Saving lives, Improving lives

NHS
Northern Care Alliance
NHS Group

Mr Adrian Farrow
HM Assistant Coroner for Greater Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

3 October 2024

Dear Mr Farrow

Re: Inquest into the death of Mrs Mary Horgan

I write regarding the inquest into the death of Mrs Mary Margaret Horgan which concluded on 6 August 2024 in which you issued a Regulation 28 report to Prevent Future Deaths.

Mrs Horgan sadly died following an admission to Salford Royal Hospital, responsibility of the Northern Care Alliance NHS Foundation Trust ("The Trust"), following transfer from Wythenshawe Hospital, responsibility of Manchester University NHS Foundation Trust ("MFT"). May I take this opportunity to express my sincere condolences to the family of Mrs Horgan.

Thank you for bringing the concerns raised in the Regulation 28 report to my attention. Your concerns were as follows:

"*Whilst the inquest found, on the evidence, that the transfer of Mrs Horgan between hospitals without an Aspen collar and spinal precautions as advised did not significantly contribute to her death, the obvious disparity revealed by the evidence between the two medical teams of their respective understanding and expectations of the way in which Patient Pass operates serves to create uncertainty and confusion and could easily give rise to a situation where the lives of patients may be put at risk*."

The Trust is always open to the opportunity to review, and where possible, strengthen our processes. I hope the below offers assurance to both you and Mrs Horgan's family that the Trust has continued to take these concerns seriously and has put in a number of steps and actions since the tragic death of Mrs Horgan.

Communication across GM sites regarding the operation of Patient Pass

Patient Pass is a web-based tertiary referral platform which facilitates referrals from hospital-based services to a selection of tertiary services hosted by the Trust and allows for real-time two-way communication between the referrer and the tertiary service.

Patient Pass is used in a number of services and was introduced as an alternative to telephone-based urgent referrals to the specialist on-call teams. Patient Pass provides a single, auditable record of referrals and advice given, which is accessible to teams at the referring organisation and the tertiary service.

The Trust acknowledges that there was sub-optimal communication between Salford Royal Hospital and Wythenshawe Hospital regarding Mrs Horgan's referral to the spinal team, resulting in her being transferred without spinal precautions.

The Trust has convened a working group, including [redacted], Consultant Vascular Radiologist and lead for Quality and Patient Safety from MFT to discuss how we can improve and strengthen communication between the Trusts, and to gain input and perspective from MFT as an external referrer. This group has reviewed this incident, and agreed a number of actions to both improve understanding of the Patient Pass system and improve the system itself to reduce the likelihood of recurrence of such an incident.

As a result, we have prepared a communications guide, which outlines the purpose of Patient Pass and clarifies the responsibilities of referrers and receivers. This document is due to be finalised shortly and will be circulated across Greater Manchester hospitals via their Medical Directors.

The guide informs the referrer that telephone contact details must be included at the time the referral is made, which will ensure that the specialist team can make timely contact by phone, if required, to provide time-critical advice. The Patient Pass system itself will also be updated to make the inclusion of a telephone number a mandatory field. Any non-urgent advice will continue to be provided via the Patient Pass system, so the guide also advises the referrer that Patient Pass should be accessed regularly for on-going communication with the tertiary service.

The tertiary services are also required to attempt to contact the referring service via telephone when there is time critical action required by the referrer, supplemented by appropriate documentation in Patient Pass. In addition to this, there are expectations on referrers and the tertiary service at an organisational level to ensure that potential users of Patient Pass are aware of how to use the system and the obligations on the user through their induction processes.

The system will be audited regularly to ensure adherence to the referral guidelines, with feedback being issued to the referring Trust as required.

Changes to Patient Pass

In order to assist with improving the operation of Patient Pass, the Trust is collaborating with the Patient Pass developers to make changes to the system as follows:

- Telephone number field is to be mandatory, with wording included such as, "Please enter a telephone number that can be contacted 24/7 to receive urgent information about the patient being referred. This number must not be a general switchboard number and should be updated as required".

- A mandatory box for the referrer to confirm the case has been discussed with a Consultant prior to referral.
- Including a screen when a new user registers to use Patient Pass outlining their responsibilities, of which users need to confirm acceptance before proceeding to use the system.

Letter of concern

I am grateful to you for alerting me to your concerns regarding the management of transferring patients between the Trusts in your letter dated 8 August 2024.

Discussions have taken place with MFT colleagues and both Trust's transfer policies have been reviewed and considered in light of Mrs Horgan's case. Both policies were appropriate, consistent and in date at the time of the incident, however, regrettably the principles within them were not fully applied.

In line with a request from the Greater Manchester Integrated Care Board, the Trusts are creating a seven-minute briefing document to share learning across Greater Manchester regarding the need to fully apply our transfer policies and to highlight the learning around the use of the Patient Pass system. We will consult with Dr Dare Seriki to prepare and circulate this in October 2024.

I hope the above offers you reassurance of the Trust's ongoing commitment to managing patient safety risks and to continually improve the care and services we provide.

Please do not hesitate to contact me if you require any further information in relation to our response.

Yours sincerely

[redacted]

Chief Executive