Caroline Topping
Surrey HM Coroner's Court
Station Approach
Woking
GU22 7AP

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

[redacted] [redacted]

25 June 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Timothy Charles Clayton who died on 12 December 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 17 April 2024 concerning the death of Timothy Charles Clayton on 12 December 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Timothy's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Timothy's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused to Timothy's family or friends. I realise that responses to Coroner Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones and appreciate this will have been an incredibly difficult time for them.

Your Report raised the concern that the pressure to vacate bed spaces impacted on clinicians' ability to prepare a properly considered discharge plan and could lead to rushed and underinformed decision-making.

The delivery plan for recovering urgent and emergency care services committed to providing the NHS with additional bed capacity to improve hospital flow and performance. The target of 5,000 additional core general and acute beds, against previously planned levels, was met and consistently exceeded in January 2024, supported by £250 million for 30 capital schemes across the country. 2024/25 operational planning guidance sets out an ask for systems to maintain their levels of acute core general and acute beds in 2024/25, and to expand their bedded and non-bedded intermediate care capacity, through the additional £400 million distributed via the Better Care Fund (BCF), to support improvements in hospital discharge and enable step-up care in the community.

The plan additionally set out to improve discharge by improving discharge processes, scaling up intermediate care and scaling up social care services, based on learning from the 6 national Discharge Frontrunner sites that have led the way in exploring how new long-term initiatives can be used to free up hospital beds for those who need them, and the 100-day discharge challenge run across the NHS in 2023. Central to

plan was the requirement that all Trusts work together with local authorities and system partners to establish a Care Transfer Hub to manage discharges for patients with more complex needs.

During 2023/24, the NHS met the ambition to ensure all hospitals have a care transfer hub in place and, due to improvements in discharge processes and increased intermediate and social care capacity, on average 500 fewer patients per day had to spend the night in hospital because of a discharge delay, and 13% more patients received a short-term package of health or social care to help them continue their recovery at home or in a community bed after being discharged from hospital. The government's refreshed statutory discharge guidance, published in March 2022, reiterates that system partners across health and social care should work together, and with patients, their families and carers, to ensure that needs are appropriately assessed to support recovery and reablement after hospital.

The Urgent and emergency care recovery plan year 2: Building on learning from 2023/24, published in May 2024, sets out commitment to continue to improve in-hospital discharge processes by ensuring early discharge planning, including the effective involvement of patients, carers and families, in line with statutory guidance. Acute providers are asked to continue to improve in-hospital processes to improve timeliness of discharge, including early discharge planning from the point of admission and early involvement of care transfer hubs where patients are likely to have more complex discharge needs.

NHS England has also been sighted on Epsom and St Helier University Hospitals NHS Trust's response to your Report. We note that the Trust has taken a number of actions related to the care experienced by Timothy. This has included updating the Hospital Discharge and Criteria to Reside Policy and process for identifying vulnerable patients under the Trust's care, emphasising the importance of family involvement in decision-making and undertaking communications with staff to emphasise the importance of safe discharge.

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