Department of Health

From Jackie Doyle-Price MP
Parliamentary Under Secretary of State for Mental Health and Inequalities

39 Victoria Street
London
SW1H 0EU

020 7210 4850

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23 FEB 2018

Mr Andrew McNamara
HM Assistant Coroner, Nottinghamshire
Office and Main Court
The Council House
Old Market Square
Nottingham NG1 2DT

Dear Mr McNamara

Thank you for your letter of 18 December to the Secretary of State about the death of Mr Ryan James Vout. I am responding as minister with responsibility for mental health.

I was very saddened to read of the circumstances surrounding Mr Vout's death. Please pass my condolences to his family and loved ones. I appreciate this must be a very difficult time for them.

Your report raises three areas of concern. Firstly, around discharge planning; secondly, the ability to pre-book appropriate transport for conveyance of a patient being sectioned under the Mental Health Act; and thirdly, the risk assessment conducted by the police prior to the exercise of a section 135 warrant.

The latter area of concern is one for the police and I will not address this in my response.

The other two areas of concern fall to health services. The matters raised are operational and relate to the Nottinghamshire Healthcare NHS Foundation Trust and the ambulance service and I trust the responses you will receive from those organisations will be helpful. My response will focus on the national policy expectations in relation to the issues you have raised.

With regard to discharge planning from inpatient to community care, I have noted your concerns around the lack of co-ordinated discharge planning in Mr Vout's case. This is clearly regrettable.

Learning lessons where things have gone wrong is essential to ensuring the NHS provides safe, high quality care. I am advised that the Nottinghamshire Healthcare NHS Foundation Trust conducted a serious incident investigation that identified a number of recommendations for learning from this case. I understand the report of the investigation has been shared with you, and I am assured that Nottingham City Clinical Commissioning Group (CCG) is liaising with the Trust through its quality assurance processes.

In terms of national policy, I would like to assure you that we recognise that robust discharge planning and follow-up support are crucial to ensuring that people have a good experience of acute mental health care and can be stepped down to the most appropriate and least restrictive setting for their needs, safely and at the earliest opportunity.

The Mental Health Act 1983 Code of Practice, whilst being statutory guidance for providers of services under the Act, should be observed as best practice by all commissioners and providers of services to people who may become subject to the Act. We revised the Code of Practice in 2015 and set out guiding principles to improve the care for patients. The principles include mental health providers involving patients' carers and families in decisions about their care. The Code of Practice also makes it clear that we expect multi-disciplinary teams involved in care planning and discharge to include all relevant professionals and agencies which may be involved in a person's care.

Additionally, over the last 12 months, NHS England has been working closely with the National Collaborating Centre for Mental Health and a number of local areas to identify and share best practice in relation to the acute mental health care pathway, which includes well-managed discharge.

The following principles have been identified and are now being communicated as key components of robust discharge processes:

- if the person agrees, and in accordance with the Mental Capacity Act 2005, Mental Health Act 1983 (amended 2007) and Care Act 2014, their family, carers and significant others should be engaged throughout their care. They should be involved in care decisions from the very start of the pathway through to the end of care and given information about the care plan, discharge decisions and changes to treatment. Families and carers should be supported throughout;

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- the discharge destination should be considered early on in admission to acute care, particularly for people with housing needs, and everyone should have a clear discharge plan in place, including an estimated date;
- all inpatient wards should have an effective interface with other services, particularly community-based acute mental health services, to facilitate access, transfer of care and discharge back into the community; and
- crisis resolution and home treatment teams operating in line with the evidence-base should have the means to facilitate safe discharge from inpatient settings and support people to go home on leave from wards.

With regard to the second area of concern, that of the conveyance of patients being sectioned under the Mental Health Act, I should point out that the Mental Health Code of Practice is clear that local policies should be agreed between services:

16.30 Local authorities, NHS commissioners, hospitals, police forces and ambulance services should have local partnerships in place to deal with people experiencing mental health crises. The objective of local partnership arrangements is to ensure the people experiencing mental health crises receive the right medical care from the most appropriate health agencies as soon as possible. The police will often, due to the nature of their role, be the first point of contact for individuals in crisis but it is crucial that people experiencing mental health crises access appropriate health services at the earliest opportunity.

16.31 It is also important to ensure that a jointly agreed local policy is in place governing all aspects of the use of section 135 and section 136. Good practice depends on a number of factors. For example:

- *local authorities, hospitals, NHS commissioners, police forces and ambulance services should ensure that they have a clear and jointly agreed policy for use of the powers under sections 135 and 136, as well as the operation of agreed places of safety within their localities;*
- *all professionals involved in implementation of the powers should understand them and their purpose, the roles and responsibilities of other agencies involved and follow the local policy;*
- *professionals involved in implementation of the powers should receive the necessary training to be able to carry out fully the role ascribed to their agency; and*

- *the parties to the local policy should meet regularly to discuss its effectiveness in the light of experience and review the policy where necessary, and partner agencies should decide when relevant information about specific cases can be shared between them for the purposes of safeguarding the person and the protection of others, if there is thought to be a risk of harm.*

The Code of Practice is available at:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf.

You may also be aware that we launched the Mental Health Crisis Care Concordat in 2014 which has been signed by all services, including the police service and the NHS, involved in providing care for people who may experience a mental health crisis. The Crisis Care Concordat is clear that every local area should have agreed clear protocols for local services responding to a mental health crisis which clearly identify roles and responsibilities. Every local area has a Mental Health Crisis Care Concordat Action Plan in place and we continue to work with these areas to embed and improve their plans.

You will appreciate that arrangements within Nottinghamshire are a matter for local NHS commissioners and providers and the police service to determine.

Finally, as you may be aware, the Government has commissioned an independent review of mental health legislation and practice to tackle the issue of mental health detention.

Professor Sir Simon Wessely, former President of the Royal College of Psychiatrists, will lead the review which will deliver recommendations for change to the Government. Sir Simon will look at the evidence, review practice, and above all consider the needs of service users and their families, and how best the system can help and support them. He will identify improvements in how the Act is used in practice, as well as how we might need to change the Act itself. Vice Chairs will be appointed to work with Sir Simon and ensure the leadership of the review has comprehensive professional expertise whilst also being representative of service users and others affected by the Mental Health Act.

The review is currently gathering evidence with a view to producing an interim report on its priorities by the spring, and a full report by the autumn, with recommendations to Government and other relevant organisations.

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Further detail on the independent review, including its Terms of Reference, are available at www.gov.uk/government/news/prime-minister-announces-review-to-tackle-detention-of-those-with-mental-ill-health.

I hope this information is helpful. Thank you for bringing the circumstances of Mr Vout's death to our attention.

Jackie

JACKIE DOYLE-PRICE