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Parliamentary Under-Secretary of State for Patient Safety
Women's Health and Mental Health

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Our Ref: [redacted]

HM Coroner Nigel Parsley
Beacon House,
Whitehouse Road,
Ipswich, IP1 5PB

26 February 2025

Dear Mr Parsley

Thank you for your Regulation 28 report to prevent future deaths dated 13 December 2024 about the death of Timothy Robert De Boos. 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 Timothy'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 concerns you identified in this case were in respect of the lack of inpatient mental health beds in Suffolk and more widely throughout England and the evidence required for admission to a mental health unit.

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

Demand for inpatient services fluctuates across the 24 hour period. The Trust has in place structures and processes to ensure a coordinated and planned approach to ensure the Trust's inpatient bed capacity is optimal. This involves coordination of people who are assessed as requiring admission to hospital and working with partners to ensure timely supported discharges into the community teams. Interventions the Trust have made, alongside partners, are the use of MADE events to support collaborative focussed joint working. In Suffolk these were introduced in May 2024 and occur on a weekly basis. These have been successful coordinating efforts between the Trust, Commissioner and Local Council in helping support discharge for people with complex health needs.

In terms of the overall inpatient bed capacity in the Trust is undertaking a benchmarking exercise to review bed utilisation across the organisation in order to optimise the current bed capacity. In addition to this work, the Trust has been working with other organisations who are successful in maintaining low numbers of inappropriate out of area placements.

I understand your concerns and I know that the availability of mental health beds is an issue you have raised in previous Prevention of Future Deaths reports and I am sure you will appreciate that the number of mental health inpatient beds required to support

a local population, 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.

2025-26 Planning Guidance contains fewer targets across the board to focus on the fundamentals of good care. It instructs systems to reduce the average length of stay in acute mental health beds, and improving patient flow and ensuring appropriate placements are both essential to delivering against this target. Instead of cataloguing all actions the NHS might take, we're focusing on the things that matter most to patients and giving local leaders the freedom and autonomy they need to provide the best service to their local communities.

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.

There has also been learning from the apparent miscommunication between the community and crisis team. The Trust recognise the critical role urgent care pathway plays in supporting both Trust and wider community services. Communication is critical to ensure the correct assessments and pathways of care are provided. The Trust are midway through improvement work to support prompt and clear access to the crisis team for health professionals and internal community teams. This is involving work to maximise availability of staff to receive incoming referrals and enable prompt triage and assessment of needs. In addition, in 2025 the Trust is starting a larger transformation plan of urgent care pathways which includes refinement of the communication methods between teams.

The Crisis Team remains the assessors for inpatient services in line with national practice. This is to ensure all opportunities for community interventions are explored because the evidence confirms this generally leads to better recovery outcomes. The community team made the referral to the Crisis Team on 2 February who then completed a visit on 3 and 4 February. The visits assessed that admission to hospital was no longer the immediate care need.

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

Yours sincerely,

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PARLIAMENTARY UNDER-SECRETARY OF STATE FOR PATIENT SAFETY, WOMEN'S HEALTH AND MENTAL HEALTH