



Department
of Health &
Social Care

██████████
Minister of State for Health (Secondary Care)

39 Victoria Street
London
SW1H 0EU

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HM Coroner Alan Anthony Wilson
Blackpool & Fylde Coroner's Office,
Municipal Buildings,
Corporation Street,
Blackpool,
FY1 1GB
████████████████████

22 May 2026

Dear Mr Wilson,

Thank you for the Regulation 28 report of 9th February 2026 sent to the Secretary of State / the Department of Health and Social Care about the death of Janet Springall. I am replying as the Minister with responsibility for Health.

Firstly, I would like to say how saddened I was to read of the circumstances of Janet Springall's death and I offer my sincere condolences to their family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

The report raises concerns over the continued pressure experienced in the emergency department in Blackpool Teaching Hospital NHS Trust causing patients to remain in ambulances despite needing immediate care within the department.

In preparing this response, my officials have made enquiries with NHS England and Blackpool Teaching Hospital NHS Trust to ensure we adequately address your concerns. CQC have advised they will be providing a separate response to your concerns.

DHSC and NHS England Actions

NHS England and the Department of Health and Social Care recognise the ongoing pressures across urgent and emergency care, including ambulance services. To improve the quality and timeliness of patient care, the Department of Health and Social Care and NHS England published the 2025/26 Urgent and Emergency Care Plan (June 2025), the Medium Planning Framework 2026-27 to 2028/29 and the 10-Year Health Plan for England: Fit for the Future (July 2025). These set out key system priorities:

- reducing ambulance response times
- eliminating handover delays over 45 minutes and ending corridor care
- improving hospital flow and discharge

- expanding urgent care access across primary, community, and mental health settings

Over £370 million in national capital funding supported these improvements. The plans also commit to shifting focus from treatment to prevention, reducing pressure on urgent and emergency care. To ensure timely patient care and release ambulances back into the community, the plan mandates the “Release to Rescue” approach. This requires the handover process to begin at 30 minutes and be completed by 45 minutes.

NHS England continues to work with ICBs, acute trusts, and ambulance services to deliver the 45-minute maximum handover requirement, strengthen urgent community care, and improve hospital flow and discharge. Risks associated with long community waits for ambulances are regularly discussed at national forums to support shared understanding and coordinated action across the urgent and emergency care system. The Medium-Term Planning Framework (2026/27–2028/29) sets further ambitions for acute and ambulance collaboration, including progress toward the 15-minute handover standard.

Local Actions

Following the sad death of Ms Springall a Patient Safety Incident Investigation (PSII) involving North West Ambulance Service (NWAS) was conducted by Blackpool Teaching Hospitals NHS Trust (BTHT) under the Patient Safety Incident Framework.

The investigation highlighted Ms Springall’s attendance at the emergency department via ambulance transfer during a period of extreme pressure with the Trust was operating at OPEL 4 and ambulance handover escalation protocols should have been activated. Investigation findings noted that although Ms Springall presented with significant risk factors, the triage assessment was inaccurate, did not acknowledge her recent admission, and did not consider sepsis despite Trust guidance requiring this on presentation. The report highlighted the following key findings:

- Missed opportunities: Sepsis screening was not completed, escalation to a senior decision-maker (SDM) did not occur, and there was no clear patient ownership while she waited without a physical ED bed space.
- Documentation gaps: The triage nurse’s retrospective statement lacked detail, and escalation actions were unclear.
- Significant delays in assessment and treatment occurred.

In response to the findings BTHT have:

- Implemented the maximum ambulance handover time of 45 minutes, with a review to confirm embedding of policy scheduled for April 2026.
- Additional training and education has been delivered to all ED nursing staff in recognising sepsis and the sepsis pathway.

- The Trusts Learning Disabilities Team now regularly attends ED safety days highlighting the importance of obtaining history from families.
- The ICB has overseen the implementation of a range of national and regional initiatives across Lancashire and South Cumbria Trusts with the aim to reduce the incidents of people being held outside EDs as a result of crowding with the departments and through the hospitals.

The introduction of 'Handover 45' is a significant change from previous policy that outlined an escalation period at 8 hours. Work to reduce the current variation in compliance with Handover 45 is in place at site, trust, place and system, levels with oversight of progress via the UEC governance structures including Strategic Ambulance Improvement Group reporting into the Strategic System Improvement Group.

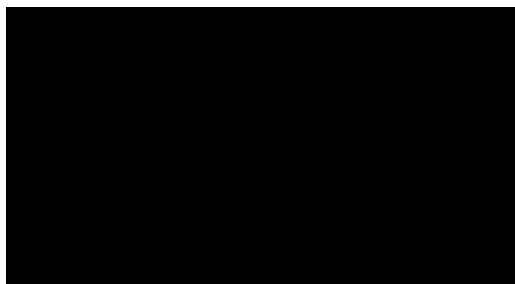
There are UEC improvement plans in place across all Place and Trust teams that describe how local schemes relating to the improvement of flow lead to the delivery of the ICB's UEC strategy. BTHT has been in Tier 1 for UEC since August 2025, requiring fortnightly reporting to NHS England on UEC performance improvements. As a result of being a Tier 1 site, they have benefitted from Getting It Right First Time UEC on-site clinical and operational improvement resource.

In addition, the Regional Head of Learning Disability & Autism has confirmed that the 'Learning from Lives and Deaths- people with a learning disability and autistic people' (LeDeR) review for this case is underway and is focusing on learning around:

- Journey prior to hospital admission – signs of deterioration, actions taken, support in the community
- Reasonable adjustments / support while waiting (during conveyance to A&E and within A&E)

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,



MINISTER OF STATE FOR HEALTH