[redacted]
Parliamentary Under-Secretary of State for
Patient Safety, Women's Health and Mental Health

Department of Health & Social Care

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Our Ref: [redacted]

Penelope Schofield
Senior Coroner for West Sussex, Brighton and Hove
County Records Office,
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04 March 2025

Dear Ms Schofield

Thank you for your Regulation 28 report to prevent future deaths dated 16 December 2024 about the death of Matthew Zak Sheldrick (Matty). 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 Matty's death and I offer my sincere condolences to their family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

I understand your concerns about a lack of inpatient beds leading to unacceptable wait times in A&E for those experiencing mental ill health. In Matty's case, this meant that a bed was not found for them within a 26-day period. You also expressed concerns that the environment in A&E as a holding place is not conducive for those who are neurodiverse, including autistic people, and can exacerbate their mental health issues. I also understand your concerns regarding a gap in services for those who do not meet the criteria for detention under the Mental Health Act but who are too high a risk to be sent home.

In preparing this response, my officials have made enquiries with NHS England to ensure we adequately address your concerns.

I am sure you will appreciate that the number of mental health inpatient beds required to support a local population, including people who are also neurodiverse and non binary/transgender, is dependent on both local mental health need and the effectiveness of the whole local mental health system in providing timely access to care and supporting people to stay well in the community, therefore reducing the likelihood of an inpatient admission being necessary.

I expect individual trusts and local health systems to effectively assess and manage bed capacity, the 'flow' of patients being discharged or moving to another setting.

2025-26 Planning Guidance contains fewer targets across the board to focus on the fundamentals of good care. It sets a requirement for Integrated Care Boards to take action to reduce the average length of stay in adult acute mental health beds, improving local bed availability and reducing the need for inappropriate out of area placement, and to reduce waits longer than 12 hours in A&E through making use of alternatives described below.

- **Reducing avoidable ambulance dispatches and conveyances, and reduce handover delays by** working towards delivering hospital handovers within 15 minutes, with joint working arrangements that ensure that no handover takes longer than 45 minutes and improving access to urgent care services at home or in the community including urgent community response (UCR) and virtual ward (also known as hospital at home) services
- **Improve and standardise urgent care at the front door of the hospital by** increasing the proportion of patients seen, treated and discharged in 1 day or less using the principles of same day emergency care (SDEC) and optimising the urgent care offer to meet the needs of their local population, including the use of urgent treatment centres (UTCs)
- **Reduce length of stay in hospital and ensure that patients are cared for in the most appropriate setting by** increasing the percentage of patients discharged by or on day 7 of their admission in line with existing guidance. Additionally, by working across the NHS and local authority partners to reduce average length of discharge delay in line with the Better Care Fund (BCF) policy framework. ICBs should review BCF commitments to ensure they represent the best use of resources, and plan sufficient intermediate care capacity to meet demand, including through surge periods across the year

As part of our mission to build an NHS fit for the future , we need to focus treatment away from hospital and inpatient care and improve community and crisis services, making sure more mental health crisis care is delivered in the community, close to people's homes, through new models of care and support, so that fewer people need to go into hospital. NHS England is already piloting the 24/7 Neighbourhood Mental Health Centre model in England, building on learning from international exemplars. 6 early implementors are bringing together their community, crisis, and inpatient functions into one open access neighbourhood team which is available 24 hours a day, 7 days a week. This means people with mental health needs can walk in or selfrefer as can their loved ones and system partners.

Anyone in England experiencing a mental health crisis can now to speak to a trained NHS professional at any time of the day through a new mental health option on NHS 111. Trained NHS staff will assess patients over the phone and guide callers with next steps such organising face-to-face community support or facilitating access to alternatives services, such as crisis cafés or safe havens which provide a place for people to stay as an alternative to A&E or a hospital admission. The new integrated service can give patients of all ages, including children, the chance to be listened to by a trained member of staff who can help direct them to the right place. These crisis lines currently take around 200,000 calls a month.

As announced in the Budget, we are committing £26 million in capital investment to open new mental health crisis centres, reducing pressure on busy A&E services and ensuring people have the support they need when they need it.

Mental Health Response Vehicles have also been established in order to see and treat patients away from Accident and Emergency. New integrated operational pressures escalation levels (OPEL) scoring systems have also been established for mental health, enabling greater transparency and escalation of risks across mental health pathways. We have committed £26 million in capital investment to open new mental health crisis centres, reducing pressure on busy emergency mental health and A&E services and ensuring people have the support they need when they need it.

I also note your concerns about the sensory environment of A&E departments for those who are autistic and regarding significant wait times for referral to assessment and treatment services. As part of our mission to build an NHS fit for the future , we will make sure more mental health care is delivered in the community, close to people's homes, through new models of care and support, so that fewer people need to go into hospital.

In November 2023, NHS England also published guidance on 'Meeting the needs of autistic adults in mental health services', which sets out 10 principles to help mental health services, including crisis services, provide high-quality assessment, intervention and support to autistic adults who have any mental health symptoms or conditions and provides practical examples of how this may be achieved. This guidance highlights that local services should recognise that emergency departments can be intrinsically overwhelming and distressing for autistic people.

We are also taking action to increase awareness and understanding of autism amongst healthcare professionals. Under the Health and Care Act 2022, service providers registered with the Care Quality Commission (CQC) are required to ensure their staff receive learning disability and autism training appropriate to their role. To support this, we are rolling out the Oliver McGowan Mandatory Training on Learning Disability and Autism. Over 2 million people have now completed the e-learning module, which is the first part of the training.

NHS England is also rolling out further training for staff working in mental health services to upskill staff in supporting autistic people in contact with those services. This includes a National Autism Trainer Programme which is co-designed, coproduced and co-delivered with experts by experience, based on a 'train-the-trainer' model and promotes an experience-sensitive, trauma-informed approach. This training is progressing across a range of children and adult mental health services. In addition, NHS England has commissioned the Royal College of Psychiatrists to deliver foundation and enhanced autism training for psychiatrists, which is aimed at upskilling psychiatrists across both specialist and mainstream settings to improve health outcomes for autistic people.

It is also important that, when people are discharged, this happens in a way that considers their needs on discharge and any risks to their safety. To help support safe and timely discharge decisions, the Department published statutory guidance on *Discharge from mental health inpatient settings* in January 2024 and which is available at: Discharge from mental health inpatient settings - GOV.UK (www.gov.uk). This sets out how health and care systems should work together to support safe discharge from all mental health and learning disability and autism inpatient settings for children, young people and adults.

I note that you have also addressed your matters of concern to NHS England and I look forward to seeing its response and working with NHS England where appropriate, to avoid a repetition of the tragic events of this case.

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

Yours sincerely,