Mr Andre Rebello
Senior Coroner
Liverpool and the Wirral Coroner's Service
Gerard Majella Courthouse
Boundary Street
Liverpool
L5 2QD

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

[redacted]

13 September 2023

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Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Stephen Norman Richardson who died on 28 September 2019.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 22 June 2023 concerning the death of Stephen Richardson on 28 September 2019. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Stephen's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Stephen's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused to Stephen's family or friends. I realise that responses to Coroner Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones and appreciate this will have been an incredibly difficult time for them.

In your Report you raised the concern that there was a national shortage of acute psychiatric beds to treat patients in urgent need of immediate mental health assessment and care as an inpatient, and that the situation has not improved since Stephen's death.

Mental health services have long been under significant pressure and there has recently been a 30% increase in referrals to community services since before the Covid-19 pandemic. NHS urgent and emergency care (UEC) are also treating record numbers of patients, while delays in discharging patients who are clinically ready to be discharged from hospital is affecting how quickly patients can access local mental health beds.

In some local areas there is a genuine need for more beds, however, this should always be considered as part of whole system transformation to reduce overall reliance on hospital-based care. This is supported by the NHS Long Term Plan (LTP), which committed to an additional £2.3bn funding invested in to mental health services from 2019/20 – 2023/24. Around £1.3bn of that funding is for adult community, crisis and acute mental health services to help adults get quicker access to the care they need and prevent avoidable deterioration and hospital admission.

NHS England is also investing £36m over three years to improve the quality of mental health, learning disabilities and autism inpatient settings. This includes a culture of care improvement programme which is being co-produced with patients, carers and families with lived experience. The programme is identifying opportunities to strengthen family/carer voice in patient care, including risk management of suicide and self-harm, and safety planning.

NHS England has also engaged with Cheshire and Merseyside Integrated Care Board (CM ICB) regarding Stephen's case.

The incident was reported to Liverpool Clinical Commissioning Group (LCCG) as a Serious Incident (SI) in 2019 in line with The Serious Incident Framework (2015) and was subsequently investigated by Mersey Care Foundation Trust (MCFT) and Liverpool University Hospital Foundation Trust as part of a joint investigation. A Route Cause Analysis (RCA) was undertaken with a subsequent action plan being produced to acknowledge and support required learning/improvement. The action plan incorporated several actions linked to safer bed management and patient placement with sufficient assurance being provided by the relevant Trusts.

The Trust actions linked to bed management are:

- Ensuring all staff are aware of the correct process to follow when Mental Health Assessment is required. Confirm and reinforce with staff how practitioners can be supported to manage risk in the community where beds are unavailable, but risk is considered high.
- To ensure that the process for escalation is reflected in the appropriate Trust policy, whether that be the Crisis Resolution Home Treatment Standard Operating Procedure or an alternative document so that practitioners are clear on how they can ensure that bed managers are aware of their opinion that priority should be given for a Patient for admission.

From a CM ICB perspective wider bed management/availability issues are being continually addressed. Both locally and nationally there remains constant pressure on acute psychiatry bed availability. In Liverpool, work continues to be undertaken with system partners within the MCFT footprint to transfer those clinically ready for discharge in a safe and timely manner to free up acute psychiatric bed capacity. Work is also being undertaken at ICB level around delays.

I would also like to provide further assurances on national NHSE 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 preventable deaths are shared across the NHS at both a national and regional level and helps us 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,

[redacted]
National Medical Director