Ms Anita Bhardwaj
Area Coroner
Liverpool and Wirral Coroner's Service
Majella Courthouse
Boundary Street
Liverpool
L5 2QD

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
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SE1 8UG

[redacted]

24 March 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Nicola Emma Owens who died on 5 October 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 31 January 2025 concerning the death of Nicola Emma Owens on 5 October 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Nicola's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Nicola's care have been listened to and reflected upon.

Your Report raises concerns over delays in ambulance attendance due to ambulance unavailability, with this delay being significantly contributed to by handover delays in hospitals. This, in turn, is contributed to by backlogs of patients who are fit for discharge but are awaiting social care packages. I was very sorry to read the Coroner's conclusion that Nicola's death was preventable, and that the unavailability of an ambulance to convey Nicola to hospital for necessary emergency treatment sooner resulted in the terminal cardiac event.

Ambulance response times and handovers

NHS England recognises the significant pressure on all NHS services, including ambulance services, and has been prioritising improvements to Category 2 response times and urgent and emergency care (UEC) services. NHS England also recognises that in order to support improved patient flow, there is the need to improve ambulance capacity through growing the workforce, reducing handover delays, speeding up discharges from hospital and expanding new services in the community.

NHS England's regional teams are continuing to work closely with commissioners, Integrated Care Boards (ICBs), acute NHS providers and ambulance services to implement plans to continue to improve patient handovers. The 2025/26 Priorities and Operation Planning Guidance sets out that the NHS should improve ambulance response times and Accident and Emergency waiting times compared to 2024/25, and that Category 2 ambulance response times should not average more than 30 minutes across 2025/26. The guidance also sets out some immediate tasks for 2025/26,

including to reduce avoidable ambulance dispatches and conveyances and reduce handover delays.

The NHS is working more closely with local authorities to improve timely discharge of patients and has developed discharge metrics to monitor performance improvements.

Patients being rehabilitated into the community

NHS England recognises that delayed discharges have a significant impact on hospital flow, capacity and ambulance handovers. In order to address this, NHS England is strengthening the use of Discharge Ready Date (DRD) data in order to gain a clearer understanding of discharge delays and their key contributing factors.

The aim of embedding DRD in operational decision-making is to:

- Identify and quantify delays at local, regional and national levels, enabling targeted interventions.
- Improve coordination across NHS teams by providing real-time insights, supporting better planning and resource allocation.
- Enhance system-wide decision-making through improved forecasting, ensuring capacity is optimised to facilitate timely discharges.

The use of this data-driven approach is helping to improve patient flow, reduce hospital pressures, and ensure that patients who are medically ready for discharge can transition safely and efficiently.

NHS England has also published the 2025/26 Better Care Fund (BCF) policy framework and planning requirements, working alongside the Department of Health and Social Care (DHSC) and Ministry of Housing, Communities and Local Government. The BCF framework supports local systems to jointly agree plans across health and care, including supporting the flow of patients through UEC.

For 2025/2026, changes in funding include:

- The NHS minimum contribution to Adult Social Care, which is one of the mandatory funding streams within the BCF, will increase by 3.9%.
- The Discharge Fund, which is £1 billion for 2024/2025, has been embedded within the NHS minimum contributions to allow systems greater local flexibility in how they utilise this funding to address flow issues.

NHS England will be working with local areas to support them to maximise the impact of this investment over the coming year, by providing additional or enhanced support to those areas which face particular challenges, and working with partners in local government and social care including Local Government Associations, Directors of Social Services, and Care and Health Improvement advisors to support local systems to improve timely discharge of patients.

My regional colleagues from the North West were also asked to review your Report. They have advised that the Integrated Health and Social Care Programme in North Mersey is focusing on three main workstreams, to improve UEC services. These are outlined below.

1. **Admission and Attendance Avoidance**

There is specific focus in the workstream to reduce the need for North West Ambulance Services (NWAS) to convey patients to hospital, by increasing the use of services in the community, NHS 111 and other dispositions. NWAS, Mersey Care NHS Foundation Trust (MCFT), the local authority and the University Hospitals of Liverpool Group are working collaboratively to embed a Single Point of Access using NHS England's framework. A Single Point of Access is intended to simplify access to services by offering clinicians advice and guidance to support onward referral, ensuring patients get the right care for their needs quickly and safely, and to improve patient outcomes regardless of where they present.

There is also work underway to reduce ambulance handover times and increase the number of streaming options away from the emergency department and into services across acute hospitals. There has been difficulty consistently utilising Frailty Units, Same Day Emergency Care Services as well as other services due, to operational pressures. Work supported by Emergency Care Improvement Support (ECIST) and the Advancing Quality Alliance (AQuA) with the acute trust will help to improve access to services and reduce ambulance turnaround times. There have been significant improvements in recent ambulance turnaround times, partly due to additional corridor and surge capacity being made available on the two sites.

The revised Frailty Plan forms part of Volume 2 of the North Mersey Urgent and Emergency Care Programme. This plan focuses on using falls and frailty services in the community to reduce the need to convey patients to hospital and to contribute to greater availability of NWAS emergency vehicles when needed.

2. **Acute Length of Stay**

There is a focus on ward processes to help reduce internal delays, reducing the length of time patients stay in hospital and creating capacity and flow out of the emergency department, which all contribute to reducing ambulance delays.

3. **Acute Discharge**

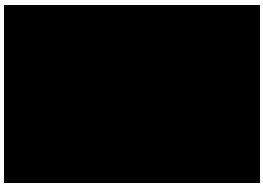
This is focusing on operational issues such as long length of stay or no criteria to reside issues relating to patients needing onward care, and is working to improve the utilisation of different discharge pathways, decreasing the over-reliance of pathway 3 bed capacity in community care (for those with the highest level of complex needs, who require discharge to a care home placement).

Each of the above workstreams have had an impact on increasing flow through the Emergency Department for patients who require a hospital admission, and the programme is currently being revised with a greater emphasis on prevention, in line with national policy. This will be presented to the UEC Programme Board for sign off. NHS England have asked regional colleagues for the date in which this sign off is expected to happen and are awaiting a response. NHS England can undertake to update the Coroner on this in due course.

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 Nicola, 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,



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National Medical Director