Department of Health

From Jackie Doyle-Price MP
Parliamentary Under Secretary of State for Mental Health and Inequalities

Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU

Your reference: 6022/CLB
Our reference: PFD 1129434

Ms Alison Mutch OBE
HM Senior Coroner, Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

11th June 2018

Dear Ms Mutch,

Thank you for your letter of 19 April to the Secretary of State for Health and Social Care about the death of Mr Adrian Jennings. I am responding as Minister with portfolio responsibility for mental health.

Your Report details a number of matters of concern, most of which are for the local NHS to address and I hope you find the responses from the Pennine Care NHS Foundation Trust, the Tameside and Glossop Integrated Care NHS Foundation Trust and NHS Tameside Clinical Commissioning Group (CCG) helpful.

However, I will take this opportunity to make clear the national policy expectations in relation to the issues you have raised.

It was concerning to read the difficulties Mr Jennings and his family experienced in understanding the plan for provision of support in the community and I note that you found it probable that the lack of effective support and communication in relation to the support plan contributed to Mr Jennings's death.

The Mental Health Act 1983 Code of Practice[1], whilst being statutory guidance for providers of services under the Act, should be observed as best practice by all commissioners and providers of services to people who may become subject to the Act. We revised the Code of Practice in 2015 and set out guiding principles to

[1] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983

improve the care for patients. The principles include mental health providers involving patients' carers and families in decisions about their care. The Code of Practice also makes it clear that we expect multi-disciplinary teams involved in care planning and discharge to include all relevant professionals and agencies which may be involved in a person's care.

Further work is underway to support improved discharge coordination with the planned publication of best practice guidance for robust, evidence-based discharge processes. In addition, NHS England is developing a framework for community mental health services on models of joint working between primary and secondary mental health services. I understand further information on these initiatives is included in NHS England's response to your report.

I am also advised that NHS England's response explains that mental health services are expected to adhere to a standard of ensuring follow-up from inpatient care settings within seven days of hospital discharge. This provides an important opportunity to ensure a person is continuing to receive appropriate support.

You raise two matters of concern relating to IT, firstly on the lack of a single IT system across the Pennine Care NHS Foundation Trust and its impact on patient information sharing. We recognise there are challenges across the service in enabling secure record sharing and there a number of steps being taken to address this, led by NHS England. I will leave it to NHS England to advise on the work currently underway around the Global Digital Exemplar Programme and the Local Health and Care Record Exemplars that are designed to join up and digitise health systems, providing clinicians with timely access to patient clinical information.

On the matter of the Lorenzo system, I can confirm that since 2016, functionality has been developed to enable the capture of the mode of arrival of the patient (such as with police assistance), with the addition of a free text facility where relevant information can be captured in accordance with local policy and practice. These functions are part of the core Lorenzo emergency department module and are standard within the current build.

Finally, you may wish to be aware that the Healthcare Safety Investigation Branch (the HSIB[2]) is conducting an investigation into the provision of care to patients who present at emergency departments with mental health problems.

---

[2] https://www.hsib.org.uk/

Department
of Health

My officials have made enquiries with the HSIB and I am informed there are similarities in the circumstances surrounding Mr Jennings' death and the reference case being utilised by the HSIB in its investigation. The investigation has identified four key areas of concern:

- The risk assessment process for patients suffering a mental health crisis attending an emergency department;
- Access to appropriate mental health professionals for adults attending an emergency department;
- Is the emergency department a 'Place of Safety' for an adult experiencing mental health crisis; and
- How information is shared between different disciplines within the same Trust.

Completion of the investigation is anticipated in the Autumn. At present, the HSIB is not able to share further information. However, the HSIB would like to extend an invitation to talk you through the investigation findings once concluded if that would be helpful. If you wish to take up this invitation, please contact the HSIB directly.

I hope the information I have provided is helpful. Thank you for bringing your concerns to our attention.

JACKIE DOYLE-PRICE