NHS
Greater Manchester
Integrated Care

[redacted]

Date: 01/12/2023

Ms J Kearsley
HM Senior Coroner
Coroner's Court
Greater Manchester North

Dear Ms Kearsley

Re: Regulation 28 Report to Prevent Future Deaths

Thank you for your Regulation 28 Report dated 1st September October 2023 concerning the sad death of Stephen Ratcliffe on 6th February 2023. On behalf of NHS Greater Manchester Integrated Care (NHS GM), We would like to begin by offering our sincere condolences to Mr Ratcliffe's family for their loss.

Thank you for highlighting your concerns during Mr Ratcliffe's Inquest which concluded on the 23rd of August 2023. On behalf of NHS GM, we apologise that you have had to bring these matters of concern to our attention. We recognise it is very important to ensure we make the necessary improvements to the quality and safety of future services.

Following the inquest, you raised concerns in your Regulation 28 Report to NHS GM that there is a risk a future death will occur unless action is taken. The medical cause of death was 1a) Respiratory Depression due to 1b) Combined Drug Toxicity 2) Developing Liver Cirrhosis and Anxiety and Depression.

I hope the response below demonstrates to you and Mr Ratcliffe'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.

The court heard that due to the deceased having compromised venous access as a result of his drug use, the GP practice were unable to take his bloods. The evidence before the court was that there is no specialist service for GPs to refer a patient to for bloods when venous access is difficult. Evidence was heard that this had been raised previously to the CCG. As a result, in this case no test for diabetes was obtained.

There are ten localities across the Greater Manchester system, each of these have commissioned phlebotomy services based on the communities they serve, this means that there are variations in service across the system.

As this incident occurred in Bury, we have sought a response directly from this locality.

There are a very small group of people who may be more difficult to take blood than others due to clinical presentation. Drug misusers are likely to be in this cohort.

Bury Clinical Senate has reviewed this incident and a new pathway has been confirmed for Bury general

4th Floor, Piccadilly Place, Manchester M1 3BN
Tel: 0161 6257791 www.gmintegratedcare.org.uk

practices in relation to patients where venous access is difficult. Where venous access is difficult general practitioners (GPs) will be able to refer into the Same Day Emergency Care (SDEC) service. This new pathway will be promoted through targeted communications across Bury.

To better understand the pathways across the other localities we will be developing a briefing, highlighting this event and using this to check and challenge what arrangements each locality has in place for access for patients where it is difficult to obtain blood.

In addition to the locality-specific actions as set out above, a GM level review of phlebotomy provision has been undertaken recently which has identified the variation in provision and sets out the intention to improve the consistency of offer to patients across Greater Manchester. This is also a priority deliverable of the Greater Manchester Primary Care Blueprint.

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

1. Learning from the check and challenge exercise to be presented/shared with the Greater Manchester System Quality Group on the 18th of January 2024. 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. There will be a follow up review of implementation in July 2024.
2. Shared learning from this 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 this case it will be discussed at the GM Primary Care Quality Group and the Long-term Condition Group in December.

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.

We hope this response demonstrates to you and Mr. Ratcliffe's family that NHS GM has taken the concerns 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 our attention and please do not hesitate to contact me should you need any further information.

Yours sincerely

[redacted]
Chief Nursing Officer
GM Integrated Care

4th Floor, Piccadilly Place, Manchester M1 3BN
Tel: 0161 6257791 **www.**gmintegratedcare.org.uk