NHS
Greater Manchester
Integrated Care

[redacted]

Date: 5 September 2025

Private & Confidential
Alison Mutch
Senior Coroner for the area of Manchester South
Manchester City Coroner's Office & Court
Exchange Floor
The Royal Exchange Building
Cross Street
Manchester M2 7EF

[redacted]

Dear Ms. Mutch

Re: Regulation 28 Report to Prevent Future Deaths – Doreen Swann

Thank you for your Regulation 28 Report dated 10 July 2025 regarding the sad death of Doreen Swann. On behalf of NHS Greater Manchester Integrated Care (NHS GM), We would like to begin by offering our sincere condolences to Doreen's family for their loss.

Thank you for highlighting your concerns during the inquest which concluded on the 5 June 2025. 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.

During the inquest you identified the following cause for concern: -

1. **The inquest heard evidence that Doreen Swann was only in hospital at the point of her fall because her discharge had been delayed due to a shortage of a suitable social care placement. The evidence was that nursing/caring for high falls risk patients in an acute setting is challenging and resource intensive.**
2. **The evidence given to the inquest was that this delayed discharge and the ongoing risk it presents was not an isolated incident at TGH -as an example the evidence given was that there were regularly 30 plus patients with a delayed discharge over 3 weeks due to a lack of social care beds .The evidence indicated that this challenge was not unique to Tameside.**
3. **The evidence indicated that managing a falls risk and the consequential risk to life is better managed outside an acute setting once the clinical need for a hospital stay has passed.**

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4. **Delayed discharges such as Doreen Swann's reduces the availability of beds for other patients and creates a knock-on impact across the hospital particularly in relation to the Emergency Department.**

As this report relates to care delivered by Tameside and Glossop Integrated Care NHS Foundation Trust, I have provided a response focusing on action within Tameside locality.

As part of a system led improvement programme, there is a continued focus on patient flow and discharge in Tameside covered by the Trust Deputy Chief Operating Officer, Trust Deputy Chief Nurse, and Director of Adult Services for the Local Authority. Progress against the delivery targets within this improvement programme is monitored through a monthly programme group which was established in April 24 and has delivered a significant reduction in patients with a No Criteria to Reside (NCTR) status over recent months. This means that patients who are medically fit for discharge are being discharged to the right place much quicker. This includes process-mapping to support front-door processes to enable deflection to other services. Intermediate Tier Services (ITS) continues to operate the Acute Frailty Unit to avoid admissions for those patients living with frailty and work streams ongoing for "front door" initiatives in line with the GM 4 Pillars of U&EC improvement.

In terms of oversight of discharge planning and patients with NCTR, the Trust's Chief Operating Officer chairs a weekly meeting to review Length of Stay and Delayed Transfers of Care. Membership includes local stakeholders and the Director of Adult Services to review each patient and ensure appropriateness of care within a hospital setting and aim to support discharge.

An additional ward was funded and opened in November 2024 which is now fully operational. The ward includes a discharge lounge that supports an increase in patient flow, in its simplest form, patients who are ready for discharge but need to wait for transport, take home medications or relatives to collect them can safety wait in this area. There is also a review of the cohort of patients within the Stamford Unit to ensure appropriate criteria is met.

To respond to the needs of patients within a hospital bed with a high risk of falls, including those with NCTR, a falls deep dive has taken place and a number of areas of improvement identified to include enhanced observations. A falls improvement group is established to review cases and identify learning and improvement actions.

The Director of Adult Services in Tameside holds regular meetings to review the Market Position Statement 2023-26 which provides an overview of the provision of Adult Social Care and support in the borough of Tameside. This sets out the commitment to meet its Care Act duties for the locality in facilitating a vibrant, diverse and sustainable market for Adult Services directive for delivering high quality care and support in the area for the benefit of the local population.

NHS GM recognises the importance of delivery of high-quality care in the best setting and, to enable this, the efficient and effective discharge from secondary care to community-based placement and services. NHS GM has commenced work to demonstrate the benefits in utilising risk stratification to target people at risk of falling to prevent them falling in the next 12 months. We anticipate that this will result in a GM Falls Prevention Strategy with a clear set of recommendations that each locality can tailor to their local population to prevent people from falling. As part of this work, we will identify how many GM residents (65+ years) are at risk of a fall and estimate the cost of a fall to health and care services. This will be shown for those living in the community and those in a care home, for each locality and collectively across GM.

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We will evidence how these falls can be prevented through targeted support and as a consequence evidence the potential cost savings through this approach to prevent people falling. This will include learning from

- A deep dive in Salford of their current falls prevention support (e.g. strength and balance classes) to help improve uptake, access and value for money.
- Direct application e-falls risk tool in practice in the Wigan SWAN pilot to identify residents at risk of a fall and discuss with them individually how best to prevent them falling.
- Success of utilisation of KoKu (an award-winning platform providing self-managed health care for older adults and NHS approved preventative treatment), Safe Steps (Safe Steps is a digital falls risk assessment tool, designed to reduce the number of falls in health & social care organisations) and other digital technologies.
- The success of return of investment on home adaptations.

I hope that my response has addressed your concerns. Please contact me if you have any further questions or require further information.

Best wishes

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

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