NHS England

Ms Sarah Murphy
Assistant Coroner for the area of Cheshire
The West Annexe
Town Hall
Sankey Street
Warrington
Cheshire
WA1 1UH

[redacted]

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

[redacted]

15 July 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Emma Louise Morris who died on 20 September 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 21 May 2024 concerning the death of Emma Louise Morris on 20 September 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Emma's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Emma's care have been listened to and reflected upon.

Your Report raises concerns over the national shortage of inpatient mental health beds and the risk of future deaths if people cannot access them at the time of clinical need. In Emma's case, she had been assessed as requiring an inpatient hospital admission to a mental health ward, and she had agreed to an informal admission, but there were no beds available nationally within the NHS or privately at that time.

The number of mental health beds required to support a local population is dependent on both local mental health need, and the effectiveness of the whole local mental health system[1] in providing timely access to care and supporting people to stay well in the community, therefore reducing the likelihood of an admission being necessary.

In some local areas there is a need for more beds. This is being addressed in part through investment in new units but should also be considered as part of a whole system transformation approach.This is supported by the NHS Long Term Plan (LTP), which is seeing an additional £2.3 billion funding being invested in mental health services from 2019/20 – 2023/24, around £1.3 billion of which is for adult community, crisis and acute mental health services to help people get quicker access to the care they need, and to prevent avoidable deterioration and hospital admission. NHS England's 2024/25 priorities and operational planning guidance reinforces this focus on improving patient flow as a key priority, with systems directed to reduce the average length of stay in adult acute mental health wards, in order to deliver more timely access to local beds.

[1] NHS England » What are integrated care systems?

To address the wider system issues that impact on health services, a further £1.6 billion has been made available via the Better Care Fund ('BCF') from 2023-25. This funding can be used to support mental health inpatient services as well as the wider system, which should help to reduce pressures on local inpatient services so that those who need to access beds can do so quickly and locally.

My colleagues within the central Medical Directorate are also seeking further information from the North West region, in respect of Cheshire and Merseyside Integrated Care Board's system arrangements for mental health beds.

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 Emma, 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,

[redacted]

National Medical Director