Christopher Campbell Wilkinson
Senior Coroner
Hampshire, Portsmouth & Southampton
Senior Corner
The Castle
Winchester
SO32 8UL

[redacted]

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

[redacted]

16 October 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Kirsty Clare Taylor who died on 25 June 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 28 July 2023 concerning the death of Kirsty Clare Taylor on 25 June 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Kirsty's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Kirsty's care have been listened to and reflected upon.

Your Report raised concerns over the connectivity between mental health services and those services supporting neurodivergent patients, the mental health provision for those with personality disorders, communication with families of patients with mental health difficulties and support for families of patients with neurodiversity. You also raised that Southern Health Foundation Trust (SHFT) needed to further develop its Personality Disorder Pathway and that more needed to be done to increase connectivity between mental health services and those services supporting neurodivergent patients.

As part of the NHS Long Term Plan, all systems in England have been receiving significant funding from 2021/22 to develop and roll out new models of integrated primary and community mental health care in line with the Community Mental Health Framework for the improved support of adults with severe mental illness in their community and to integrate mental, physical and social care. A key requirement of the new model of care is the provision of a dedicated community mental health offer for those with diagnosis of 'personality disorder' or complex emotional needs. This offer should be co-produced and provide personalised, trauma-informed, and flexible care that is responsive to individuals changing needs. NHS England has shared key principles for the development of services for people with personality disorder and will continue to share guidance and positive practice with health systems.

The Community Mental Health Framework also sets out the importance of engaging both service users and their families and carers, noting that assessments should be a collaborative process involving not only mental health team members but also the patient, their families, carers and support networks.

In September 2023, the Government also published its new Suicide Prevention Strategy for England: 2023 – 2028, a five year cross-sector strategy developed with the aim of reducing suicides in England. The strategy is underpinned by an action plan for organisations including the NHS, the Department of Health & Social Care (DHSC) and from across the voluntary, community and social enterprise (VCSE) sector. It is supported by a wide range of funding which includes £57million for suicide prevention and suicide bereavement services, as well as £150million capital investment into urgent and emergency care mental health pathways.

As part of the strategy, NHS England and DHSC will explore opportunities to improve the quality of care for patients with specific diagnoses of conditions associated with higher rates of suicide and ensure compliance with the National Institute for Health and Care Excellence (NICE) guidelines. This includes patients with personality disorders. It is also intended that by 2024/25 all parts of the country will have introduced crisis text lines to enable easier access to crisis care for people who are neurodiverse.

We also note your concern that more needs to be done within Southern Health Foundation Trust (SHFT) around development of their Personality Disorder Pathway, ADHD services and connectivity between mental health services and those supporting neurodivergent patients. NHS England is engaging with Hampshire & Isle of Wight Integrated Care Board (ICB) on the concerns raised and have been asked to be sighted on their response to your Report.

I would also like to provide further assurances on national NHS England 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 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