Alison Mutch
HM Senior Coroner
Coroner's Court,
1 Mount Tabor Street,
Stockport
SK1 3AG

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted] [redacted]

05 MAY 2023

Dear Ms Mutch

Re: Regulation 28 Report to Prevent Future Deaths – Celia Sanderson who died on 09 July 2022

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 10 February 2023 concerning the death of Celia Sanderson on 9 July 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Celia's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Celia's care have been listened to and reflected upon.

I am grateful for the further time to respond to your Report, and I apologise for any anguish this delay may have caused to Celia's family or friends. I realise that responses to Coroner Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones and appreciate this will have been an incredibly difficult time for them.

In order to be able to respond to your Report, NHS England has engaged with Greater Manchester Integrated Care (NHS GM) who is the provider of the healthcare services in question, and the Integrated Care Board (ICB) who is responsible for making decisions about commissioned health services across Greater Manchester NHS England's response to your Report is based on our informed discussions with these two organisations.

Demands on Service

Urgent and emergency care (UEC) access standards are challenged at NHS GM, where bed occupancy rates continue to be high, impacting upon flow. Significant numbers of hospital beds are occupied by people who no longer require medical treatment, but who do not have a suitable place to be discharged to. This in turn means that flow through UEC slows, and the demand on staff and resources increases. Patient safety and experience can be impacted by these delays and as a result, staff resilience is also affected.

A deep dive was undertaken into urgent care by the Greater Manchester Integrated Care Quality and Performance Committee in January 2023. Deep dives present an opportunity for quality and performance teams to work with system boards and provider partners to set out the key deliverables, challenges, risks, and impact on

safety in relation to a specific service as well as provide an update against improvement programmes and plans. To inform this deep dive, a wide range of intelligence was reviewed including quantitative and qualitative information. Qualitative information reviewed included but was not limited to learning from reports to prevent future deaths and serious incidents, complaint themes, and the friends and family test.

Further information on this deep dive can be found here: gm-quality-and-performance-committee-january-2023-public-meeting-pack.pdf (gmintegratedcare.org.uk)

NHS GM have established an Urgent Emergency Care (UEC) action plan led by the Urgent Care Board strategically and the System Operational Response Taskforce (SORT) from an operational perspective. This is an evolving action plan which now includes industrial action as a feature of operational planning, including managing the impact of staff strikes. The action plan is in line with NHS England's national requirements as set out in our guidance "Going further on our winter resilience plans" first published in October 2022 and updated in December 2022.

NHS GM and its wider system partners remain focussed on responding to pressures, utilising additional funding to ensure safe and effective urgent care. Systems are working at Organisation, Place, and Integrated Care System (ICS) level to deliver this.

In addition to the national requirements, NHS GM has been sharing and implementing best practice and monitoring impact on some additional metrics:

- 111 call abandonment (the call is ended before a conversation has occurred).
- Mean 999 call answering times.
- Category 2 ambulance response times, these calls are triaged as an emergency or potentially serious condition. These calls are responded to within an average of 18 minutes.
- Average hours lost to ambulance handover delays per day.
- Adult general and acute type 1 bed occupancy (adjusted for void beds)
- Percentage of beds occupied by patients who no longer meet the criteria to remain an inpatient.
- Delivering safe and effective care through winter (focussed winter metrics)

Learning from Deaths

In relation to this Regulation 28, NHS England have been informed that the learning is to be presented/shared with the Greater Manchester System Quality Group. This meeting is attended by commissioners, including commissioners of specialist services, regulators, Healthwatch and National Institute for Health and Care Excellence (NICE).

Shared learning from this and similar cases at Greater Manchester and borough level will be cascaded to professionals through relevant governance and learning forums. Despite the NHS being under pressure, which is expected to continue, the NHS GM has provided NHS England with assurances that they will continue to improve care quality for all patients.

The learning from the investigation into this incident has also been interrogated and used to improve practice. It has been shared with the Greater Manchester Major Trauma Network to inform learning and improvement (see below).

Trauma Network & Multi-Disciplinary Support

We understand that NHS GM formed a Greater Manchester Major Trauma Network (GM MTN) in April 2012. It is a coordinated and inclusive collaborative partnership between staff, services and organisations in Greater Manchester that provide care to patients who have sustained major trauma injuries. Its purpose is to deliver safe, equitable and effective care to patients who have suffered serious, and often multiple, injuries where there is a strong possibility of death or disability.

The network management team consists of a Quality Improvement Lead, Network Manager and Network Administrator. Clinical leadership is provided by a Network Medical Lead. Within the Trauma Network there are also consultant leads for rehabilitation, governance, surgery as well as frailty.

All NHS hospitals and pre-hospital services in Greater Manchester who provide trauma care are members of the Network. Hospitals provide a different function depending on the services they have on site – there are two adult major trauma centres (MTCs), three major trauma units (TUs) and six local emergency hospitals (LEHs) within Greater Manchester.

As a clinical network, they are part of the GM Critical Care & Major Trauma Operational Delivery Network (ODN). The ODN is funded by commissioners of specialised services at NHS England and NHS Improvement. The ODN is hosted by Manchester University NHS Foundation Trust: https://www.gmccmt.org.uk/major-trauma/about/.

As mentioned above, NHS England have been advised that the learning from the investigation into this incident is to be used to improve practice across the Trauma Network for Greater Manchester.

National Guidance on UEC Recovery

NHS England has recently published the *Delivery plan for recovering urgent and emergency care services.* This plan recognises that urgent and emergency care services have been through the most testing time in the history of the NHS; that patients have been spending longer in Accident & Emergency departments than they should; and that flow, within some hospitals, is slower than it should be. In relation to the concerns identified by HM Coroner in terms of demand on urgent and emergency care services, the published plan sets out the steps that the NHS are taking to respond to this demand safely.

Nationally, there are clear requirements placed on NHS Trusts to ensure that the right skill mix of medics and other professional groups are in place to respond to the anticipated demand throughout a day. This includes the expectation that senior decision makers are available to support more junior doctors and that diagnostics can occur in line with best practice and clinical standards set by the National Institute for Clinical Excellence (NICE) and other bodies such as Royal Colleges and Faculties.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Celia are shared across the NHS at both national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

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,

Medical Director for Professional Leadership and Clinical Effectiveness
NHS England