Department of Health & Social Care

From Maggie Throup MP
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08 October 2021

Thank you for your letter of 21 May 2021 related to the death of Martin Gibbons. I am replying in the capacity of a duty Minister, and am grateful for the additional time in which to do so.

Firstly, I would like to say how saddened I was to read of the circumstances of Martin Gibbons' death and I offer my sincere condolences to his family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention.

In preparing this response, enquiries have been made with NHS England and NHS Improvement (NHSE/I) and their regional and local partners, and the Care Quality Commission (CQC).

You raise a number of concerns in your report that I will address in turn.

With regard to a shared definition of *risk*, evidence from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)[1], as well as National Institute for Health and

[1] https://sites.manchester.ac.uk/ncish/reports/the-assessment-of-clinical-risk-in-mental-health-services/

Care Excellence[2] guidance, suggests that risk assessments must not be seen as a form of a risk prediction. It is emphasised that whilst standardised tools may provide the impression of precision, they are poor in terms of prediction of suicide or a particular behaviour. Instead evidence suggests that assessments should be personalised according to individual circumstances.

Recently, (and in part due to concerns raised by your report) NHS England has asked all parts of the country to ensure that they have in place clear written protocols for escalation and actions to be taken when patients are waiting long periods, or a bed cannot be identified. The handover and management of a patient between services (in this case, acute and mental health services) is a local operational matter and the safety of these processes is the responsibility of the clinicians and operational managers involved in the direct care of the patient. There is a significant body of guidance that emphasises the importance of sharing patient information (which includes assessments and care plans) between clinical teams for the purposes of direct clinical care. National guidance[3] on care for people with mental health needs in emergency departments has been published by NHS England. All hospitals should have a process for providing safe, dignified care for patients with mental health needs who wait for long periods.

I am pleased to note the actions that the Tameside and Glossop Integrated Care NHS Foundation Trust and the Pennine Care NHS Foundation Trust have taken to improve local communication and handover processes and to clarify responsibilities in relation to a person presenting to the emergency department who is considered a high risk to themselves.

The provision of 24/7 liaison psychiatry has consistently been highlighted as the priority action by NCISH and through a special report by the Healthcare Safety Improvement Board (HSIB) to improve safety for mental health patients in emergency departments. We have through the Five Year Forward for Mental Health (2016) invested £249million in liaison psychiatry, to provide specialist mental health assessment and treatment. Through the NHS Long Term Plan, we are providing an additional £58million funding by 2023/24.

All acute hospitals now have an adult liaison service in place, with 78 per cent of these services operating 24 hours a day, 7 days-a-week, which is an increase from 39 per cent in 2017, and this expansion is continuing through the NHS Long Term Plan. NHSE/I is working with local areas to design and implement care pathways that are integrated with the wider health and social care system, including timely sharing of information between liaison psychiatry teams and community mental health services.

I have noted your concerns about the time taken to identify and confirm a mental health bed for Mr Gibbons. The provision of mental health beds is determined by local NHS commissioners, taking into consideration local need as well as the effectiveness of the local mental health system in providing access to care and support to people in the community, thereby reducing the requirement for admission to hospital. While in some local areas there may be a genuine need for more inpatient capacity, this should always be considered as part of whole system transformation to reduce over reliance on hospital-based care. The NHS Long Term Plan (LTP) will provide an additional £2.3billion a year invested into mental health services by 2023/24, approximately £1.3billion of which relates toadult community, crisis and acute mental health services in order to provide quicker access to care, and prevent avoidable deterioration and hospital admission.

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[2] National Institute for Health and Care Excellence

[3] https://www.england.nhs.uk/wp-content/uploads/2016/11/lmhs-guidance.pdf

You may also wish to note that, while we are emerging from the crisis period resulting from COVID-19, we continue to monitor the impact of the pandemic and adjust policy and investment priorities where necessary. The NHS will be investing significantly in mental health service capacity this year, with an additional £500million in 2021/22 to support recovery in mental health services on top of the funding already committed through the NHS Long Term Plan. This investment includes funding to bring forward existing plans to improve/expand community mental health services, crisis care services and support for people to be discharged from hospital in a timely manner. All of which should help to both reduce pressures on local inpatient services so that those who need to access beds can do so quickly and locally.

In relation to local commissioning arrangements, it is usually the case that the closest hospital to where the patient is resident will provide the most effective and best experience of care for that individual, ensuring strong continuity of care at admission and discharge and helping to maintain connection with support networks.

There may be a small number of circumstances where it might be appropriate for a patient to be admitted to a hospital which is further away from where they live. For example, emergency admissions whilst away from home, safeguarding concerns, or where patient choice is exercised. Clinical consideration should always be given as to where it is best to admit someone, taking individual needs into account and not based solely on how services are commissioned in an emergency situation.

Finally, reducing suicide and preventing self-harm remains a key priority for the Government.

We are investing an additional £57million in suicide prevention by 2023/24 through the NHS Long Term Plan. This will see investment in all areas of the country to support local suicide prevention plans and the development of suicide bereavement services. In addition to this, we are also providing an extra £5million in 2021/22, to be made available specifically to support suicide prevention voluntary and community sector organisations.

In March 2021, we published the latest progress report against the National Suicide Prevention Strategy and, within this, a refreshed cross-government suicide prevention workplan. This sets out a comprehensive and ambitious programme of work across national and local Government, and delivery partners, which sets the framework for how we intend to reduce suicides in England.

I hope this response is helpful.

MAGGIE THROUP MP