Ms Alison Mutch
HM Senior Coroner
Manchester South
1 Mount Tabor Street
Stockport
SK1 3AG

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
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12 September 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Evelyn Mary Dutton who died on 13 August 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 19 July 2023 concerning the death of Evelyn Dutton on 13 August 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Evelyn's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Evelyn's care have been listened to and reflected upon.

In your Report you raised a concern over pressures on the ambulance service and the pressures being experienced at Stepping Hill Hospital's Emergency Department (ED), which caused delays an ambulance responding to Evelyn following a fall, as well as to her admission at ED.

NHS England recognises the significant pressure on ambulance services since the Covid-19 pandemic, which has seen longer response times across all ambulance call categories than before the pandemic, as well as issues associated with handing over ambulance patients in a timely way as well as the flow of patients in and out of some NHS Trusts. That is why NHS England are focusing on improving ambulance performance for 2023/24, supported by the Delivery plan for recovering urgent and emergency care services, published in January 2023. The plan outlines the actions and steps that we are taking across England to recover and improve urgent and emergency care services, including improving ambulance response times, increasing ambulance capacity through growing the workforce, improving flow through hospitals, speeding up discharges from hospitals, expanding new services in the community, and taking steps to tackle unwarranted variation in performance in the most challenged local systems.

In July 2023, we also published a letter to Integrated Care Boards, NHS Trusts and Primary Care Networks titled Delivering operational resilience across the NHS this winter. This also included focusing on improvements around Accident & Emergency handover and ambulance handover times.

You also raised a concern over the delays transferring patients to hospital and wards and the risks to health and wellbeing of elderly, frail patients, such as Evelyn, this caused. NHS England's services such as Urgent Community Response and Virtual

Wards, Enhanced Health in Care Homes, and the development of Proactive Care services, are designed to offer support and timely access to alternatives to hospital admission. Whilst Evelyn required acute hospital care for her hip fracture, these improvements aim to reduce delays for those that do require urgent, inpatient care. Measures are also in place to increase throughout in Intermediate Care (IC) to help reduce delays in discharge from acute beds and speed up admission from ED.

NHS England has also engaged with Greater Manchester Integrated Care Board (GM ICB) on the concerns raised in your Report. They have advised that at the time of your concerns regarding Evelyn's care, in June 2022, there was a period of documented system pressure within the North West region. This was reflected in handover delays at hospitals which then impacted ambulance availability in the region, and, in turn, contributed to longer North West Ambulance Service (NWAS) response times. The work of the North West Every Minute Matters Hospital Handover Collaborative, which began in 2018, has seen improvements, particularly within Greater Manchester. In June 2022, the average hospital ambulance turnaround times for Greater Manchester were 41 minutes and 42 seconds. The considerable work that has been undertaken across the North West region has resulted in Greater Manchester meeting the national target of 30 minute response times to Category 2 call-outs by June 2023, achieving a monthly average of 22 minutes and 48 seconds. Improvements have also been made to Category 3 response times.

Within the North West, ambulance performance is reviewed regularly via the Strategic Partnership and Transformation Board, a joint committee between NWAS and the Integrated Care Boards in the region. We acknowledge that there remains work to be done to improve NWAS performance but are committed to achieving the Ambulance Response Programme's standards in the region.

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,

[redacted]

National Medical Director