Courts and Tribunals Judiciary

RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

When a coroner sends a prevention of future deaths (PFD) report to a person or organisation, they must respond within 56 days. Recipients of a PFD report can apply to the coroner for an extension. A response to a PFD report must detail the action taken or to be taken, whether in response to the report or otherwise, or it must explain why no action is proposed.

The purpose of the response template below is to promote clarity, ensure that responses address the coroner's concerns directly and transparently, and support consistency and good practice across organisations and sectors. It does not restrict how a person or organisation formulates their response; recipients remain responsible for determining what action is appropriate and for ensuring that their response accurately reflects the steps taken or planned.

In accordance with the Chief Coroner's PFD Publication Policy (2026) representations regarding publication of a response should be sent to the coroner. These representations should be made at the same time as the response is provided. The coroner will pass any representations received to the Chief Coroner for a decision

	RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS **REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013** (Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026)) THIS RESPONSE IS BEING SENT TO: HM **SENIOR/AREA/ASSISTANT** Coroner **Louise Hunt** for Birmingham and Solihull in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28'** following an inquest into the death of Elsie Margaret Jones that concluded on 7th May 2026**.**
1	**RESPONDENT** In line with our duty under Regulation 28 of the Coroners (Investigations) Regulations 2013, Birmingham and Solihull ICB provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths
2	**DATE OF RESPONSE** 2nd July 2026

3	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report as follows: The coroner highlighted that patients with severe dementia who require specialist placements are experiencing prolonged delays in hospital while funding approvals and suitable placements are secured. During these extended stays, the acute ward environment is not always able to provide the level of supervision required, increasing the risk to these patients. The coroner expressed concern that these systemic delays in both funding and placement availability create an ongoing risk of harm and potential future deaths, and that action is required to address this.
4	**DETAILS OF ACTION TAKEN**, how has the concern been addressed. (If no action is proposed please explain why here) Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. • A system-wide integrated escalation framework has been established across health and social care to ensure timely identification and resolution of delays. This includes the routine escalation of patients experiencing extended lengths of stay, specifically those exceeding 7, 14 and 21 days, through structured long length of stay reviews within both acute and community bedded settings. These reviews bring together multidisciplinary and multi-agency teams to identify barriers to discharge, agree clear actions, and expedite decision-making relating to funding, placement, or care provision. This coordinated approach strengthens joint accountability, ensures that complex cases receive appropriate senior oversight, and reduces the risk of unnecessary prolonged hospital admission, thereby improving patient flow and supporting safer, more timely discharge. • Strengthened community-based alternatives through the enhanced utilisation of Urgent Community Response (UCR) services, the development of Pathway 1 (P1) step-up provision, and the implementation of a Single Point of Access (SPA – established November 2025). UCR services now operate to a two-hour response standard, providing rapid clinical intervention in patients' usual place of residence to prevent unnecessary hospital admission and support timely discharge. In addition, P1 step-up pathways have been expanded, enabling patients to be safely managed at home with health and social care support as an alternative to admission or prolonged hospital stay. Access to these services has been streamlined through a Single Point of Access, ensuring timely triage, coordination, and mobilisation of appropriate community services. Collectively, these improvements reduce reliance on inpatient beds, support Home First principles, and contribute to minimising delays in discharge by ensuring that patients can be safely supported in the community at the earliest opportunity. • Development of a sustainable winter resilience plan (2025/2026) which included the provision of additional surge capacity across pre-hospital and community services. This includes increased capacity within community-based teams to support admission avoidance, facilitate earlier discharge, and respond to periods of heightened demand. By strengthening provision upstream of hospital admission and within community pathways,

the system is better able to maintain patient flow, reduce pressure on acute services, and minimise delays in discharge. Delivery of this plan is supported through ongoing monitoring and system oversight to ensure that additional capacity is deployed effectively and continues to meet patient need during peak periods. Winter Resilinec plan for 26/27 is in development.

- The ICB both embodies and facilitates an open and transparent reporting of patient safety events, both within our organisation and across our system. The transparency required for a thorough, candid, and systematic approach to learning and improvement is supported by our quality governance and oversight mechanisms which are embedded across the system. Organisations and across the system has strengthened its approach to learning through the Patient Safety Incident Response Framework (PSIRF) by ensuring that findings from Patient Safety Incident Investigation (PSII) and After Action Reviews (AARs) are consistently shared across all partner organisations, including acute, community, mental health and Local Authority services. The ICB-facilitated system patient safety group ensures that patient safety and the PSIRF framework (Patient Safety Incident Response Framework) is robustly linked to continuous improvement in teams. This approach ensures that where delays in discharge have contributed to patient harm or risk, the contributory factors such as delays in care package provision, funding decisions, or multi-agency coordination are identified and disseminated beyond the originating organisation. Learning is translated into system-wide actions, including improvements to pathway management (P1/P2/P3), escalation processes, and multidisciplinary working, with actions formally tracked through system governance structures. This collective and transparent approach enables recurring themes to be addressed at scale, strengthens joint accountability, and ensures that learning directly informs service improvement, with the aim of reducing delays, improving patient flow, and minimising the risk of similar incidents occurring in future.

- The system has expanded the Same Day Discharge Service to include all community bedded settings. Previously, patients requiring a Pathway 1 discharge experienced delays of up to 2–5 days due to the need for care packages to be brokered prior to discharge. The revised model removes this dependency by enabling immediate discharge with care arrangements put in place on the same day, aligned to Home First principles. This change ensures that all patients entering Pathway 1 can now be discharged within the 24-hour expectation, reducing unnecessary length of stay, minimising the risk of deconditioning associated with prolonged hospital admission, and improving patient flow. The impact of this service change is subject to ongoing monitoring through system oversight arrangements to ensure it delivers sustained improvement in timeliness and safety of discharge.

  The system has strengthened community-based alternatives through the enhanced utilisation of Urgent Community Response (UCR) services, the development of Pathway 1 (P1) step-up provision, and the implementation of a Single Point of Access (SPA). UCR services now operate to a two-hour response standard, providing rapid clinical intervention in patients' usual place of residence to prevent unnecessary hospital admission and support timely discharge. In addition, P1 step-up pathways have been expanded, enabling patients to be safely managed at home with health and social care support as an alternative to admission or prolonged hospital stay. Access to these services has been streamlined through a Single Point of Access, ensuring timely triage, coordination, and mobilisation of appropriate community services. Collectively, these improvements reduce reliance on inpatient beds, support Home First principles, and contribute to minimising delays in discharge by ensuring that patients can be safely supported in the community at the earliest opportunity.

	• Weekly escalation meetings with Local Authority leads provides a structured, system-wide forum for identifying, escalating, and resolving delayed discharge issues requiring Local Authority intervention, ensuring timely patient flow in line with Home First and D2A principles. The objectives of these meetings is to unblock complex discharge delays, enable rapid senior decision making and improve system floe and reduce length of stay, strengthen accountability and ownership, identify and address recurring system barriers and support safe, risk managed discharge decisions. • The system has commenced comprehensive demand and capacity modelling across all Intermediate Care services, with completion scheduled for July 2026. This work will provide a robust, data-driven assessment of current and future demand against available capacity across Pathways 1, 2 and 3, enabling the identification of gaps contributing to discharge delays. The outputs will directly inform system planning and commissioning through the Neighbourhood Health Boards, ensuring that community provision is aligned to population need at a local level. This approach will support targeted investment, optimise the use of intermediate care resources, and strengthen community capacity, thereby reducing reliance on inpatient beds and minimising delays in discharge. • The system monitors delivery of Better Care Fund (BCF) metrics through formal BCF governance meetings, providing a joint forum for health and social care partners to review performance and drive improvement. These meetings oversee key metrics including reduction in delayed discharges, time from Discharge Ready Date to discharge, length of stay, non-elective admissions (65+), and reablement outcomes, in line with national BCF requirements. BCF meetings are attended by Integrated Care Board (ICB) representatives (System Discharge Director, Finance, Commissioning and Informatics), Local Authority leads. acute, community and mental health providers, and wider system partners, with input from finance, commissioning, and operational leads where required. This ensures that discharge performance is reviewed through a multi-agency lens, with shared accountability for delivery across the system. Through this forum, partners agree and monitor locally defined trajectories for improvement, challenge areas of underperformance, and implement corrective actions. This structured approach strengthens oversight, transparency and joint ownership, ensuring that discharge delays are actively managed, and that patients awaiting discharge continue to receive safe, coordinated, and high-quality care while system-wide improvements are delivered.

5	**DETAILS OF FURTHER ACTION PROPOSED** Please *note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.* • A model of developing 'Anchor Contracts' model is being established, with University Hospitals Birmingham (UHB) accountable to the ICB. This provides devolves more of the budget for the urgent care pathway to one organisation allowing a more co-ordinated repose. As part of that contract the intention is to standardise the approach to areas such as Single Points of Access to provide a consistent offer for both patients and professionals in organisations such as West Midlands Ambulance Service. To support this delivery, a Neighbourhood Health Board is being implemented to provide clear oversight, assurance, and escalation across system partners. In its first year, the Board will focus on driving integration and service transformation at both system and locality level, working with existing commissioned providers to strengthen key interfaces that impact patient flow. This work will be delivered by the Neighbourhood Health Group, reporting into the Neighbourhood Health Board and includes urgent and emergency care pathways, intermediate care services (including step-up, step-down and discharge pathways), neighbourhood health provision (such as Single Point of Access, Urgent Community Response and discharge coordination), and long-term condition management. This structured governance approach will improve alignment across organisations, enable timely escalation of risks, and support the development of more responsive, community-based services, thereby reducing delays in discharge and improving patient outcomes. • A programme of work has commenced to transform the Transfer of Care Hubs (ToCH) and Bed management teams in line with NHS England national guidance and action cards. This programme, being delivered in partnership with the Neighbourhood Health Group, is focused on developing a fully integrated, system-wide coordination function, bringing together health, social care, and community partners into a single, aligned model. The transformation aims to strengthen multidisciplinary working, improve real-time oversight of patients awaiting discharge, and ensure timely escalation and decision-making across pathways. This integrated approach will enhance coordination across services, reduce fragmentation at key interfaces, and support more timely and effective discharge planning, thereby minimising delays and improving patient flow across the system. • The system has undertaken comprehensive demand and capacity modelling across all intermediate care pathways, with completion expected in July 2026. Once complete, this will provide a robust, system-wide understanding of current capacity, demand pressures, and variation across Pathways 1, 2 and 3. The outputs will be used to identify commissioning gaps and inform targeted service redesign, enabling the system to prioritise investment and transformation activity where it will have the greatest impact. This will support the development and implementation of co-ordinated transformation plans across all discharge pathways, strengthening community capacity, improving pathway flow, and reducing delays in discharge through a more sustainable and responsive model of care. • Work has commenced through the Neighbourhood Health Group to develop shared system-wide data dashboards to provide real-time visibility of discharge performance. These dashboards will incorporate key metrics, including NCTR measures, discharge pathway data, and reasons for delay, enabling consistent tracking of patients awaiting discharge across all partners. The dashboards will be embedded within the system's governance and quality oversight framework, with routine reporting into programme boards, quality and

safety committees, and escalation forums, ensuring that risks relating to delayed discharge are identified early and acted upon. This approach strengthens system-wide transparency, accountability, and data-driven decision-making, enabling more timely escalation and intervention, and supporting continuous improvement in patient flow and discharge outcomes.

- The system is exploring the viability and effectiveness of implementing a risk stratification tool for patients awaiting discharge to support earlier identification of those at risk of prolonged length of stay. This approach would utilise standardised criteria to assess factors such as patient complexity, discharge pathway (P1/P2/P3), delays related to funding or placement, and risks associated with extended hospital admission. By proactively stratifying patients, the system aims to prioritise high-risk individuals for early escalation, targeted intervention, and senior oversight, ensuring that barriers to discharge are addressed in a timely and coordinated manner. Subject to feasibility and evaluation, the tool would be embedded within existing operational and governance processes, including escalation forums and performance dashboards, enabling a more consistent, data-driven, and proactive approach to reducing delays and improving patient flow.

- The system will monitor discharge performance against national expectations and locally agreed trajectories through the Neighbourhood Health Board. This will include oversight of key indicators such as time from being medically optimised to discharge, pathway utilisation (P1/P2/P3), and length of stay. Performance will be routinely reviewed to identify variation, emerging risks, and areas requiring intervention, with clear escalation routes where delivery is not on track. This approach provides system-wide visibility, accountability, and assurance, enabling timely corrective action and supporting continuous improvement in reducing delays and improving patient flow.

- In response to the concerns raised regarding delayed discharge, the system will monitor performance against national discharge expectations and locally agreed trajectories through established governance arrangements, including Better Care Fund (BCF) meetings. Nationally, this includes expectations that patients are discharged promptly once medically optimised, with a 24-hour expectation for Pathway 0/1 discharges, timely transfer through Pathway 2/3, and adherence to the Discharge to Assess model and Home First principles.
  Performance will be monitored against key indicators including time from ready for discharge to actual discharge, length of stay (including >14 and >21 day patients), pathway utilisation, and reduction in delayed discharges, in line with Better Care Fund metrics, which require systems to demonstrate improvement in discharge timeliness and patient outcomes.
  Oversight is provided through BCF governance meetings, attended by the Integrated Care Board, Local Authority representatives (including adult social care), acute and community providers, and wider system partners, where progress against locally agreed trajectories is reviewed, variation is challenged, and corrective actions are agreed.
  In addition, the ICB works collaboratively with partners to ensure that patients awaiting discharge continue to receive safe, high-quality care, including regular clinical review, multidisciplinary oversight, risk stratification (under development), and proactive escalation where delays present a risk of deterioration.
  Where performance is not in line with expected trajectories, this is escalated through system governance structures, with further actions implemented to increase capacity, address process delays, and strengthen community provision, ensuring continuous improvement in patient flow and minimisation of discharge delays.

	• The system is undertaking a review of current arrangements for individuals with complex dementia to determine the most appropriate commissioning and operational oversight, specifically whether these pathways should sit within Urgent and Emergency Care (UEC) or Long-Term Conditions (LTC) frameworks. This review is aimed at ensuring that patients with complex dementia are managed within the most appropriate pathway, with clear accountability, timely access to specialist provision, and streamlined decision-making processes. By clarifying pathway ownership and strengthening alignment across health and social care, the system seeks to reduce delays associated with funding, placement and coordination, improve patient flow, and ensure that individuals with complex dementia receive care in the most suitable setting at the earliest opportunity. • The system has established a robust, integrated approach to audit, learning, and quality oversight. Actions arising from incidents and delays are formally tracked and subject to ongoing audit within provider organisations, with progress and outcomes routinely reviewed through Quality and Safety Committees and Contract Quality Review Meetings (CQRMs). Learning from these reviews is embedded into practice and aligned with system-wide Quality Surveillance processes, ensuring that themes relating to discharge delays are consistently identified, scrutinised, and escalated where required. This coordinated governance approach strengthens accountability, transparency, and continuous improvement across organisational boundaries, ensuring that actions are implemented, impact is monitored, and the risk of recurrence is reduced through sustained oversight at both provider and system level.
6	**SIGNATURE** [redacted] [redacted] Chief Executive Officer NHS Birmingham & Solihull and Black Country ICBs 2 July 2026