

Adam Hodson

The Birmingham and Solihull Coroner's Court
Steelhouse Lane
Birmingham
B4 6BJ

National Medical Director

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

17 June 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Ronald Henry Spencer who died on 2 December 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 23 April 2024 concerning the death of Ronald Henry Spencer on 2 December 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Ronald's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Ronald's care have been listened to and reflected upon.

Your Report raised concerns over staffing issues being experienced across the NHS and the challenges these cause nationally.

NHS England is working at a national level to deliver the [Long-Term Workforce Plan](#). This is a robust and effective strategy to ensure we have the right number of people, with the right skills and support in place to be able to deliver the kind of care people need. It heralds the start of the biggest recruitment drive in health service history, but also of an ongoing programme of strategic workforce planning. It includes ambitious commitments to grow the workforce by significantly expanding domestic education, training and recruitment, as well as actions aimed at improving culture, leadership and wellbeing so that more staff are retained in NHS employment over the next 15 years. These actions will aim to close anticipated staffing shortfalls in the NHS in the long term.

Your Report also raises the impact of delays to patient care being caused by 'winter pressures' and that there is 'inadequate cohesive forward thinking or planning' to short-term pressures such as these.

NHS England continues to plan for and provide support to systems ahead of winter pressures. Further information and links to historic plans and letters to our systems can be found on our [winter resilience](#) website pages. For the most recent winter period (2023/24), we sent out a [letter](#) to our Integrated Care Boards and Trusts, setting out our national approach to winter planning and our four areas of focus:

1. Continuing to deliver on the [Urgent & Emergency Care Recovery Plan](#) by ensuring that high-impact interventions are in place.

2. Competing operational and surge planning to prepare for different winter scenarios.
3. Ensuring that there is an effective system working across all parts of a health system, including acute trusts and community care, elective care, children and young people, mental health, primary, community, intermediate, social care and the voluntary, charitable and social enterprise sector.
4. Supporting the workforce to deliver over winter.

This followed the publication of our ongoing delivery plans for [recovering Urgent and Emergency \(UEC\) Care services](#), [Primary Care Recovery Plan](#) and [Elective Recovery Plan](#), all of which provide a strong basis for winter preparedness.

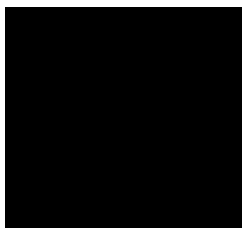
Trusts do have a responsibility to ensure safe staffing levels in the current day to day operation of their hospitals. This is in line with the [Care Quality Commission \(CQC\) Regulation 18](#) which states that providers must deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements.

I would therefore refer you to NHS Birmingham and Solihull Integrated Care Board and University Hospitals Birmingham NHS Foundation Trust for more local arrangements on staffing and workforce. However, NHS England understands that there have been several appointments since Ronald's death and that there is now increased resilience in the emergency surgery rota and that recommendations are expected to be made regarding their oesophago-gastric service configuration. NHS England have been asked to be sighted on their final responses to the coroner.

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 line]

National Medical Director