NHS England

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[redacted]

24 December 2024

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Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Tamara Davis who died on 13 December 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 15 October 2024 concerning the death of Tamara Davis on 13 December 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Tamara's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Tamara's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to respond to your Report, and I apologise for any anguish this delay may have caused to Tamara'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 raises the concern that patients are being treated in the corridors of Emergency Departments when the departments have reached their full capacity and space in clinical areas is not available. This is considered by the Coroner to be a national issue and does not just apply to the Royal Sussex County Hospital in Brighton, where Tamara passed away.

My response to the Coroner has been informed by colleagues in the Urgent and Emergency Care Team at NHS England and the South East Regional Clinical Quality Improvement Team.

The delivery of care in temporary escalation spaces (TES) in departments experiencing patient crowding (including beds and chairs) is not acceptable and should not be considered as standard across the NHS. TES refers to care given in any unplanned settings (such as corridors) and recently NHS England have published a set of principles for supporting improved quality of care should patient demand outstrip capacity - NHS England » Principles for providing safe and good quality care in temporary escalation spaces (16 September 2024). These principles have been developed to support point-of-care staff to provide the safest, most effective and

highest quality care possible when TES care has been deemed necessary, and the principles should be applied alongside any local standard operating procedures and arrangements governing flow pathways and safe staffing.

In the meantime, NHS England is working through the operating model so that NHS England's Regions can support providers to eliminate crowding in Emergency Departments in the longer term. Improvements are being demonstrated through NHS England's operational planning guidance, where systems were asked to focus on areas to deliver improved patient flow, and this has included increasing the productivity of acute and non-acute hospital services, improving flow and length of stay, as well as clinical outcomes. In addition to this, we are continuing to develop services that shift activity from acute hospital settings to settings outside an acute hospital for patients with unplanned urgent needs, supporting proactive care, alternatives to admission and improving hospital discharge.

My Regional colleagues in the South East Clinical Quality Improvement team have recently visited the Emergency Departments at both University Hospitals Sussex in Worthing and Royal Sussex County Hospital as part of a programme of joint Nursing and Integrated Care Board (ICB) visits to NHS Trusts, led by their Deputy Director. The programme of visits aims to understand how and why patients are selected to reside in non-designated areas, how they are observed for deterioration, and how dignified care can be provided. These focused reviews of non-designated care practices in the Emergency Department have included engaging with staff, patients and relatives to test safety measures in place and provide detailed feedback for the organisations on areas for improvement.

NHS England has also reviewed the response to the Coroner from University Hospitals Sussex NHS Foundation Trust dated 10 December 2024. We note and welcome the various workstreams in place to improve flow through the hospital, reduce hospital attendance and optimise discharge pathways.

I would also like to provide further assurances on the 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 events, such as the sad death of Tamara, are shared across the NHS at both a national and regional level and helps us to 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