Department of Health & Social Care

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

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Tom Osborne
HM Senior Coroner, Milton Keynes
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27 August 2021

Dear Mr Osborne,

Thank you for your letter of 2 July 2021 to Sajid Javid about the death of Brooke Martin. I am replying as Minister with responsibility for suicide prevention and mental health.

I would like to start by saying how sorry I was to read the circumstances of Brooke Martin's death. I can appreciate how distressing her death must be for her family and loved ones and I offer my most heartfelt sympathies. We must do what we can to learn from Miss Martin's death to prevent future tragedies.

Following evidence heard at the inquest into Miss Martin's death, you are concerned about the compatibility of electronic patient record systems across the NHS, particularly in relation to out of area placements for care, and the potential to support improved outcomes for patients where electronic patient records can be shared between providers of care.

I would like to assure you that our aim is to ensure that all authorised health and care professionals in England are able to access patient-based information about the person they are caring for when they need it, where they need it and in a form they require, regardless of the organisation that captured that information. Achieving this involves the interconnection of multiple information systems across the NHS and social care and other providers of health and care services.

Through the national Shared Care Records programme, by September this year, we expect the majority of Integrated Care Systems (ICS's) to have a basic shared care record in place. Initially, local teams have been asked to aim, as a minimum, for sharing between NHS trusts and general practices within the area covered by their local shared record. Beyond that, we expect local teams to extend the number of partners that participate in their local shared care record to include social care and independent sector providers. The sequencing of this will be determined by the ICS based on their local priorities and existing information systems.

Secondly, we expect each shared care record to begin to exchange information with others so that we can establish national interoperability. The aim is to have this largely in place by March 2023. This will ensure that authorised health and care professionals with a legitimate need to know can readily access the historical records, and, in due course the care plans, associated with an individual in their care.

In parallel with the strategic Shared Care Records programme, all health and care professionals are currently able to access the Summary Care Record with Additional Information[1]. This is a subset of patient information held on GP systems including the SystmOne system referred to in your report. I am advised that there are currently 56,251,937 enhanced Summary Care Records, representing 92.5 per cent of the population registered with general practices. Patients have the right to opt-out of having a basic or an enhanced Summary Care Record. Clinicians have been reminded of the existence of this service, available now, pending the wider deployment of more extensive shared care records in the coming years.

In preparing this response, my officials made enquiries with NHS England and NHS Improvement and its South East region. I am advised that as part of the referral process, comprehensive information relating to Miss Martin was shared by the Surrey and Borders Partnership NHS Foundation Trust, which Elysium Healthcare considered sufficient to proceed with Miss Martin's admission. This included care plans, incident log, risk assessment and clinical information. In addition, I am informed that Miss Martin's referral to Elysium Healthcare was discussed over a number of weeks between Trust and Elysium Healthcare staff, with continuing communication, including the submission of monthly reports, during Miss Martin's admission to Chadwick Lodge.

In relation to the circumstances leading up to Miss Martin's death, and the missed opportunities your investigation has identified, I am advised that Elysium Healthcare conducted an investigation and instigated an improvement plan which I understand has been shared with you. I expect Elysium Healthcare to reflect carefully on the findings of your investigation to determine whether it has taken all the learnings from the circumstances of Miss Martin's death. I am aware that Elysium Healthcare has taken action in several areas including improvements to documentation and dissemination of patient information, monitoring and auditing, as well as training in multi-disciplinary care.

The Care Quality Commission (CQC), the independent regulator for quality, was notified of Miss Martin's death and took steps accordingly to determine whether regulatory activity was appropriate. The CQC is aware of the findings of your investigation and will take these into consideration as part of its monitoring and oversight processes.

You may also wish to note that in the South East region, where electronic sharing of patient information is not yet possible, to support patient care each ICS has adopted a set of Continuity of Care Principles regarding the commissioning of acute and psychiatric intensive care out of area placements. The Principles include requirements in relation to the sharing of patient information.

[1] Additional Information in SCR - NHS Digital

In addition, NHS England and NHS Improvement has established a programme of work to improve mental health inpatient experience, safety and outcomes. The ambitions in the NHS Long Term Plan to reduce the number of deaths by suicide and self-injury and to achieve zero-suicide within inpatient care are key components of this programme of work. There will be a focus on improving collaboration and joint-working and information sharing across secondary, primary and independent care, including digital enablement of record sharing and improved mitigation of risk when this is limited by differing IT systems. In addition, a South East region task and finish group will look at a region-wide approach to training to improve the consistency and quality of nursing observation for patients at risk of self-harm and suicidal ideation. The group will also monitor and audit improvements implemented following incidents to ensure learning is embedded and best practice shared.

Reducing the number of suicides remains a priority for the Government, not least the number of suicides of mental health inpatients. We expect all providers of inpatient mental health services to regularly conduct risk assessments to reduce access to the means to complete suicide and to take all necessary steps to prevent inpatient suicides.

The suicide prevention strategy for England, *Preventing suicide in England: a cross-government outcomes strategy to save lives,* recognises people in the care of mental health services, including inpatients, as high risk and therefore requiring actions to prevent suicides in this group. The strategy sets out that providers should carry out regular assessments of ward areas to identify and remove potential risks, including ligature points, and that ward staff need to be constantly vigilant to potential risk.

In March 2021, we published *Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives*. This includes a cross-Government COVID-19 suicide prevention workplan setting out a list of new actions agreed across Government to prevent suicides, specifically in response to the pandemic; and, an update on ongoing and completed actions from the first cross-Government suicide prevention workplan published in January 2019. The plan includes actions being taken by NHS England and NHS Improvement to prevent suicides amongst mental health inpatients through work led by the National Patient Safety Improvements Programme team.

The programme aims to reduce the number of suicides that occur across inpatient mental health and learning disability services through a range of activities, including supporting the assessment of ligature risks and adherence to the national guidance for ligature management from April 2021.

More generally, we are investing an additional £57million in suicide prevention by 2023/24 through the NHS Long Term Plan. This will see investment in all areas of the country to support local suicide prevention plans and the development of suicide bereavement services.

We are also taking action to support all people with a serious mental illness to be supported in the community where possible. Under the NHS Long Term Plan, we are introducing new models of care which will, by 2023/24, give 370,000 adults with serious mental illnesses greater choice and control over their care and support them to live well in their communities.

On 27 March 2021, we published our COVID-19 mental health and wellbeing recovery action plan, backed by £500million, to support people's mental health in 2021/22. £58million of this will be used to accelerate the roll-out of the community mental health framework to treat adults and older adults with serious mental illness. This includes bringing forward the expansion of integrated primary and secondary care for adults and older adults with serious mental illness; embedding mental health practitioner roles in Primary Care Networks across the country from 2021 to 2022 to better meet the needs of people living with severe mental illnesses in primary care; and, expanding peer support and non-clinical workforce to boost the capacity of community mental health services.

The Recovery Action Plan also includes £6million funding to boost support for specific suicide prevention work. £1million will bolster NHS England and NHS Improvement's work on suicide prevention and £5million is being made available to support voluntary sector organisations that prevent suicide in the community.

Finally, I would like to add that every suicide is a tragedy for the person concerned and their family and friends. NHS England and NHS Improvement South East region and the Surrey Heartlands Integrated Care System have expressed to my officials their commitment to ensuring that the learning from Miss Martin's death is not lost and that family and friends affected by Miss Martin's tragic death, receive appropriate care and support if required.

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

NADINE DORRIES

MINISTER FOR PATIENT SAFETY, SUICIDE PREVENTION AND MENTAL HEALTH