Department of Health & Social Care

From [redacted]
Minister of State for Care

39 Victoria Street
London
SW1H 0EU

Our ref: [redacted]

HM Coroner Ian Brownhill
Mid Kent and Medway Coroner's Service
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8AE

By email: [redacted]

17 January 2025

Dear Mr Brownhill,

Thank you for the Regulation 28 report of 7 October 2024 sent to the Department of Health and Social Care about the death of John Eyre. I am replying as the Minister with responsibility for hospital discharge.

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

The report highlights concerns about the lack of a clear escalation route and national guidance for prison healthcare staff to address issues with discharging a serving prisoner from an acute hospital setting. In preparing this response, my officials have made enquiries with NHS England to ensure we adequately address your concerns.

As the Minister responsible for hospital discharge, I recognise the importance of ensuring that people are discharged from hospital when they are clinically ready, and to an appropriate setting where they will have the right care and support in place. Doing so will help to ensure that people are able to recover in a safe and timely way.

As set out in the Hospital Discharge and Community Support Guidance (January 2024), NHS bodies should work closely with care providers and other partners to ensure people's care is timely, optimal and co-ordinated, while also practising active risk management to reach a reasonable balance between safety and minimising delays when patients are ready to be discharged. I will ask my officials to consider whether an amendment to the hospital discharge guidance is required to make more explicit the obligation to consider concerns raised by care providers before the discharge of patients to custodial settings. Furthermore, as required and described in the Health and Social Care Act 2012, patients within secure settings should receive the same quality and access of healthcare as the rest of the population, both in terms of the range of interventions to meet their needs, and the quality

and standards of those interventions. As signatories to the National Partnership Agreement for Health and Social Care for England, the Department of Health and Social Care, HM Prison and Probation Service, the Ministry of Justice, NHS England, and the United Kingdom Health Security Agency have a shared understanding of, and commitment to, how we work together to support the commissioning and delivery of healthcare in English prisons.

Relevant NHS bodies and local authorities have legal obligations to ensure that appropriate arrangements are put in place in order to ensure a safe discharge from an acute hospital setting. These obligations are set out in the Care Act 2014 and ensure that prisoners are entitled to the same equivalent care provision as someone in the community. Therefore, maintaining effective continuity of care between acute and custodial settings is essential to ensuring that people in prison receive good and safe care. The Health Services Safety Investigations Body is currently conducting a series of investigations into healthcare provision in prisons, examining emergency care, continuity of care and data sharing and IT. Reports on the first two topics have been published, with the data-sharing and IT report not yet released. You can find out more about the investigation here: Healthcare provision in prisons (hssib.org.uk).

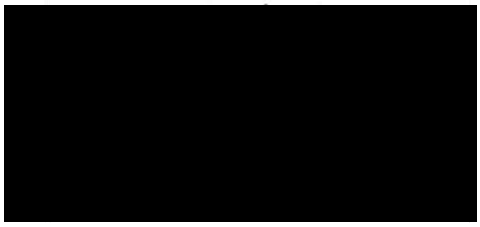
Your report also highlights the lack of an escalation route through which healthcare staff in prisons can raise their concerns to hospital staff. I am grateful for NHS England for advising that, since the inquest, Medway Maritime Hospital have been working with their system partners – including providers of healthcare services at Sheppey prisons - to co-create a written document setting out the process for effective and safe discharges of Trust patients who are serving prisoners. The hospital is hoping to ratify the document with relevant governance committees in the near future, and the document will seek to action the concerns raised by your report.

The Trust has also implemented twice-daily board rounds, where the status of all patients is discussed by a multidisciplinary team. The team use an electronic bed management system called TeleTracking that enables them to update patient records in real time, including any concerns raised about the safety or appropriateness of their discharge. Consultants are responsible for ensuring any concerns are addressed before they confirm that the discharge can safely proceed.

Such actions will strengthen the discharge process in similar cases within the Trust, ensuring they meet the obligations set out in legislation. NHS England's National Regulation 28 Working Group's seven regional leads will be asked to share the Trust's learnings, including the collaborative development of standard operating procedures, from this incident with their systems.

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

Yours sincerely,



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