives. At 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 Maureen's admission to Tameside General Hospital, the Trust, like other Trusts nationwide, was experiencing sustained and significant operational pressures within the Emergency Department (ED) and wider hospital, and was 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 Maureen 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 hip fractures from the moment that the patient has had 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 required 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 bed due to a hip fracture.

In response to your second concern, the Trust recognises 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 - Overview | Hip fracture: management | Guidance | NICE. 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 hip fractures 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 these patients is also provided to the surgical bed meeting each morning, including the status of each patient and the current wait time for surgery.

For those patients who can proceed to surgery, this will be scheduled to take place within the 36 hour 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 is then devised. The detailed plan is then enacted with the approval of the Divisional Management Team (DMT) and the patient is scheduled into theatre.

For those patients who are deemed unfit for surgery, the trauma coordination team supports the orthopaedic and anaesthetic clinicians to determine the appropriate 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.

Where the Trust is not able to meet the 36 hour timeframe for surgery for a patient with a hip fracture, a clinical incident report is submitted. Following the incident, a root cause analysis (RCA) is completed by the trauma coordinators to identify the reasons for the delay and opportunities for learning. The RCA investigations are reviewed weekly in the "Neck Of Femur (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 also 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 coordinators daily.

In addition to this, the Trust has 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 would also like to provide further assurances on the national NHSE work taking place around the Reports to Prevent Future Deaths generally. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Maureen, are shared across the NHS at both a national and regional level, and helps us to pay close attention to any emerging trends that may require further review and action.

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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National Medical Director