

Alison Mutch
Senior Coroner
Greater Manchester South
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]
11 September 2023

[REDACTED]
Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Marianne Erika Oldham who died on 17 December 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 20 July 2023 concerning the death of Marianne Oldham on 17 December 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Marianne's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Marianne's care have been listened to and reflected upon.

In your Report you raised concerns over the demands being placed on Emergency Departments (EDs) and the delays this was causing to triaged patients being seen by clinicians, particularly during the winter period. You also raised the concern that delays were being compounded by a shortage of radiographers and radiologists.

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 including 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 (UEC) 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 includes focusing on reducing waiting times for patients and crowding in A&E departments, improving flow, and reducing length of stay in hospital settings.

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. It is, however, acknowledged that resourcing remains an issue across the NHS, with local services reporting over 112,000 vacancies. In June this year, the NHS published its [Long Term Workforce Plan](#), setting out how we will ensure that staffing is put on a sustainable footing over the next fifteen years to improve patient care. The plan sets out three core priorities; to improve training and education, ensure that we retain more staff, and to reform. The plan is underpinned by the biggest recruitment drive in NHS history.

NHS England has also engaged with the Greater Manchester Integrated Care Board (GM ICB) regarding your concerns about Marianne's care. Within Greater Manchester, and at Tameside General Hospital, demand on the Emergency Department was exceptionally high at the time of Marianne's attendance. Patients were seen and assessed in clinical priority order to ensure that the most acutely unwell patients were given priority. The department had to utilise escalation areas which meant caring for nine patients on the corridor and they were experiencing ambulance handover delays. There were no gaps in the medical workforce and one Registered Nurse gap on the night shift. All Greater Manchester acute providers reported being at Operational Pressures Escalation Levels Framework (OPEL) level 3 (the health and social care is experiencing major pressures compromising patient flow) during the week of Marianne's death.

Attendances at Type 1 Emergency Departments are significantly higher in the winter months than in the summer months, and the usual winter pressures were compounded during the week commencing 12th December 2022 by particularly cold weather with snow in some areas and an increase in influenza-type illnesses compared to the previous two years and an increased acuity of patients leading to longer lengths of stay for patients.

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: gmintegratedcare.org.uk/wp-content/uploads/2022/12/gm-quality-and-performance-committee-january-2023-public-meeting-pack.pdf.

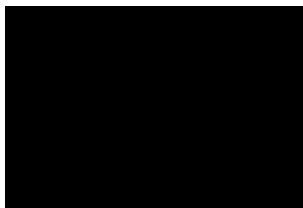
There is a 15% vacancy rate across Greater Manchester of radiologists at consultant grade. The GM Imaging Network are supporting the upskilling and change of skill mix within the imaging workforce by allocating funding for reporting radiographers, focusing on computerised tomography (CT) and magnetic resonance imaging (MRI) reporting radiographers. Furthermore, the Network are coordinating international recruitment via a Clinical Diagnostic Centre's funding stream to bring in more radiologists.

The Imaging Network are exploring the use of a collaborative staff bank, including CT, to reduce reliance on third parties. The future introduction of Picture and Communication Systems (PACS) based reporting will also be an enabler for a more centralised service to be used for reporting. PACS provide economical storage and convenient access to images from multiple modalities and could therefore be used as central storage systems that can be used across GM, reducing the staffing resource required for reporting. The implementation of PACS is currently a key scheme within GM's Imaging Digital Programme.

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,




National Medical Director