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National Medical Director
NHS England
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24 December 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Anne Taylor who died on 31 July 2024

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 8 November 2024 concerning the death of Anne Taylor on 31 July 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Anne's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Anne's care have been listened to and reflected upon.

I note that your Report has also been sent to Salford Royal Hospital Foundation Trust, who are the appropriate organisation to respond to the concerns raised. NHS England has asked to be sighted on the Trust's response to the Coroner and will review this once received.

The matters of concern in your Report relate to Anne electing to leave hospital on 19 July 2024 due to waiting times, before being clinically assessed. You raised that there was no consideration of whether secondary investigations could have been undertaken during the waiting time (e.g. a CT scan), which would have likely been required to make a diagnosis.

My regional colleagues in the South West have engaged with Greater Manchester Integrated Care Board (GM ICB), the responsible commissioner for the services provided by Salford Royal Hospital Foundation Trust.

They advise that in line with quality oversight and governance arrangements as defined by GM ICB, the Salford Locality Quality Team continue to have fortnightly relationship meetings with Salford Care Organisation Clinical Governance Team. In addition, the Quality Team attend the Salford Care Organisation weekly safety summit meetings where quality assurance and improvement is overseen. The purpose of the local relationship meetings is to:

- Support and promote the quality and safeguarding agendas so that Salford residents receive safe effective care that results in a positive experience of services.

- Maintain an open and transparent relationship between the NHS GM Salford and Provider Quality and Safeguarding Teams.
- Promote and support the delivery of national, GM and local quality improvement initiatives.
- Review and discuss the areas of focus and escalation.
- Review any additional reports as requested/put forward by Salford Care Organisation.

In addition to this, the ICB will be undertaking a quality assurance visit to Salford Care Organisation. This will include oversight of patient pathways including discharge planning.

NHS England recognises the significant pressures on all NHS services and, in January 2023, published a two-year Delivery plan for recovering urgent and emergency care (UEC) services. The plan prioritised improvements to four hour performance in Emergency Departments and outlined key actions to recover and improve urgent and emergency care services. Despite significant challenges, including higher than anticipated demand, there has been a marked improvement in the headline ambition, with over 2.5 million more people completing their Accident & Emergency treatment within four hours in 2023/24 compared to 2022/23.

NHS England is working to support its regions to support providers to eliminate crowding in Emergency Departments in the longer term. Improvements are being demonstrated through NHS England's operational planning guidance where health 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 as well as clinical outcomes.

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 Anne, 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,

[redacted]

National Medical Director