Department of Health & Social Care

From Minister Ashley Dalton MP
Parliamentary Under-Secretary of State for Public Health and Prevention

39 Victoria Street
London
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Our ref: PFD – 25-06-05 - BENDELL

HM Senior Coroner Nigel Parsley
The Coroner's Court and Offices
Beacon House
Whitehouse Road
Ipswich
IP1 5PB

By email to: coroners.service@suffolk.gov.uk

26 August 2025

Dear Mr Parsley,

Thank you for the Regulation 28 report of 5 June 2025 sent to the Secretary of State / the Department of Health and Social Care about the death of David Thomas Bendell**.** I am replying as the Minister with responsibility for Public Health and Prevention.

Firstly, I would like to say how saddened I was to read of the circumstances of David Bendell'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. Thank you for the additional time provided to the department to provide a response to the concerns raised in the report.

The report raises concerns that with current rehabilitation options available being either in a specialist hospital ward or at home, other individuals in David's situation who are not deemed suitable for in-patient hospital will also be placed at risk by being sent home when it is not safe to do so.

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

Commissioning of stroke services, including rehabilitation, is the responsibility of Integrated Care Boards (ICB).

The integrated community stroke service model (ICSS) came into policy in 2021. This model describes stroke services that are integrated, specialist, responsive and of sufficient intensity to meet the needs of the patient. It also describes delivery of equitable access to the integrated community stroke rehabilitation services regardless of discharge destination.

With regards to step down care to support more dependent patients to rehabilitate, there are three discharge pathways described in the model: (1) to home with no social care required, (2) home with social care support and (3) discharge to a care home (which may be considered as a step-down bed), all with access to needs-led rehabilitation. For those patients discharged to community beds or nursing home care, this constitutes in-reach from integrated community stroke rehabilitation teams, to ensure that the rehabilitation needs of the patients are met.

Suffolk and North East Essex Integrated Care System (SNEE ICS) offers commissioned rehabilitation beds for patients requiring complex post-stroke care with a nationally set criteria. Following clinical assessment by SNEE ICS, Mr Bendell was deemed appropriate for discharge home, supported by Early Supported Discharge (ESD) services and four times a day (QDS) social care package (four visits from a caregiver or healthcare professional) to ensure his care needs were met.

SNEE have stated that, in the context of evolving patient pathways and changing clinical scenarios, it is essential to reinforce with their multidisciplinary team (MDT) colleagues the importance of reassessing a patient's clinical needs and personal preferences. This ensures that individual patients remain empowered to make informed choices about their ongoing care and health requirements. Learning about patient needs will be shared openly and transparently at the future SNEE System Quality Group meeting in 2025, where senior provider leaders will be present to support shared reflection and continued improvement in practice.

Rehabilitation support can be delivered by SNEE ICS, if appropriate for the individual, within a residential or nursing care home setting. In these circumstances ESD services offer in-reach rehabilitation (either within a community setting or a patients home), functioning as a 'halfway house' model.

Rehabilitation bed commissioning is regularly reviewed by the SNEE ICS Neuro Rehabilitation Programme Group, chaired by a Consultant Neurologist. The group meet on a bi-monthly basis. Within the group's remit is assessing the suitability and capacity of commissioned beds for patients needing specialist neuro-rehabilitation. The group will develop and review a strategic action plan to guide future commissioning of rehabilitation pathways within SNEE.

In addition to work at ICS level by SNEE, NHS England (East of England) has commissioned [redacted], University of Essex, to lead a project to map the current community rehabilitation services and their interface with bed-based care within the region. This project is scheduled for completion by October 2025 and will inform future rehabilitation pathway development. The project has committed to share its findings and establish a review process to ensure this information remains current.

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

Yours sincerely,