Alison Mutch
Senior Coroner
Greater Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

[redacted]

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

[redacted]

12 September 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Albert Dovey who died on 4 February 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 21 July 2023 concerning the death of Albert Dovey on 4 February 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Albert's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Albert's care have been listened to and reflected upon.

In your Report you raised concerns about the delays for ambulances to be processed at Tameside General Hospital's Emergency Department (ED). This was due to pressures on Greater Manchester services which was impacting on handovers between ambulances and ED's. You raised that the impact on these delays on elderly, frail people, following a fall, such as in Albert's case, gave rise to an increase in death. In preparing this response, NHS England has engaged with NHS Greater Manchester (NHS GM) as well as our National Ambulance Team.

It is not clear from your Report the date that North West Ambulance Service (NWAS) attended at Albert's home address but I note that he sadly died on 4th February 2022 following deterioration after his fall, which was within a period of documented extreme pressure within the North West region. In response to the harm identified in the winter period, NWAS and commissioners shared an analysis of high-risk incidents with the wider system to stimulate reflection and discussion as to how all partners could improve safety. This particularly related to the delays seen in hospital handover. The work of the handover collaborative continues across the North West and improvements have been seen, especially within the area of your coroner's office, Greater Manchester, achieving the national target of 30 minutes in June and July 2023 with a monthly average of 29 minutes. The monthly average for hospital handover in January 2023, was 40 minutes and 38 seconds for Greater Manchester, so significant improvement has been achieved.

NHS England recognises the significant pressure on ambulance services since the Covid-19 pandemic, which has seen longer response times across all categories than before the pandemic, as well as issues associated with handing over ambulance patients in a timely way at some NHS Trusts and the flow of patients in and out of some NHS Trusts. That is why NHSE 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.

Current performance levels in the North West have improved since the winter period and started improving at the beginning of this year. The monthly average response time in January 2023 for NWAS for Category 2 mean was 29 minutes and 53 seconds, so was achieving the UEC recovery plan target of 30 minutes, and in Greater Manchester was in a better position achieving 24 minutes and 23 seconds. The monthly average for July 2023 Category 2 mean performance in Greater Manchester has seen further improvement achieving 21 minutes 42 seconds. These are far closer to the Ambulance Response Programme's (ARP) standards and we hope to see further progress as the recovery plan is implemented.

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 ARP 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