Department of Health

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Mr E. Thomas,
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03 Dec 2015

Dear Mr Thomas.

Thank you for your letter of 8 October 2015, following the inquest into the death of Rebecca Jones. I was sorry to hear of Ms Jones's death and wish to extend my condolences to her family.

You raise four concerns as a result of this case:

- the design of Section 136 Suites;
- the importance of continuous observation of the mental health patient;
- the training provided for bleep holders; and
- the need for good communication between mental health trusts.

Although steps have already been taken by the Hertfordshire Partnership University NHS Foundation Trust to address these concerns, you suggest that such issues might need to be addressed across all Mental Health Trusts.

Both NHS England and the Care Quality Commission (CQC), through the winter resilience programme and the annual survey of health based places of safety respectively, are aware that some areas still do not have adequate capacity for health-based places of safety. To remedy this, NHS England is spending £15m in 2016/17 to boost provision in those areas that need it most. This will include improving standards in existing places of safety to ensure that they are equipped to care for people safely and compassionately when detained under the Mental Health Act.

NHS England, as part of its national crisis care programme, will be developing commissioning guidance for effective crisis response. This will include specific

guidance on health-based places of safety and the clinical and physical standards of s.136 suites. This process will have a multi-agency group including leading experts from healthcare, policing, social care, and other representatives. Part of this work will see the development of national datasets so that standards of mental health crisis care can be measured and made transparent at a national level.

The CQC has also undertaken valuable work focussing on health based places of safety. In October 2014, they published the report, *A safer place to be,* which details findings from a survey to examine the provision, use and accessibility of health-based places of safety for people detained under section 136 of the Mental Health Act. In June 2015, CQC published, *Right here, right now*, a review of the quality, care and effectiveness of care provided to those experiencing a mental health crisis.

Both of these publications fulfilled some of CQC's commitments under the national Mental Health Crisis Care Concordat, a national agreement setting out how health, policing and local government partners should improve their responses to people experiencing a mental health crisis.

CQC has also selected health-based places of safety as one of the core services to be regularly inspected as part of its comprehensive inspection activity for specialist mental health services.

In addition, local multi-agency Concordat action plans have been in place across the whole of England since May 2015, and local partnerships are working together to review their section 136 protocols as part of this process.

Your second concern relates to patient observation. You report that the lack of continuous observation was a factor in Becky's absconding. However, her initial low risk assessment on admission to Lister Hospital's Section 136 Suite should have determined the level of patient observation that was considered necessary at the time.

There is guidance for professional staff in this area. The Mental Health Act Code of Practice is clear that increased levels of observation (which includes intermittent observations) may be used to prevent suicide or serious self-harm. Levels of observation and risk should be regularly reviewed and a record made of agreed decisions in relation to increasing or decreasing the observation.

NICE have also produced guidelines. Guideline 25, "*The short term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments*" recommends nationally prescribed levels of observation based on the patient's risk level.

Although such observation guidelines exist, their implementation is a matter for each local NHS Trust. However, I would expect all hospitals to have clear written policies on the use of observation. This should include requirements to record when observations are carried out and the findings.

The National Confidential Inquiry into Suicide and Homicide (NCISH) undertook a review of constant and intermittent observation on mental health units entitled, *"In-patient suicide under non-routine observation"* published in March 2015. Current observation approaches were found not to be safe enough and new models should be developed and evaluated. NHS England will ensure that the recommendations of the NCISH report, including those which relate to improving the reliable delivery of effective observation, are considered and implemented.

"Bleep holder" training is part of Continuing Professional Development (CPD) and such training is primarily the responsibility of employers. However, Health Education England (HEE) spends approximately £215million per year on activities which together are termed as 'workforce development'. HEE is undertaking a root and branch review of its workforce development spend, in response to its mandated commitment to ensuring professional and personal development beyond the end of formal training.

The Health and Social Care Act places a duty on the health system to promote autonomy for providers of healthcare or those that provide services that assist that purpose. Although HEE cannot impose specific CPD activities on employers or the workforce, it endorses the policy of Hertfordshire Partnership University NHS Foundation Trust in providing more training for bleep holders adopted in the wake of Ms. Jones' death.

It is vital that there is good communication between professionals across agencies to ensure continuity of care for the patient and to provide the most appropriate support for patients whenever and wherever they present to a service.

NHS England recognises the importance of effective, timely and appropriate transfer of key information that follows the patient through the healthcare system. Working with partners, NHS England is currently developing a range of tools and guidance to support commissioners and providers in the transformation of urgent and emergency

care services. This will include use of enhanced summary care records and will enable better access to patient care plans, end of life care records, special patient notes and mental health crisis notes. Such moves will help to improve communication between mental health trusts and ensure that those caring for patients transferred between services are kept fully informed of the patient's care needs.

I am grateful to you for bringing the circumstances of Ms Jones's death to my attention and hope that you find this reply helpful.

Yours sincerely

Alistair Burt

ALISTAIR BURT