NHS England

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National Medical Director
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12 June 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Mr Joseph Willy Maunick (Will) who died on 15 March 2022

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 20 April 2023 concerning the death of Mr Joseph Willy Maunick ("Will") on 15 March 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Will's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Will's care have been listened to and reflected upon.

The first concern you raised related to a national social care shortage, and the impact this has had on the quality of care provided to Will. The Department of Health and Social Care (DHSC) are best placed to comment on this issue as they hold responsibility for social care provision. The DHSC have committed to adult social care reform and have committed £700 million to transform and improve the adult social care system in England, to include around access to support and joining up of services as part of their 'People at the Heart of Care' plan.

Your second concern highlighted the severe pressures being placed on West Suffolk Hospital, including its Emergency Department (ED), and the significant impact on resourcing this was having. Your Report concludes that Will was not able to receive the supervision he required or be transferred to a more appropriate ward at an earlier opportunity.

We have engaged with West Suffolk NHS Foundation Trust regarding Will's care on his admission to the ED as a social admission on 4 March 2022, while diagnosed with dementia and at risk of falls. At the time of Will's admission, the Trust was operating under an internal critical incident, due to a lack of flow and shortage of available beds. As a result of these pressures Will was in the ED for a total of 15.5 hours. It is documented that he fell in the ED despite receiving 1:1 supervision at the time of his fall which resulted in a left subdural haematoma which he did not recover from. He received palliative care until he passed away on 15 March 2022.

Actions have now been taken locally to minimise the risk of such an incident from happening again at the Trust. These actions include:

- The Trust plan to share a report with the Integrated Care Board (ICB) Quality and Safety Teams to raise awareness of available community resources. This will align with reducing the lack of available resource/facilities in the community to provide emergency placement/respite resulting in an avoidable hospital admission.
- A review will be undertaken with ED staff to support the development of appropriate pathways for vulnerable patients suffering with conditions such as dementia and those at high risk of falls to ensure support is available in making clinical decisions and ability to escalate a patient as a priority for a ward bed.
- A pilot of a quality improvement project within the ED will be undertaken to raise awareness of high risk falls patients and a thematic review of falls within the ED will also be undertaken. This will identify any wider themes and areas for further learning and improvement. The Trust will also ensure that assistive technology is available to staff to support in identifying when a patient is mobilising.

In January 2023, the Delivery plan for recovering urgent and emergency care services was published by NHS England, which sets out the steps that the NHS are taking to respond to the demand being placed on urgent and emergency care (UEC) services at a national level. The plan also includes details for the expansion of community services including more joined-up care for older people living with frailty, including scaling up urgent community response, frailty and falls services across the whole country – meaning the right people delivering the right care and avoiding admission to hospital where it's not necessary. We will also work with Integrated Care Systems (ICSs) to provide streamlined pathways for older adults, including people with dementia. Falls are the number one single reason why older people are taken to the emergency department, and around 30% of people aged 65 and over will fall at least once a year.

It is one of the core objectives of NHS England's 2023/24 Operational Planning Guidance to improve retention and staff attendance, through a systematic focus on all elements of the NHS People Promise. This includes taking advantage of opportunities to deploy staff more flexibly, improving staff experience and increasing productivity. Nationally, there are also 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.

I would also like to provide further assurances on national NHSE 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 preventable deaths are shared across the NHS at both a national and regional level and helps us 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,

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National Medical Director