Ms Sally Robinson
HM Assistant Coroner
East Riding of Yorkshire and
City of Kingston Upon Hull
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[redacted]

National Medical Director
NHS England
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[redacted]

22 January 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Colin Wiles who died on 27 March 2023

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 24 November 2024 concerning the death of Colin Wiles on 27 March 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Colin's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Colin's care have been listened to and reflected upon.

My response to the Coroner focuses on those areas of concern that sit within NHS England's national policy and programme remit. It is appropriate for the other organisations you have addressed your Report to, Hull University Teaching Hospitals NHS Trust and East Riding of Yorkshire Council Adult Social Care and Health, to address the local and system concerns you raise.

You raised the concern that it does not seem clear whether callers are advised to call the emergency services back if they continue to have concerns.

Instructions on worsening conditions, including specifically to call back on 999 should the patient's condition change or deteriorate, are standard components of the case exit script. If the call is made via a second party, ambulance services should ensure there is a process in place to be assured the caller is able to monitor the condition of the patient, and that they can be called back when the patient is not able to call back or answer a call themselves. If this was not provided in a clear and easy to interpret manner, this is a matter for the relevant ambulance service to resolve locally as a training issue for their call handlers.

You also raised a concern over the waiting times for ambulances to handover patients at Hull Royal Infirmary, which were excessive on 27 March 2023, leading to 160 hours of lost ambulance time.

Excessive hospital handover delays remain a key issue for the NHS. Rapid handovers are essential to ensure patients reach definitive care promptly, which includes both those waiting to receive care in the emergency department (ED), and those waiting in

the community. NHS England are continuing to work with trusts and services with significant handover challenges at the 'front end', alongside recognising the importance of reducing length of stay and timely discharge to maintain adequate patient flow and allow new patients to be handed over more promptly to EDs.

To deliver this, the NHS's ambitions for 2024/25 have been set out in the NHS priorities and operational planning guidance. These are:

- improve A&E performance with 78% of patients being admitted, transferred, or discharged within 4 hours by March 2025
- improve Category 2 ambulance response times relative to 2023/24, to an average of 30 minutes across 2024/25

NHS England's operational planning guidance has asked systems to focus on three areas to deliver these ambitions:

1. maintaining the capacity expansion delivered through 2023/24
2. increasing the productivity of acute and non-acute services across bedded and non-bedded capacity, improving flow and length of stay, and clinical outcomes
3. 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, admissions avoidance, and hospital discharge.

Evidence of the impact of system actions to improve patient flow and relieve pressures on EDs includes:

- tens of thousands more people received the care they needed to return home quickly and safely due to the expansion of same day emergency care (SDEC) services
- on average, around 500 fewer patients a 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 after discharge
- urgent community response teams provided 720,000 people with an alternative to going to hospital between April and January 2024
- virtual wards have supported more than 240,000 people to get the hospital-level care and monitoring they needed in the comfort of their own home

Additionally, during 2024/25, providers have access to £150 million of funding to support specific local improvement plans for urgent services, including for mental health care. These new improvements will support patients being treated more quickly in A&E or by other services in the community. Up to £150 million will also be available to incentivise the best performing areas and those that improve fastest. The NHS and local authorities will also work together to expand intermediate care services, both in people's own homes and in community beds, thanks to the additional £400 million Better Care Fund (BCF) available to support further improvements in hospital discharge. There will also be further improvements to, and co-ordination of, community-based services that support people to avoid ambulance call-outs and hospital admissions, by treating people in the most appropriate place for their level of need.

NHS England will also be prioritising:

- improving length of stay for all admitted patients (specifically emergency admissions with a length of stay of 1+ day)
- reducing delays
- improving length of stay in NHS commissioned community beds

My regional colleagues for North East and Yorkshire have also engaged with Humber Health Partnership, of which Hull University Teaching Hospitals NHS Trust is a member, regarding the concerns raised in your Report. We note and welcome the actions they are taking to reduce ambulance handover times and restore patient flow. We are advised that the Trust has also implemented a Temporary Escalation Space (TES) and Boarding Standard Operating Procedure to improve patient flow and increase availability of beds for patients attending the Emergency Department. I refer you to Humber Health Partnership's response to your Report for further information.

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 Colin, 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