NHS
Greater Manchester
Integrated Care

[redacted]

31 August 2023

Ms A Mutch
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

[redacted]

[redacted]ort to Prevent Future Deaths – Bernhard John Marek 6th January 2023

[redacted]ulation 28 Report dated 19/07/2023 concerning the sad death of Mr Bernhard [redacted]23. On behalf of NHS Greater Manchester Integrated Care (NHS GM), I would like to begin by offering our sincere condolences to Mr. Marek's family for their loss.

Thank you for highlighting your concerns during Mr. Marek's Inquest which concluded on 31st of May 2023. On behalf of NHS GM, I apologise that you have had to bring these matters of concern to our attention. We recognise it is also very important to ensure we make the necessary improvements to the [redacted]ces.

[redacted]d concerns in your Regulation 28 Report to NHS GM that there is a risk [redacted]tion is taken. The medical cause of death was 1a) Hospital Associated [redacted] of Femur (operated); II) Squamous Cell Carcinoma Lung, Acute Kidney [redacted]

I hope the response below demonstrates to you and Mr. Marek'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 NHSGM and how we can share the learning from this case.

The inquest was told that the wait time that was given at the time of the initial call was due to demand on the ambulance service and that such delays were not unusual throughout December due to demand and resources. As a consequence, frail elderly patients such as Mr Marek with hip fractures were regularly waiting significant periods of time for the ambulance service.
The resource issues faced by the ambulance service were exacerbated by long delays faced by ambulances to offload patients at Emergency Departments.

The date of the incident in question, December 2022, fell within a period of documented extreme pressure within the region. North West Ambulance Service (NWAS) declared a number of critical incidents during the weeks leading up to Christmas 2022 and the situation was further exacerbated by ongoing industrial action. In response to the harm identified in this period, NWAS and commissioners shared an analysis of high-risk incidents with the wider system to stimulate reflection and discussion as to how all partners could improve safety. This particularly related to the delays seen in hospital handover. The work of the handover collaborative continues across the North West and improvements

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have been seen, especially within the area of your coroner's office, Greater Ma[redacted] National target of 30 minutes in June 2023 with a monthly average of 29 minutes. The monthly average for Hospital Handover in December 2022, when Mr Marek had his fall, was 1 hour 10 minutes and 13 seconds for Greater Manchester

As you will be aware, the NHS remains a system in recovery following the COVID-19 pandemic and the pressures arising from it and the societal response. As part of this, NHS England has published a series of recovery plans, including one for Urgent and Emergency Care. This contains nine key workstreams covering capacity, workforce, hospital discharge and care outside hospitals. One specific workstream covers increasing ambulance capacity, as it recognises the increased complexity of ambulance call-outs [redacted] ided at scene. The national plan sets a goal to reduce the Category 2 response [redacted] minutes this year – itself recognising that resolving the response time issue [redacted] ges, including additional vehicles and workforce.

[redacted] l specific objectives to be delivered across all ambulance services:

[redacted] plan-for-recovering-urgent-and-emergency-care-services.pdf (england.nhs.uk)

Current performance levels in the North West have improved since the date of this incident. The monthly average response time in December 2022 for NWAS in Greater Manchester for category 2 was 1 hour [redacted] and for category 3 response was 7 hours 1 minute and 9 seconds. The [redacted] Category 2 mean performance in Greater Manchester was 22 minutes [redacted] his had improved to 2 hours 33 minutes and 41 seconds. These are far [redacted] se Programme (ARP) standards, and we hope to see further progress [redacted] nted.

[redacted] est, ambulance performance is reviewed regularly via the Strategic Partnership and Transformation Board, a joint committee between NWAS and the Integrated Care Boards in the region. We acknowledge that there remains work to be done to improve NWAS performance but are committed to achieving the ARP standards in the region.

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

1. Learning to be presented/shared with the Greater Manchester System Quality Group on 21st September 2023. This meeting is attended by commissioners, including commissioners of specialist services, localities, regulators, Healthwatch and NICE. Through sharing in this forum, we expect members to review and ensure learning is incorporated into their commissioned services.

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 to ensure that learning is incorporated into their services.

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.

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I hope this response demonstrates to you and Mr. Marek's family that NHS GM [redacted] you have raised seriously and is committed to working 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]

[redacted]
Chief Nursing Officer
GM Integrated Care

[redacted]

[redacted]
Stockport Place Based Lead

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