Ms Anna Loxton
HM Assistant Coroner for Surrey
HM Coroner's Court
Station Approach
Woking
GU22 7AP

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

12 January 2023

Dear Ms Loxton,

Re: Regulation 28 Report to Prevent Future Deaths – Sandra Kirk who died on 2 August 2021

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 26 September 2022 concerning the death of Sandra Kirk on 2 August 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Sandra's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Sandra's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise to the family for the delay, as I appreciate this will have been an incredibly difficult time for them.

Following the inquest, you raised concerns in your Report regarding the relevant Ligature Risk Reduction Policy which was in place, which does not give guidance on minimising potential ligatures themselves (only ligature anchor points) and does not emphasise the very real risk that specific items of clothing, such as belts and shoelaces, can pose to vulnerable patients. Further, there is only a limited degree of risk reduction with observations taking place 4 times per hour for high-risk patients not in immediate crisis, as death by ligature can occur within a few minutes. You therefore directed that the efficacy of the policy should be considered, including whether it can be improved.

Suicide Prevention

- Integrated care systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. NHS England » What are integrated care systems? As part of the £2.3 billion settlement for mental health in the NHS Long Term Plan, NHSE are providing targeted and ring fenced funding to ICSs so they can deliver their multi-agency plans. This includes suicide prevention activities such as Zero Suicide Plans in inpatient services,

initiatives to prevent self-harm and putting in place postvention bereavement support.

- With the publication of the Long Term Plan (LTP), we committed that, from 2019/20, every area of the country would receive funding for suicide prevention and bereavement services by 2023/24, from the total pot of money of £57 million allocated through the Long Term Plan. Local areas are required to prioritise groups at high risk of suicide in their multi-agency plans, including mental health inpatients.
- Key components will include supporting services with safety planning, using resources such as The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) 'Safer services: A toolkit for specialist mental health services and primary care'

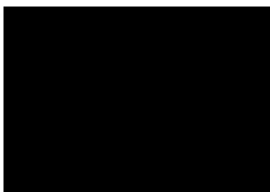
Quality Programme

- NHS England has established a new programme to support the sector with tackling significant quality and safety concerns within Mental Health, Learning Disabilities and Autism (MHLDA) inpatient services.
- The establishment of this new programme has been co-produced with local systems, providers, regions and clinicians and people with lived experience.
- The programme will focus both on helping systems to transform their current service offer, so that only those models of inpatient care which can deliver safe, high quality, therapeutic care are commissioned with community alternatives stood up, and to ensure effective quality improvement support is in place for appropriate models of inpatient care.
- In the aftermath of recent incidents of patient safety and quality failures, NHS England asked every MHLDA provider to review their oversight of patient safety, mitigation for closed cultures, safeguards for patients and patient advocacy arrangements. The outcomes of their reviews have been made publicly available by each Trust at the end of December 2022 in their Trust Board papers.
- In addition to this, NHS England is working to drive longer-term improvements in the following key areas:
    - Providing support to those units across the NHS and independent sector in urgent need of support today.
    - Expediting our work to redesign the model of care more in line with the latest evidence – including addressing risk factors which are more likely to lead to poor outcomes.
    - Driving cultural change and improvement through leadership development, inpatient workforce redesign and change programmes.
    - Change the way we oversee the quality of MHLDA inpatient settings so that the metrics we collect are based upon the known risk factors.
- We are also working with the sector to agree the most impactful immediate actions they can take to improve lived experience oversight of quality and local quality improvement

I would also like to provide further assurances on the national NHSE work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Sandra, are shared across the NHS at both a national and regional level, and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



National Medical Director
NHS England