

Department of Health Richmond House 79 Whitehall London SW1A 2NS

Ms L Hashmi HM Assistant Coroner for the County of Greater Manchester (North District) The Phoenix Centre L/Cpl Stephen Shaw Way (Formerly Church St) Heywood OL10 1LR

1 1 FEB 2015

No Hash

Thank you for your letter to Jeremy Hunt about the death of Samiyo Farah. As minister with responsibility for mental health policy I have been asked to respond on his behalf. Please accept my apologies for the delay in replying, which has been caused by an administrative error.

Thank you for your comprehensive account of this case in which you described events leading to Miss Farah's suicide with a homemade ligature on 30 December 2012.

In your report, you drew attention to two issues with relevance for this Department. The first was that there are no observation protocols specifically tailored to young people with mental health issues; and the second that there appears to be a lack of communication between transferring establishments and a lack of national protocol, particularly between the NHS and private sector.

Young people are one of the groups receiving special attention in the Department's suicide prevention strategy for England, published on 10 September 2012.

In addition, the National Institute for Health and Care Excellence (NICE) has already produced detailed guidance on the management and support of children, young people and adults who self-harm, including a quality standard published in June 2013 which covers many of the issues you raise including moving between services. A copy of the quality standard can be found on the following link:

http://www.nice.org.uk/guidance/QS34/chapter/introduction-and-overview

In September 2014, the Government also asked NICE to produce guidance and a quality standard on suicide prevention.



In January 2014, the Department also published an annual report summarising the developments on the suicide prevention strategy at national level. The report sets out the key actions that local areas can take to prevent suicides. It also highlights the importance of responsive and high quality care for people who self-harm.

With regard to transfer protocols between the NHS and the private sector, each Trust currently develops their own. This is because the private sector is not uniform in its approach and it is necessary to take account of this variance as well as relevant patient factors. In general, Trusts would be expected to establish good working relationships and transfer arrangements with those private sector providers with whom they regularly deal.

However NHS England has adopted a number of interim generic policies which underpin its direct commissioning responsibilities. These interim policies have been in place since 1 April 2013 and set the overall parameters within which care is evaluated, planned and delivered.

The policy document - '*Commissioning Policy: Defining the boundaries between NHS and Private Healthcare*' - defines the boundaries between privately funded treatment and entitlement to NHS funding under a range of circumstances and can be found at <u>http://www.england.nhs.uk/wp-content/uploads/2013/04/cp-12.pdf</u>. A copy is also enclosed for your convenience.

In addition, the Royal Pharmaceutical Society has produced guidance about safety and the transfer of patients. *'Keeping patients safe when they transfer between care providers'* can be found at

http://www.nhs.uk/news/2011/07july/documents/transfer%20of%20care%20professional%20guidance%20-%20final.pdf

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Ms Farah's death to our attention.

NORMAN LAMB