Professor Fiona J Wilcox
Westminster Coroner's Court
65 Horseferry Road
London
SW1P 2ED

[redacted]

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

[redacted]

30 April 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Adrian Michael James who died on 21 June 2021

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 7 March 2024 concerning the death of Adrian Michael James on 21 June 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Adrian's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Adrian's care have been listened to and reflected upon.

NHS England recognises the need to improve community mental health services to ensure high quality care and support can be accessed in a timely way. This is underpinned by commitments set out in the NHS Long Term Plan to improve community mental health, so people receive the support that they need to help them stay well.

All local areas have received funding to develop and begin delivering new models of care that integrate primary care and community mental health services for adults with severe mental health problems, with care provided to at least 370,000 adults per year nationally.

These models of care will give people greater choice and control over their care. They will also improve access to a range of interventions and support, including psychological therapies, physical health care, employment support, medicines management and support for self-harm and coexisting substance use, with care increasingly personalised and trauma informed. The new models should also ensure appropriate links are made with other mental health services, for example inpatient and crisis services, to ensure patients have a seamless experience of care and that their needs can be met in the most appropriate setting.

It is not within NHS England's remit to respond to the specific concerns set out by the Coroner in your Report and it is appropriate that Central and North West London NHS Foundation Trust ("the Trust") respond to these. We understand you have also directed your Report to the Trust to respond to your concerns. NHS England has been asked to be sighted on the Trust's response to you and will carefully consider this.

Your Report and concerns have also been shared with and considered by NHS England's national Mental Health Team.

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,

[redacted]
National Medical Director