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

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

[redacted] [redacted]

05/08/2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Amina Ahmed Ismail who died on 15 September 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 14 June 2024 concerning the death of Amina Ahmed Ismail on 15 September 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Amina's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Amina's care have been listened to and reflected upon.

Your Report raises concerns over delayed transfers of out-of-area patients from an independent provider's hospital, who are in need of in-patient mental health care services, along with the number of available mental health beds (including PICU beds) and specialist / rehabilitation units within a patient's local area.

In 2022, NHS England launched the Mental Health, Learning Disability and Autism Inpatient Quality Transformation programme. A core aim of the programme is to localise and realign care, harnessing the potential of people and communities. The programme is built upon the cornerstones of good mental healthcare; continuity of care, therapeutic relationships and a relentless commitment to mental health care meeting the needs of all citizens.

To support this aim, NHS England published the Commissioning Framework for Mental Health Inpatient Services in early 2024 and introduced a requirement in its Operational Planning Guidance (2024/25) that each Integrated Care Board (ICB) develop and publish a 3 year plan to localise and realign care to the evidence-base summarised in the Framework. Local plans need to cover within them how they will cease the practice of sending people to inpatient services at a distance from their home and/or to outdated or risky models of provision – underpinned by the philosophy that 'all means all', and people with acute mental health needs should have access to the evidence-based therapeutic offers they need as close to home as possible and adjusted to their needs. This includes acute and rehabilitation inpatient services. Final ICB plans are due for publication, and £42 million recurrent funding has been provided to ICBs to support delivery.

This sits alongside work focused on improving the culture of inpatient services. In 2024, NHS England launched a universal Culture of Care Improvement Programme,

partnering with the National Collaboration Centre for Mental Health and the Foundation of Nursing Studies (as well as a consortium of other organisations). The Improvement Programme includes six support offers which all NHS and major Independent Sector providers have subscribed to. These include a Ward Manager Development Programme, support on personalised risk and safety planning, and a universal Staff Support Offer. The Culture of Care Improvement Programme is based upon co-produced Culture of Care Standards for Mental Health Inpatient Services, where the purpose of inpatient care is for people to be consistently able to access a choice of therapeutic support, and to be and feel safe.

We have also contacted our regional colleagues in the North West who have engaged with the Greater Manchester Integrated Care Board (GM ICB), who have oversight of The Priory Cheadle. The Stockport Safeguarding Partnership Board and Stockport Locality Group have had full oversight of the learnings from Amina's care and a Serious Adult Review is in progress. GM ICB's oversight currently includes:

- Monthly assurance visits that take place to review key lines of enquiry, looking at metrics and a key focus for that month.
- Bi-monthly relationship meetings with the hospital director.
- The Priory is involved in system deep dive work.
- Monthly catch ups with the Local Provider Collaborative to ensure triangulation of intelligence.
- Escalation of support around patients who are medically optimised and ready for discharge.

My regional colleagues in the Midlands have also been made aware of this case, and we note that Birmingham and Solihull Integrated Care Board, and the providers involved in Amina's care, are named as interested parties in your Report.

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 Amina, 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