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29 July 2024

**Private & Confidential**
Priya Malhotra
Assistant Coroner for Inner West London
Inner West London Coroner's Court
33 Tachbrook Street
London
SW1V 2JR

Our internal Reference: [redacted]

Dear Madam

**Re: Regulation 28 Report to Prevent Future Deaths – Mr Juan David Martin**

We are writing to you following receipt of the Regulation 28: Report to Prevent Future Deaths (PFD) dated 11 June 2024 (received on 13 June 2024), regarding the sad death of Mr Juan David Martin.

You have requested that South West London and St George's Mental Health NHS Trust (SWLStG) and NHS South West London Integrated Care Board (SWL ICB) respond to the matters of concern that you have detailed in your correspondence.

We have taken a joint approach exploring the matters of concern and provided responses below including actions we are taking and how we will work together to improve.

We thank you for your consideration and commitment to the prevention of future deaths and helping us to learn.
We would like to express our deep sympathy to the family and friends of Mr Martin for their loss. While we seek to make improvements within the Trust and local system to help ensure we are able to provide the necessary bed provision, we recognise that this cannot diminish their pain and anguish.

The Trust and ICB remains committed to continuous learning and improvement and we are very grateful for all those involved in the Inquest.

Sincerely

[redacted]

[redacted]

**Chief Executive Officer**
South West London and St George's Mental Health NHS Trust

[redacted]
**Chief Executive Officer**
South West London ICB

**Bed capacity: Matter of Concerns and Actions**

The **MATTERS OF CONCERN** are as follows:

(1) Juan Martin was held informally on 7 April 2022 and following a mental health assessment on 11 April subsequently became liable for detention. He therefore spent 6 days in the Lotus Assessment Suite. Witnesses confirmed that no suitable bed was identified until approximately after 15:00 on 12 April 2022, which then became unavailable.

(2) The Matron in Acute and Urgent Care confirmed bed capacity remains an ongoing problem and has not been resolved. The Matron provided one recent example where a patient waited for 7 days in the Accident and Emergency Department for a mental health bed.

(3) The Matron added there was an exceptional process which required a considered decision at a high level to make a bed available through identifying someone currently occupying a bed space to be discharged and that the 'flow' of patients being discharged or moving to another setting amplified the bed capacity issue.

Based on the evidence heard, my principal concern is that bed capacity in London remains inadequate. Whilst some action may have been taken by the Trust to better triage the need for beds it is insufficient to resolve the problem. It follows there is a genuine risk of future deaths directly connected to a shortage of mental health bed spaces in London unless further action is taken.

**South West London and St George's Mental Health NHS Trust - Response**

The Trust (SWLStG) fully acknowledges the concern regarding insufficient bed capacity in London and the reason why the Coroner has cause to raise these concerns.

SWLStG recognises this as a key risk to patient safety, which is fully captured and articulated within our Board Assurance Framework, and we are working to mitigate the risk as far as possible. We note, as has the Coroner, that this is not fully within our control due to the increasing complexity and level of demand for acute mental health services and the constraints on funding and resources to provide acute mental health beds. Where appropriate and available, we seek acute mental health beds in the private sector, but with a recognition that this is not always in the best interest of the patient as these admissions can be remote from a patient's local support networks and disconnected from their broader NHS care.

As part of our integrated transformation programme, we have implemented a range of projects aimed to improve acute mental health patient flow and bed access, including:

- Discharge planning best practice implementation in line with NHS guidance (100-day discharge challenge; 10 high impact interventions; ward workflows project).
- Collaborative discharge and flow work with Local Authority partners through the Strategic Operational Interface Programme.

- Revised and strengthened our Bed Management Policy, including additional actions at higher levels of escalation, and moved to real-time electronic bed status and waiting list management.
- Embedded a clinical prioritisation tool into our acute flow management process to ensure that patient safety and risk is foremost in allocating limited bed capacity. This tool has subsequently formed the basis of a London-wide prioritisation scoring tool commissioned by NHSE London and to be adopted by all mental health trusts in 2024.
- Commissioned additional, unfunded private sector acute mental health beds from a local provider, and stepdown hostel beds to support flow.
- Invested significantly into community and crisis prevention services to support patients to remain well in the community and avoid the need for an acute admission, thus helping to also provide more available beds.

Despite this, we appreciate there is still a risk around patients awaiting admission due to the lack of beds and we are undertaking further work in the following areas:

- Intensive support to our acute ward teams to identify barriers to flow and enhance best practice ways of working, with swift but safe discharges.
- Further transformation of our mental health crisis offer, including developing mental health triage and rapid access services to support our local Emergency departments with patients presenting with mental health needs.
- Review of our rehabilitation and mental health supported living settings in partnership with Local Authorities and the South London Partnership for mental health complex care programme, to support improved access to onward care settings.

We would support any further review of the sufficiency of acute mental health beds in South West London and London-wide to meet the increased and more complex demand for these services.

**South West London Integrated Care Board – Response**

SWL ICB recognises the demands and pressures on acute mental health inpatient beds. There are a range of reasons including increased demand, increased acuity of patients and delays caused by people who are clinically ready for discharge but are delayed accessing their onward accommodation.

The ICB is working with SWLSTG and other healthcare providers in South West London to address situations where patients experience delay in all parts of the care pathway. This includes work focused on reducing length of stay and minimising the use of out of area placements. As part of the 2024/25 planning process, ongoing investment was made into commissioning additional beds in the private sector to mitigate the current bed pressures while longer term work on improved patient flow continues.