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National Medical Director
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[redacted] [redacted]

10 June 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Margaret Avril Burman who died on 13 July 2021.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 17 April 2024 concerning the death of Margaret Avril Burman on 13 July 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Margaret's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Margaret's care have been listened to and reflected upon.

Your Report raises concerns over appropriate staffing falls mitigation measures on wards occupied by people at risk of falls, in particular patients with dementia or Alzheimer's Disease, and that there should be 'national leadership and a standardised toolkit when assessing falls risks on hospital wards' and that there should also be a greater degree of sharing of learning.

National leadership has already developed national guidance based on evidence-based practice which include falls risk assessment and toolkits to support implementation of appropriate interventions. At the time of Margaret's admission to hospital in 2021, there was existing guidance available to support best practice around patients at risk of falls.

The National Institute for Health and Care Excellence (NICE) CG161 guidelines were first published in 2013 and cover assessment of fall risk and interventions to prevent falls in people aged 65 and over. The guidelines include recommendations on:

- multifactorial risk assessment of older people who present for medical attention because of a fall, or report recurrent falls in the past year
- multifactorial interventions to prevent falls in older people who live in the community
- multifactorial risk assessment of older peoples' risk of falling during a hospital stay. This multifactorial assessment includes assessment of someone's cognitive impairment.
- multifactorial interventions to prevent falls in inpatients at risk of falling.

The following guidance was also freely available in 2021:

- The Fallsafe Project care bundle Fallsafe | British Geriatrics Society (bgs.org.uk), (2018)
- Falls and fractures: applying All Our Health - GOV.UK (www.gov.uk), (2015)
- Preventing falls in older people (nice.org.uk) for people at home (2013).

Guidance and resources to support best practice is also readily available and was available during 2021. As well as the NICE guidance referenced above, the following national resources were also available:

- NHS England » Development of the 'Avoiding Falls Level of Observation Assessment Tool' in the NHSE Atlas of Shared Learning, (2019)
- Falls and fractures: applying All Our Health - GOV.UK (www.gov.uk), (2015)

Since 2021, the British Geriatrics Society were also involved in developing the *World Guidelines for Falls Prevention and Management for Older Adults: A Global Initiative*[1] published in 2022. These include a chapter on *Falls in hospitals* that conditionally recommends performing a multifactorial falls risk assessment in all hospitalised older adults >65 years of age.

Regarding staffing levels, the headcount for registered nurses and support staff has increased over the last decade,[2] however difficulties do remain in ensuring appropriate levels of staffing, especially to cover wards where patients are at risk of falls. Local nurse leaders are responsible for calculating safe levels of staffing using the Safer Nursing Care Tool - Shelford Group and Boards for NHS Trusts have been required to report on their staffing levels to NHS England on a six-monthly basis since 2014.

As part of our response to the ongoing challenges around workforce, we published the NHS Long Term Workforce Plan June 2023, which sets out our plans to increase, train, retain and reform the NHS workforce over the next fifteen years.

Your Report also raises a concern around patients medically fit for discharge are remaining in hospital due to a lack of appropriate community care being available. This remains a challenge for the NHS and social care services across England. As a key part of NHS England's Urgent & Emergency Care recovery, NHS England together with colleagues across the DHSC and the Department for Levelling up, Housing and Communities (DLUHC) are focussed on improving discharge processes and capacity modelling to ensure the right number of commissioned beds/non-bedded care.

A range of programmes aimed at improving both admissions avoidance and discharge flow is being undertaken to support the reduction in the number of patients in acute medical beds with no criteria to reside. This work is a key priority for the NHS and is being driven through the published NHS Operational Planning Guidance and the Better Care Fund planning process and has associated improvement support available to regions and local systems.

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[1] https://www.bgs.org.uk/wfg
[2] NHS Digital, 2024. NHS Workforce Statistics, January 2024 England and Organisation.xlsx (live.com)

There is statutory guidance available on how health and care systems should support the safe and timely discharge of people who no longer need to stay in hospital: Hospital discharge and community support guidance - GOV.UK (www.gov.uk).

Following review of Margaret's care and your Report, my regional colleagues in the South West will be asked to engage with the Bath and North East Somerset, Swindon and Wiltshire System to seek assurance that local leadership is embedding national guidance and best practice.

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,

[redacted]
National Medical Director