NHS England

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04 April 2023

Dear Ms Loxton,

Re: Regulation 28 Report to Prevent Future Deaths – Mr Zachary Klement who died on 02 March 2021

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 26 January 2023 concerning the death of Mr Zachary Klement on 02 March 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Zachary's family and loved ones. NHS England is keen to assure the family and the coroner that the concerns raised about Zachary's care have been listened to and reflected upon.

We are aware across both the mental health and learning disability and autism programmes that autistic people can have mental health conditions. Part of our ongoing work is to ensure a greater understanding of the impact of autism on, and better diagnosis for, both autism and the mental health conditions that autistic people may have. We are working with the Royal College of Psychiatrists, and others, to support best practice in diagnosis and treatment for mental health conditions for people who are autistic.

The Health and Care Act 2022 made it mandatory for all staff in regulated services to complete the Oliver McGowan mandatory Training to raise awareness of autism and learning disabilities and to better equip staff to support people who are autistic.

It is a requirement of the Equality Act 2010 that public services make reasonable adjustments for people who have a disability, and this includes people who are autistic. These reasonable adjustments should be across inpatient, community services and talking therapies for mental health services. Services need to ensure that they are not discriminating against people because of their autism and should be providing suitably adapted services.

Person centred services should always be delivered based on the individual's needs – autism does not present in the same way for every person and so services need to meet everyone's needs as they present.

We would always expect that people are offered the least restrictive and least harmful option in terms of care, which may or may not be an inpatient stay. If an

inpatient stay is agreed to be the right option for an individual at any given time, then reasonable adjustments should be made for that individual. However, all options should be considered before an inpatient stay is decided upon. All inpatient units should be places that meet the patients' needs. The sensory-friendly resource pack, which includes the Green Light Toolkit and the sensory guide, supports Trusts to ensure that they meet the needs of people who are autistic. More broadly, we know that the quality of the support provided to people with mental health problems, including people with a learning disability and autistic people in inpatient settings, can vary. In response to this, a new Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme was established in 2022 to support cultural change and a new bold, reimagined model of care for the future across all NHS-funded mental health, learning disability and autism inpatient settings. More information about this new programme of work is available here.

An overarching aim of the Long-Term Plan for Mental Health is to deliver increasingly responsive services, to remove thresholds for access to care and to embed a "no wrong door" mentality across mental health services. The funded expansion and transformation of services through the Long-Term Plan should support this important shift in clinical practice and it should no longer be the case that an assessment of risk leads to a door being closed to a patient. There is clear evidence that risk assessment tools are not an effective basis on which to predict future suicidal behaviour and incidents of self-harm, and should therefore, not be used as a basis for deciding whether to make care and treatment available for an individual. Following the recently updated NICE guidelines for Self-harm: assessment, management and preventing recurrence, NHS England wrote to all Mental Health Providers in England emphasising that clinicians should not use risk assessment tools, scales, or stratification approaches to predict future suicide or to determine who should be offered treatment, or who should be discharged. To support services to adhere to NICE guidance and to enable a definitive change in clinical practice and culture, NHS England is working with NICE, the Department of Health and Social Care (DHSC) and experts in suicide and self-harm prevention to further develop evidence-based best practice in safety planning and the management of needs and risks. This work is being co-produced with experts by experience, local clinical leaders and in line with evidenced based practice.

Through the Long Term Plan, there has also been significant investment in Crisis Resolution and Home Treatment teams, the majority of which are now open-access and operating 24/7 in line with national expectations. While access and capacity has improved significantly since 2017, we know variation in experience and outcomes still exists, and in light of this the recently published Urgent and Emergency Care Recovery Plan sets out that NHS England will support systems to build on the expansion of Home Treatment teams for people with acute mental health needs, with a clear focus on the quality of provision going forward.

Adapted therapeutic approaches can meet the needs of people who are autistic and are suitable to support recovery. The national expectation is that people will access therapies within a few weeks and that for people who are autistic these will be reasonably adjusted using the above resources as guides.
We have also been assured that Surry and Borders Partnership NHS Foundation Trust have taken time to assess training needs for staff and have undertaken a Trust

exercise in providing staff with autism training. All staff since June 2022 have undertaken autism spectrum disorder (ASD) awareness training.

I would also like to provide further assurances on national NHS England work that is 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 preventable deaths are shared across the NHS at both a national and regional level and helps us 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