NHS England

Mrs Catherine Wood
HM Assistant Coroner
North East Kent
Coroner Service Team
Cantium House
Sandling Road
Maidstone
ME14 1XD

[redacted]

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

[redacted]

28 March 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Dorothy Lilian Reid who died on 3 April 2024

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 4 February 2025 concerning the death of Dorothy Lilian Reid on 3 April 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Dorothy's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Dorothy's care have been listened to and reflected upon.

Your Report raises concerns over long waits and availability of beds at Emergency Departments (EDs) and the risks these present to future deaths. You also raised that beds were being blocked by patients who were medically fit for discharge, along with the concern that the long waits could deter some patients from attending EDs.

NHS England's work to improve 4-hour performance

NHS England recognises the significant pressures on all NHS services and, in January 2023, published a two-year Urgent & Emergency Care (UEC) Recovery Plan. The plan prioritised improvements to the 4 hour standard in Emergency Departments (ED) 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 treatment in EDs within 4 hours compared to 2022/23.

NHS England will continue to work through the operating model and assist its Regions with supporting providers to reduce crowding in EDs. In the longer term, NHS England hopes to eliminate this by focusing on reducing the number of patients that wait longer than 12 hours in EDs. Improvements are being demonstrated through NHS England's operational planning guidance, where systems were asked to focus on areas to deliver improved patient flow such as increasing the proportion of patients streamed to alternative services such as urgent treatment centres (UTCs), same day emergency care (SDEC) and acute frailty services (AFS). This includes increasing the productivity of acute and non-acute hospital services, improving flow as well as clinical outcomes.

Improvements to patient discharge

NHS England recognises the significant impact that delayed discharges have on hospital flow, ambulance handovers and the patients affected by these delays. To address this, we are strengthening the use of Discharge Ready Date (DRD) and Reason for Discharge Delay (RfDD) data to gain a clearer understanding of discharge delays and their key contributing factors, both locally and nationally, so that measures can be taken to reduce the number of patients occupying beds who are ready for discharge.

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

For 2025/26, 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 (£1 billion for 2024/25) that was previously ringfenced has now been embedded within the NHS minimum contributions to allow systems greater local flexibility in how they utilise this funding to address flow issues.

Over the coming year we will be working with local areas to support them to maximise the impact of this investment, for example by providing additional or enhanced support to those areas which face particular challenges, and working with partners in local government and social care including the Local Government Association (LGA), Directors of Social Services (DASSs) and Care and Health Improvement advisors (CHIAs) to support local systems to improve timely discharge of patients.

Ongoing work to reduce long waits for patients in A&E and for those waiting to be discharged

NHS England has commenced a data collection of patients experiencing long waits in Emergency Departments on a daily basis and will ensure actions are in place to appropriately accommodate these patients as soon as possible. The data is discussed at the National Coordination Centre call, with actions tracked to ensure executive oversight and assurance as well as patient safety and harm reviews of/for patients waiting.

In addition, to reduce the number of very long discharge waits, we have been collecting weekly data to identify the number of patients waiting over 100 days and will ensure actions are being taken through system leadership to enable patients to be discharged to the most appropriate setting as soon as possible. The patients identified as waiting over 100 days will be discussed at a weekly National Coordination Centre call, and themes will be tracked through weekly regional engagement meetings.

Regional / Local work to reduce long A&E waits

East Kent have seen a small improvement in the total number of beds being occupied by patients who longer meet the criteria to reside ('No Criteria To Reside'), from 17.5% of beds in April 2024 to 16.9% in January 2025. They are currently in the process of developing a new plan to reduce their greater than 12 hour waits in the ED.

NHS England's South East region has undertaken Quality & Safety visits to EDs across the region to understand the challenges faced in delivering safe and effective care. This has identified next steps, to include sharing learning and best practice, and ensuring a quality and safety focus on performance recovery and improvement.

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 Dorothy, 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