Ms Rachel Redman
East Sussex Coroners Court
Westfield House
St Anne's Crescent
Lewes
BN7 1UE

[redacted]

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

[redacted]

20 July 2026

Dear Ms Redman,

Re: Regulation 28 Report to Prevent Future Deaths – Neeshat Dalal who died on 14th December 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 5th June 2026 concerning the death of Neeshat Dalal on 14th December 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Neeshat's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Neeshat's care have been listened to and reflected upon.

Your Report raises concern that there is a lack of funding for the specific provision of appropriately qualified dieticians who can meet the nutritional needs of inpatients undergoing psychiatric care.

Integrated Care Boards (ICBs) are responsible for commissioning services in line with population need. This includes providing appropriate care for people with additional nutritional needs when they admitted to hospital whether their primary issue is due to a physical or mental health need. NHS England also published coproduced Culture of Care Standards for mental health inpatient services in 2024 which sets the expectation that "Staff (working in psychiatric hospitals) are equipped to support people with their physical health needs, and understand the higher risk of premature mortality and co-morbidities ...". NHS England also delivered a two year Culture of Care Improvement Programme which all NHS and major independent mental health providers participated in.

Access to wider Multi-disciplinary Team (MDT) members in core mental health services has been shown to be highly variable in recent evidence, which includes dieticians. A recent rapid review of learning from quality and safety incidents found that the understanding and recognition of Allied Health Professional (AHP) roles, which would include dieticians, is lacking at all levels of healthcare organisations. It highlighted the need to raise awareness of the essential roles of AHPs to improve quality and safety in inpatient mental health, learning disability and autism services.

In response to this paper the Royal College of Psychiatry have updated their core standards for inpatient and community mental services to include the following "desirable" standards:

- Community:

  5.4. The team has access to Allied Health Professionals to meet a range of patient needs that may be identified as part of care and treatment planning. There is sufficient sessional time and/or a pathway/shared care arrangements in place to draw on these staff on an as needed basis.

  Guidance: As a minimum, this includes dietetics, physiotherapy and speech and language therapy with appropriate experience in mental health.

- Inpatient:

  6.3. *The ward has access to Allied Health Professionals to meet a range of patient needs as identified in their care plan. There is sufficient sessional time and/or pathway arrangements in place to draw on these staff on an as needed basis.*

  Guidance: This includes dietetics, physiotherapy, speech and language therapy. The ward monitors its demand for and access to these services, the response time when input is needed and any delays in accessing input on patient progression through the inpatient pathway

There are currently no AHP safer staffing standards, but these are being developed by NHS England. They will be considered by NHS England's National Quality Board in September 2026. This guidance will include principles that would apply to mental health services.

Workforce models and local arrangements for dietetic provision are determined by providers and commissioners. NHS England will continue to support multidisciplinary and integrated approaches to care through its published specifications and guidance.

NHS England would advise that any further enquiries as to the specific arrangements for nutrition assessment and support for inpatients for psychiatric care in SPFT should be sent to the ICB directly for a response as they are the most appropriate organisation to respond.

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 Neeshat's, 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,

National Medical Director
NHS England