Department of Health & Social Care

Maria Caulfield
Parliamentary Under Secretary of State for
Mental Health and Women's Health Strategy
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[redacted]

Our Ref: [redacted]

Andrew Cox
Senior Coroner
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21 June 2024

Dear Andrew,

Thank you for your Regulation 28 report to prevent future deaths dated 14 May 2024 about the death of Sally Poynton. I am replying as the Minister with responsibility for mental health and patient safety.

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

Your report raises concerns over inadequate action taken with regard to her son [redacted] on his discharge from hospital, lack of engagement with patients' family members, the impact of staffing shortages on community mental health teams and a lack of continuity of care and communication between different primary care agencies.

I would expect the Cornwall and Isles of Scilly Integrated Care Board to respond in detail to the concerns you have raised about the specifics of the care that Sally's son received.

From a national perspective, we recognise how vital it is that organisations across the health system work together to ensure effective discharge planning and the best outcomes for people who are discharged from hospital, and that people and their chosen carers are fully involved in the process. On 26 January 2024, new statutory guidance for discharge from all mental health and learning disability and autism inpatient settings for children, young people and adults was published. The guidance provides clarity in relation to how health and care systems can work together to support discharge from all mental health inpatient settings and ensure the right support is in place in the community. The guidance also includes best practice on how patients, carers and family members should be involved in discharge planning.

We recognise that there are particular challenges around referrals and discharge where patients do not engage. In the *2024/25 priorities and operational planning guidance*, NHS England has asked local health systems to review their community services by September 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge.

Turning to your concerns around the impact of staffing shortages on service delivery, the Government is not able to comment on staffing levels locally, as responsibility for the staffing and operations of mental health services lies with the relevant trust. However, we recognise the need to increase workforce capacity in NHS mental health services overall. Nationally, positive progress has been made on growing the mental health workforce which, as at December 2023, had increased by around 20,800 compared to 2019/20. In addition, the NHS Long Term Workforce Plan sets out an ambition to grow the mental health, primary and community care workforce by 73% by 2036-37.

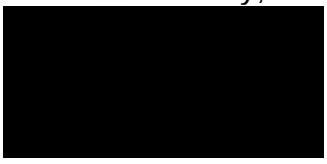
With regard to your suggestion that representatives from integrated care boards (ICB) might attend multi agency safeguarding hubs (MASH) meetings on behalf of GPs, the Department does not believe this alone would reduce the risk of lack of timely information sharing as you envisage. This is because the average population covered by an ICB is 1.5 million people, with some considerably larger. It is unlikely therefore that one ICB representative could be responsible for knowing the circumstances of the individual primary care patients within their ICB's footprints or that this would be a reliable mechanism for facilitating information sharing.

However, ICBs across England should ensure they have in place robust information sharing processes that connect information presented at MASH and other safeguarding meetings with the network of primary care providers. ICBs have dedicated safeguarding and mental health leads who are best placed to set up these processes within their local setting. Primary care professionals themselves remain best placed to attend relevant safeguarding meetings regarding individual cases. Primary care professionals should also work to transfer patient records from one practice to another in a timely way, when a patient registers with a new practice.

I should also add that information on the role and rights of a person's Nearest Relative forms part of a series of factsheets on the Mental Health Act made available through the NHS website at: MH-CoP-Nearest-relative.pdf (assets.nhs.uk)

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,



MARIA CAULFIELD