Ms Jyoti Gill
HM Assistant Coroner
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

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

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14 May 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Winnie Harrop who died on 16 August 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 19 March 2025 concerning the death of Winnie Harrop on 16 August 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Winnie's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Winnie's care have been listened to and reflected upon.

Your Report raised a concern around there being no clear guidance between health and social care as to the circumstances in which it is appropriate to send a patient back to a care home following a hospital admission. You also raised that Winnie's discharge letter failed to refer to the level of sedation provided or that there was a new oxygen requirement. This particular concern falls outside of NHS England's remit and should be raised locally with Tameside and Glossop Integrated Care NHS Foundation Trust, should the Coroner require any further information beyond what is set out in this response.

My response to the Coroner has been aided by engagement with NHS England's National Clinical Director for Older People and our North West Regional Teams.

The safe discharge of older people with frailty should always be a bespoke process, depending on the specific context of both the patient and the place of residence. NHS England would discourage blanket discharge policies which address the responsibilities of care homes. There is substantial variability within the sector as to the competencies and equipment staff hold. However, when handing over care to any other care setting, including care homes, the correct policy should be that diagnosis, prognosis and future management are communicated by the discharging organisation. In the case of care homes, where competencies are not always straightforward and cannot be taken for granted, future management should not just be communicated but agreed with the duty manager for the home. If the home cannot meet the patient's needs, as would seem to be the case in this instance, then it is incumbent for the NHS to continue to provide care.

The Department of Health and Social Care (DHSC), to whom your Report is also addressed to, has published statutory guidance on how health and care systems should support the safe and timely discharge of patients from hospital, which includes guidance on care homes. The guidance was last updated in January 2024. The guidance and supporting documentation can be found here: Hospital discharge and community support guidance - GOV.UK.

My colleagues from the North West region have been in contact with Tameside and Glossop Integrated Care NHS Foundation Trust, who have advised us that there is currently no Standing Operating Procedure (SOP) in place for discharges from the Emergency Department (ED). However, where any patients are being returned to a care home, the home are contacted and updated on all events that have occurred in the ED and staff ensure completion of a 'Return to 24 hour care' form', which includes sections for interventions, results, treatments given and a plan. This form does not currently have any dates or version control, however the Trust have confirmed it is being updated and will include version control and review dates. Changes are expected to be approved by the Trust's Quality and Safety Meeting later in May 2025.

The Trust advise that all patients have a discharge summary completed which outlines all key points of their hospital attendance and the management of their care during their admission within the ED. In addition, the Trust is currently reviewing and updating the safe sedation policy to include input from the ED. As per the Trust's Patient Safety Incident Investigation (PSII) action plan, the immediate deployment in the ED of the Royal College of Emergency Medicine (RCEM) Guideline for Procedural Sedation in the Emergency Medicine (2024) has been completed. The Trust's policy reflect the RCEM guidance.

As additional oversight, there are weekly discharge planning meetings that take place which include representation from social care in terms of appropriate management of discharges back to 24-hour care/care homes. There has been a meeting held with informatics to review discharge letters and discharge checklists and further work is ongoing, which will be presented to a Working Group to improve.

We understand that the Coroner was satisfied with the Trust's action plan from the PSII that took place.

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 Winnie, 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