Greater Manchester Integrated Care

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[redacted]

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Private & Confidential
Ms Alison Mutch
H M Senior Coroner for South Manchester
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Prevention of Future Deaths Report re Mr Alan William Rowland Smith

I refer to the Regulation 28 Report issued following the inquest into the death of the above named. I am sorry to learn of the circumstances of Mr Smith's death and would ask that you pass on my sincere condolences to his family.

During the inquest you identified a number of causes for concern which I will now address in order:-

(1) The inquest heard evidence that a prompt referral to Vascular Services was important in cases such as these, where GPs would have limited expertise in managing the risks and offering effective treatments. The need for early referral was not, the inquest was told, widely understood

Following the inquest and the issuing of the Regulation 28 in this case, the GP partners have undertaken a full review of Mr Smith's journey of care, focusing on the timing of referrals into specialist services including referrals to the vascular surgery team. The practice maintain that the management of Mr Smith's leg swelling was appropriate.

In circumstances where a GP has a query in relation to a leg swelling and whether to refer into vascular surgery, the process is for a referral to be completed so that the vascular team can then triage and determine if the patient is appropriate for them and / or to advise on the way forward.

In light of the findings in this case, a Masterclass learning event will be delivered in September 2024 to include advice and guidance in relation to the circumstances in which to refer and the information required within a referral to ensure timely triage and progression to care under the vascular surgery team as appropriate.

(2) Where such referrals were made, it was essential that sufficient information be provided to ensure that the degree of risk could be accurately assessed and effective prioritisation could take place

It is expected that any referral into any specialist service will be complete to include all relative information to enable the team reviewing / triaging the referral to do so in a timely manner. In circumstances where a referral is processed but the team are unable to promptly triage due to insufficient information, the referral is rejected with details of the information or action required in order to progress.

The Masterclass training event being put in place will include reference to 'what a good referral into this service should look like.'

(3) The inquest was told that as well as referral to vascular services it was important that GPs understood that District Nurses were a resource that should be utilised with prompt referrals. This could be challenging as the District Nursing Service was under huge pressure due to demand. However, they were well used to recognising high risk patients and clearer guidance for GPs around when to refer would ensure that their expertise would be available at an early stage. Management of any case such as Mr Smith's would of necessity involve the District Nursing Team as compression bandaging was the most effective treatment to prevent a critical situation such as Mr Smith's arising and the District Nurses were best placed to provide this. In Mr Smith's case the referral for District Nursing input was not until a very late stage even though the GP had identified at an early appointment that compression would be of benefit.

Regardless of the level of demand on the District Nursing (DN) Team, all referrals are triaged and prioritised appropriately so that patients are seen in order of clinical need. The service confirm that they welcome enquiries from their GP colleagues and where an enquiry indicates the potential need for a DN visit this is arranged.

The GP referral to the DN in this case was made on 17 August 2023 for urgent assessment of Mr Smith's leg and on the following day a member of the DN team attended Mr Smith at his home to carry out a full assessment. This included taking wound swabs for culture and sensitivity testing and with consent to the taking of photographs. Contact was made with the GP and antibiotic therapy was commenced. A senior district nurse attended the following day and a regular pattern of visits was agreed.

The GP Practice have undertaken a review of this case and explain that the referral was processed when infection and ulceration was noted. Prior to that Mr Smith's bilateral leg swelling was managed with a trial of diuretics, prescribed compression hosiery and advice to elevate the legs where possible which is the appropriate management.

I am satisfied that when the GP identified the potential benefit of compression, suitable compression hosiery was ordered for him and the referral to the DN Team made when clinically indicated.

Your inquest highlighted that GPs generally could benefit from additional training to enable consistent recognition of the point at which specialist DN support and advice should be sought. There is open communication between the DN Service and the GPs for when advice is needed but in order to strengthen awareness the Masterclass referred to above will include DN advice around timely referral.

Our Masterclass sessions are recorded and it would be our intention to record this planned session so that our wider NHS colleagues can also access the advice and guidance provided.

(4) The evidence before the inquest was that there were multiple specialisms across multiple GM Trusts with different IT systems involved in Mr Smith's care. As a consequence communication was poor with a limited understanding of his overall condition and fragmented input. The inquest was told that a framework that promoted a structure for a multi-disciplinary team approach across trusts in GM would avoid many of the challenges around information sharing across trusts.

There is a 'joint' care record that exists across Greater Manchester (the GM Care Record) which holds information from various organisations including GP Practices, Acute Trusts, Adult Social Care (Local Authority) and Mental Health Trusts. Most clinicians have access to this system and to provide an indication of how often it is used, in February 2024, 708 individual acute trust staff accessed records 12,715 times, viewing 8,243 patients.

Whilst data tells us that the system is being accessed and patient information being appropriately shared via the GM Care Record, it is acknowledged that not all health care professionals are accessing the benefits of this system. With this in mind, there is a programme of work currently underway with a plan to update the web page and re-launch the GM Care Record in early June 2024. The re-launch aims to raise awareness further and I can confirm that eLearning has been updated in addition to which additional training will be provided on how to access and use the system.

I have included below links to additional information about the GM Care Record which I hope will be helpful to you:-

- www.gmwearebettertogether.com (public facing information)
- www.gmwearebettertogether.com/training (training information)
- The GM Care Record - Health Innovation Manchester (info for health & social care teams)

In circumstances where a patient is being cared for across multiple specialist areas, information is shared within the GM Care Record, which supports but is not intended to replace a face to face MDT process where the overall care of a patient can be discussed. Technology such as Microsoft Teams enables representatives in multiple organisations,

regardless of location (not just within GM), to 'meet' to discuss individual patients and this is a process that happens regularly.

(5) In Mr Smith's case there had been advice from secondary care to his GP that he should be referred on the 2 Week wait path for dermatology. That advice was not taken by his GP who felt such a referral was not necessary. It was unclear what if any protocol was in place across GM when such advice was given but not followed

The standard protocol for onward referrals from secondary care (Stepping Hill Hospital) is that if a secondary care provider considers that an urgent referral onto a two week wait care pathway is required, then the referral should be completed by the secondary care clinician. This is because of the additional time involved in sending a recommendation into primary care and the referral then being completed.

In circumstances where a routine referral is thought appropriate, and where this is directly related to the presenting condition then secondary care should process that referral. However, if this is not the case then it would be appropriate for the referral to be passed back to the primary care provider for their action.

In regard to a GP making a decision not to follow the advice of a secondary care colleague, the GP would always be responsible for their clinical decision making. It would be unusual to ignore advice from a colleague without clinical justification. In this case, my understanding is that Mr Smith was scheduled to imminently attend for a scan and the GP decision was therefore to await scan findings prior to progressing the request to process this referral. From a clinical perspective this would be appropriate and in the interest of the patient.

I hope the above information is helpful to you and that you are satisfied that steps are been taken to ensure wider learning from this case and to promote improved communication between services.

Yours sincerely

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Interim Deputy Chief Executive Officer and Chief Nursing Officer
NHS Greater Manchester

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Chief Executive and Place Based Lead