Professor Stephen Powis
National Medical Director
Skipton House
80 London Road
SE1 6LH

Mr James Bennett
HM Assistant Coroner Birmingham
and Solihull
Coroner's Court
50 Newton Street
Birmingham
B4 6NE

29th April 2019

Dear Mr Bennett

Re: Regulation 28 Report to Prevent Future Deaths – Anthony John William Watson, deceased 22.10.2018

Thank you for your Regulation 28 Report (hereinafter the 'report') dated 12th February 2019 concerning the death of Mr Anthony John William Watson on 22nd October 2018. Firstly, I would like to express my deep condolences to Mr Watson's family.

Your report concludes that Mr Watson's death was as a result of significant head trauma following a fall from height. The incident occurred whilst Mr Watson was waiting to be admitted to a local inpatient mental health bed based on the advice from the mental health services that immediate admission was necessary.

Following the inquest and noting the report's similar themes to the 7 reports issued by the Birmingham and Solihull Coroners on 4th October 2018, you highlighted the ongoing issue that not all patients who require immediate admission for inpatient mental health treatment in Birmingham and Solihull are found an appropriate bed in the area. As such, you expressed your concerns that there are an insufficient number of beds in Birmingham and Solihull, and that out-of-area beds are too far away. Further, in this particular case, you also noted the impact of Mr Watson's age on the inability of Birmingham and Solihull Mental Health NHS Foundation Trust ("Trust") to find him an appropriate bed for a timely hospital admission.

I note that a copy of your report has been sent to the Trust, however, you may wish to seek a formal response from the Birmingham and Solihull Mental Health NHS Foundation Trust regarding the concerns raised in your report for a response on the specific circumstances relating to Mr Watson's death. At the same time, I wanted to highlight some key national policies and priorities which I believe are relevant to the issues you have identified in your report as both having a bearing on Mr Watson's death and continuing to pose ongoing concerns for patient safety.

Concern 1 – the lack of beds and that Mr Watson was not offered a bed out-of-area

In recognition of the importance of continuity of care and the proximity to existing support networks, NHS England has committed to eliminating the practice of sending people out of area for non-specialist acute inpatient care due to local bed pressures by 2021. This applies to older adult beds, as well as general adult and psychiatric intensive care units (PICUs) and is underpinned by the expectation that there is always local capacity to meet the needs of individuals requiring this type of support.

Concern 2 – similar themes to the 7 linked PFDs issued on 04/10/2018

I have enclosed a copy of the letter sent to Mrs Louise Hunt, senior coroner of Birmingham and Solihull, in December 2018, in response to the concerns she raised about the 7 linked deaths identified by Birmingham and Solihull coroners. It includes a summary of relevant outcomes from a 'deep dive' meeting in November 2018, which brought together all stakeholders involved in the commissioning, provision and regulatory oversight of mental health services in Birmingham and Solihull in response to the concerns raised.

More recently, members of the national NHS England Mental Health Team attended a further follow-up deep dive meeting in March 2019 focused on Birmingham's Suicide Strategy and Mental Health Improvement Plan, which included very senior representation from the CCG, Trust, local authority public health team and regional NHS England and NHS Improvement teams.

Concern 3 – Mr Watson's age

Under the Equality Act 2010, it is unlawful to deny an older person treatment on the basis of their age. NHS England's national policy position is that the decision whether to admit a person to a general adult or older adult mental health service should not be based on a person's age but on their needs. This decision should not be made at the expense of the person's immediate safety. As this decision is the provider's responsibility, you may wish to seek a formal response on this specific issue from Birmingham and Solihull Mental Health NHS Foundation Trust.

Concern 4a – Availability of beds on young adult units on 18-22 October 2018; Concern 4b – Offer of an out of area bed due to contractual issues; Concern 4c – at least one patient every day in Birmingham and Solihull is advised no bed is available; and Concern 5 – lack of inpatient beds – insufficient numbers of beds in Birmingham and Solihull and out of area beds

The reduction of out of area placements (OAPs) is a high priority both nationally and locally and I can confirm as part of the 2019/20 NHS Operational Planning and Contracting Guidance all Sustainability and Transformation Partnerships (STPs) are reviewing their plans and trajectories for reducing these placements. Over the last year we have been working jointly with NHS Improvement to provide a clinically-led support offer to assist areas in their work to reduce OAPs. This has involved local workshops run by clinical experts with the necessary experience of leading complex system change, which is required to enable the safe and sustainable reduction of OAPs. Birmingham and Solihull STP are engaged with this support offer and participated in a bespoke clinically-led workshop in March 2019. This provided an opportunity for system stakeholders to discuss current approaches and to have their local plans reviewed and informed by the national team's clinical experts.

However, further to this issue it is important to note that ending OAPs by 2021 is a stretching ambition as OAPs are an indicator of broader system pressures and underlying capacity challenges, and therefore, long-term system-wide transformation is required if OAPs are to be sustainably eliminated. Bearing this in mind, NHS England and NHS Improvement have clearly communicated that patient safety should be prioritised above all else; no one in need of an acute inpatient admission should be turned away to avoid using an OAP. Trying to end OAPs too quickly, without making the appropriate system changes, will be unsustainable in the long-term and has the potential to risk patient safety if the quality and timeliness of care are compromised to reduce OAP usage. While your report states that Mr Watson would very likely have declined an out-of-area bed had one been offered, due to the significant distance involved, it is still concerning that this offer was not made, and that there was nothing else available in closer neighbouring areas because of 'contractual issues'. Your report mentions that you are already aware of local remedial action underway to address issues raised in the 7 linked reports of 4 October 2018. From a national perspective, NHS England and NHS Improvement will continue to follow up through our regional colleagues in the West Midlands and existing governance structures to ensure that all of the actions described and committed to in response to these reports have been taken, and that lessons have been learned, with this learning applied to improve safety and quality. This will follow on from discussions that took place in March 2019 referred to above.

NHS England's ambition

NHS England is committed to ensuring that by 2020/21 all areas have properly resourced Crisis Resolution and Home Treatment Teams (CRHTTs); providing a high-quality, 24/7, community-based crisis response and intensive home treatment, as a genuine alternative to hospital admission for adults of all ages. This commitment is supported by central investment and is intended to:

- ensure people can be effectively supported in the least restrictive setting where it is safe and appropriate for the individual; and in doing so
- help address avoidable pressures and high bed occupancy in the acute mental health pathway, to ensure beds are always available for those that need them.

I can confirm that evidence from those areas which maintain local bed availability suggests that this is not simply down to the number of locally commissioned beds, but largely related to the effective management of the whole system pathway and investment in local services, in particular community alternatives. As such, I also wanted to reassure you about the specific steps we are taking to improve access to, and quality of, crisis and community mental health care as part of the NHS Long Term Plan, which includes a specific focus on provision for older adults:

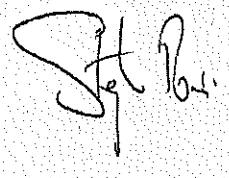
- By 2023/24, anyone experiencing mental health crisis will be able to call NHS 111 and access 24/7 age-appropriate mental health community support.
- By 2020/21 no acute hospital will be without a mental health liaison service for all ages in A&E departments and inpatient wards, and at least 50% of these services will meet the 'core 24' service standard as

a minimum. Increasing to 70% by 2023/24, working towards 100% coverage thereafter.

- Finally, the NHS Long Term Plan also details how new and integrated models of primary and community health services will support adults and older adults with severe mental illnesses. A new community-based offer will include access to psychological therapies, improved physical health care, employment support, personalised and trauma-informed care, medicines management and support for self-harm and coexisting substance use. By 2023/24, new models of care, underpinned by improved information sharing, will give 370,000 adults and older adults greater choice and control over their care, and support them to live well in their communities.

I hope the information above addresses the concerns you have raised within your report and provides you with the assurances that you requested. If you require any further information, please do not hesitate to contact me.

Yours sincerely,



Professor Stephen Powis
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NHS England and NHS Improvement