NHS England

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12 February 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Andrew Michael Lewis who died on 7 May 2024

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 19 December 2024 concerning the death of Andrew Michael Lewis on 7 May 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Andrew's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Andrew's care have been listened to and reflected upon.

Your Report raised concerns over the pressures being placed on ambulance trusts, and the delays to response times this can cause. You raised concerns regarding South Central Ambulance Service (SCAS) specifically, but also the national picture.

NHS England recognises the significant pressures on all NHS services, including ambulances, and has been prioritising improvements to Category 2 response times and urgent and emergency care services. NHS England has also recognised the need to increase ambulance capacity through growing the workforce, improving flow through hospitals and reducing handover delays, speeding up discharges from hospital and expanding new services in the community; all of which support improved patient flow and ambulance response times. The NHS is also working more closely with local authorities to improve the timely discharge of patients and has developed discharge metrics to monitor performance improvements.

NHS England's ambitions for 2024/25 have been set out in the NHS priorities and operational planning guidance. These include:

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

Improvements to ambulance response times are also being enabled by addressing excessive handover delays. Rapid handovers are essential to ensure that 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 continues 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.

Your Report also raised that there appears to be no oversight of Prevention of Future Death (PFD) Reports written to ambulance trusts, and a significant number of these Reports relate to ambulance delays. PFD Reports sent to ambulance services are reviewed by the Association of Ambulance Chief Executives (AACE) National Ambulance Services Medical Directors’ Group (NASMeD) and the AACE Quality Governance Group to capture themes and learning. I also wish to provide assurance that all PFDs regarding ambulance services that are sent to NHS England are reviewed by our National Ambulance Team, as well as being discussed at our Regulation 28 Working Group (see penultimate paragraph below). NHS England is unable to provide comment on individual trusts not responding to PFD Reports.

Regarding SCAS specifically, they have advised us that PFD Reports addressed to them are shared with all SCAS clinical leads and executives for awareness. On review, if it is felt that changes are required then these are discussed with the relevant service line director and governance leads who will determine the best way to mitigate or eliminate the concern raised, with proposed responses being reviewed by the CEO. They are required to share all PFD Reports received with the Care Quality Commission (CQC) and their commissioning Integrated Care Boards. As well as sharing PFD Reports and responses with AACE, they will also share them with NASMeD.

SCAS also advise that they review other ambulance service PFD Reports through their Learning from Deaths (LFD) forum, which is chaired by an Assistant Medical Director. The forum will discuss whether concerns addressed to other ambulance services are also relevant to SCAS and whether additional action is required.

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 Andrew, 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,

Professor Sir Stephen Powis
National Medical Director