Andrew Bridgman
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

[redacted]

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

[redacted]

9 November 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Lauren Elizabeth Bridges who died on 26 February 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 19 September 2023 concerning the death of Lauren Elizabeth Bridges on 26 February 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Lauren's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Lauren's care have been listened to and reflected upon.

In your Report you raised concerns over underfunding of local mental health beds and the mental health impact of Out of Area (OAP) placements and an over-reliance by the NHS on independent providers. You also raised the issue of inadequate and insufficient communication between the Trust, independent provider and other relevant parties, the challenges that can be posed by having separate NHS commissioning bodies, and the need for protocols/standardised operating procedures to avoid delayed discharge from OAPs/Psychiatric Intensive Care Units (PICUs).

The NHS remains committed to eliminating the practice of adult acute Out of Area Placements. All Integrated Care Boards (ICBs) were asked to work towards eliminating the practice in NHS England's 2023/24 Priorities and Operational Planning Guidance. An ICB is a statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services within a given geographical area. They replace clinical commissioning groups (CCGs), taking on the NHS planning functions previously held by CCGs, as well as absorbing some planning roles from NHS England.

While good progress was being made ahead of the Covid-19 pandemic in eliminating the practice of OAPs, the subsequent increase in prevalence of mental health problems against the backdrop of an existing treatment gap has made this even more difficult.

Further, while the level of NHS investment in mental health services is higher than ever before and investment targets are being met nationally, pressures on both community and inpatient services remain very high.

In July 2023 NHS England published renewed guidance to support the commissioning and delivery of timely access to high quality therapeutic inpatient care, close to home and in the least restrictive setting possible. Key to this are the principles of: timely and purposeful admissions that are local, timely discharge, joined-up care and continuous improvement.

To implement this, all ICBs have been tasked with developing 3-year plans to localise and realign inpatient mental health care, including care provided by the Independent Sector, as part of the mental health, learning disability and autism inpatient quality transformation programme launched in 2022. Health and Care systems across England are currently being supported to operationalise the guidance via 3-year plans with direct support from regional and national teams. The transformation programme is underpinned by a £36 million investment.

NHS England recognises the critical importance of strong commissioner oversight and joint working in inpatient mental health care, and as such has made it a requirement that these 3-year plans be co-produced – including with patients, families and their carers.

We are also currently engaging on how the roles and responsibilities for commissioning and assuring the quality of mental health, learning disabilities and autism inpatient care across the NHS and the independent sector can be strengthened, with a view to embed learnings and best practice in National Quality Board policy and governance frameworks from 2024 onwards.

My regional colleagues in charge of quality of care in the South West have also engaged with Dorset Healthcare University NHS Foundation Trust ('the Trust') on the matters raised in your Report. The Trust have acknowledged that there were missed opportunities in Lauren's care, and I understand have written to Lauren's family separately to express their regret. They have also provided NHS England with assurances that actions have been taken to address the identified learnings. These actions have included:

- Reviewing all standard operating procedures
- Improving the way we engage and communicate with providers and families
- Better care co-ordination and involvement of local teams to address our patient's clinical needs and plans for repatriation.
- Improved data and oversight including regular auditing of care arrangements.
- Appointment of an out of area co-ordinator and a programme of quality assurance of providers used by the Trust.

The Trust advises that the work is resulting in improvements and a reduction in the time patients are receiving care outside of area, where there is no clinical need. They have also secured planning permission to rebuild some of their mental health inpatient facilities and increase the availability of PICU for adults and younger people. Subject to business cases and plans being agreed, they hope to have new facilities in 2026. In the shorter term they have also taken the opportunity of using winter monies to create a discharge and flow team for mental health and have recently appointed a Consultant Psychiatrist to provide clinical leadership to this team.

The Trust now has a formal arrangement with Marchwood Priority in Southampton, for those occasions where an OAP may still be required based on clinical need and due to capacity. Marchwood Priory is geographically one of the closest providers to Dorset, which hopefully improves the chances of families being able to visit and maintain contact.

I would also like to provide further assurances on 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 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,

National Medical Director