Department of Health & Social Care

From Nadine Dorries MP
Minister of State for Patient Safety,
Suicide Prevention and Mental Health

39 Victoria Street
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[redacted]

[redacted]

Mr James E Thompson
HM Assistant Coroner, County Durham and Darlington
HM Coroner's Office
PO BOX 282
Bishop Auckland
DL14 4FY

1 June 2021

Dear Mr Thompson,

Thank you for your correspondence of 9 April 2021 about the death of Mina Topley-Bird. I am responding as Minister responsible for mental health services.

Firstly, I would like to take this opportunity to offer my sincere condolences to the family, friends and loved ones of Ms Topley-Bird.

I have noted carefully your concerns about national policy to co-ordinate the transfer of mental health patients back to their 'Home' area, when a person is admitted as an emergency to an NHS Trust outside their normal locality. You also raise concerns about escalation policy when a bed cannot be obtained; and also a process to 'apply' for a bed in another NHS Trust area.

Your report also notes the 'ad hoc' nature of the approach taken by NHS Trusts which may create delays in the transfer of patients.

The Government is committed to eliminating inappropriate out of area placements in mental health services for adults in acute inpatient care and in 2016 provided guidance on out of area placements[1] to NHS Trusts to support this ambition.

The guidance states an out of area placement may be appropriate when: "the person becomes acutely unwell when they are away from home (in such circumstances, the admitting provider should work with the person's home team to facilitate repatriation to local services as soon as this is safe and clinically appropriate)".

In addition, the guidance advises regular reviews and assessments to enable the patient's return to their local service as soon as possible.

[1] Out of area placements in mental health services for adults in acute inpatient care - GOV.UK (www.gov.uk)

In preparing this response, my officials have made enquiries with NHS England and NHS Improvement (NHSE/I) and the Care Quality Commission (CQC).

Your report notes that medical information received from South London and Maudsley NHS Foundation Trust (SLAM) was not sent on to, or requested by, West Park Hospital – part of The Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) – upon Ms Topley-Bird's admission as an emergency patient. This information would have provided a full understanding of Ms Topley-Bird's mental health and previous attempts to take her own life.

NHSE/I acknowledged to my officials the increased risk to patient safety and the negative impact on experience and outcomes associated with patients being placed out of their usual local network of care for acute mental health treatment. NHSE/I has assured the Department it is working to eliminate all inappropriate acute mental health out of area placements (OAPs) as soon as possible.

NHSE/I has told my officials that the decision to admit Ms Topley-Bird to hospital in Darlington was appropriate in the circumstances of her requiring emergency inpatient admission away from home. NHSE/I notes that the decision about when to transfer Ms Topley-Bird back to London should have been clinically-led with clinicians able to access her full medical history during the interim period to ensure her care was as safe and effective as possible.

Mental health services provided by TEWV are locally commissioned and therefore operational processes, such as those described, are the responsibility of local NHS providers and their clinical commissioning group (CCG) system partners, which commission the services.

However, NHSE/I has noted your concern about an apparent lack of robust information sharing and established transfer protocols and will use the learning from your report to work with its regional teams to consider whether any further guidance or escalation processes should be developed to support local NHS staff to reduce the risk of similar tragic events reoccurring.

I understand Tees, Esk and Wear Valleys NHS Foundation Trust are to respond to you directly on the matters raised at the inquest. TEWV has informed NHSE/I of local action taken following Ms Topley-Bird's death, notably:

- where admission is indicated to a local bed, any information from the home Trust will be forwarded by email directed to the Nurse in Charge of the admitting ward;
- the Trust is exploring compatible electronic solutions to enable staff to print information at non-TEWV sites, with an interim system set up whereby staff follow the Out of Trust Patient Checklist on information sharing; and a new electronic system to be introduced by June 2022 to allow for the printing of medical notes in premises shared with another Trust;
- ongoing work at TEWV to focus on bed management and facilitate patient transfers;
- on admission of a new patient, comprehensive risk profile information is obtained from the admitting team and the home Trust Ward with a checklist to support this,

approved by the Adult Mental Health Speciality Development Group in August 2020 and implemented by all wards during September 2020.

The TEWV's Harm Minimisation Lead has incorporated learning from this case into the Trust's mandatory risk assessment training, with an emphasis on the importance of ensuring that historical risk information is included in the formulation of risk, risk management and contingency planning.

My officials also approached the Care Quality Commission (CQC). The CQC has sought assurances from the Trust in relation to its investigation and has concluded that there is no ongoing risk to service users and that enforcement action was not required.

CQC requested, and was provided with, further information from the Trust to assist with its review of the Trust. In light of your report, the CQC has since written to the Trust to request further information in relation to the incident. This information was provided on 4 May 2021 which is I understand is currently being reviewed by the CQC.

I hope this information is helpful and explains the actions being taken to address the matters of concern. Thank you for bringing these matters to my attention.

NADINE DORRIES