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Coroner's Chambers
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[redacted]

National Medical Director
NHS England
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16th January 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Kathleen Booth who died on 13 June 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 22 November 2023 concerning the death of Kathleen Booth on 13 June 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Kathleen's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Kathleen's care have been listened to and reflected upon.

Your Report raises the concern over under staffing and under funding of NHS services and that the fact that the injury happened on a weekend meant less staff and experience were available for Kathleen's care and treatment.

In 2013, NHS England published its 7-Day Hospital Services (7DS) Programme which introduced clinical standards regarding the provision of a "truly seven-day NHS" and requiring acute trusts to provide board assurance compliance. The Programme focuses on the provision of acute medical care in such a way that there is no difference in quality for patients, whether it is a weekday or a weekend. There is a good level of compliance with these standards across acute trusts and many services and surgical and diagnostic lists are operating at weekends and evenings.

In January 2023, NHS England published the Delivery plan for recovering urgent and emergency care services. This is a two-year delivery plan which sets the NHS commitment to the public to improve waiting times and patient experience within urgent and emergency care (UEC). This includes commitments to:

1. Increase capacity (to include dedicated funding of £1 billion for additional capacity, including 5,000 new beds).
2. Grow the workforce, including introducing more flexible ways of working.
3. Speed up discharge from hospitals.
4. Expand new services in the community, as up to 20% of emergency admissions can be avoided.
5. Help people access the right care first time.

In June 2023, NHS England also published the NHS Long Term Workforce Plan, setting out how it will train, retain and reform its workforce across the next fifteen years

to ensure that we are improving access, providing safe and timely urgent and emergency care and continuing to reduce elective care backlogs. The Plan is underpinned by the biggest recruitment drive in NHS history.

Elective care recovery also continues to be a priority for the NHS. In February 2023 the Delivery plan for tackling the Covid-19 backlog of elective care was published by NHS England. This focused on four areas of delivery to increase health service capacity, prioritise diagnosis and treatment, transform how we provide elective care and provide better information and support to patients. This is supported by a government spend of more than £8 billion between 2022/23 and 2024/25, including a £5.9 billion capital investment in new beds, equipment, and technology. Further priorities were set out in a letter to NHS acute Trusts in May 2023, which can be found here: NHS England » Elective care 2023/24 priorities.

The NHS continues to encourage local health systems to develop effective workforce planning to ensure that they have the sufficient qualified staff working across their Trusts and wider system that are required for their population care needs. The NHS People Promise also helps NHS providers to consider ways to recruit and retain staff. Work is in progress to ensure that future distribution of training posts to help ensure the supply of doctors is matched to population need. You will need to refer to Staffordshire and Stoke-on-Trent Integrated Care System on what system arrangements they have in place for their UEC provision and workforce.

I would also like to provide further assurances on 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 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