NHS
Improvement

Medical Directorate

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Nicholas Leslie Rheinberg
Assistant Coroner for Wiltshire and Swindon
Wiltshire & Swindon Coroner's Court
26 Endless Street
Salisbury
Wiltshire
SP1 1DP

19 November 2018

Dear Mr Rheinberg

RE: Terence Andrew Bennett deceased

I am writing in response to your letter dated 14 September and the attached copy of the report following the Inquest into the death of Mr Bennett. Please accept my apologies for our delay in responding. On behalf of NHS Improvement (NHSI) may I take this opportunity to express our sincere condolences to the family of Mr Bennett following his tragic death.

NHSI is grateful to you for sharing the report and, as you suggest, acknowledge the findings have relevance to other Trusts in the country. We will ensure they are shared internally.

The Coroner may also find it helpful to know about a national programme to improve mental health services and how we are working with the Trust to address the failings identified in the Coroner's report. I have set out details below.

This year NHSI in partnership with the Care Quality Commission (CQC) was tasked by the Secretary of State to improve patient safety in mental health trusts by delivering a national mental health safety initiative.

The overall aim of the programme is for every NHS trust providing core mental health services in England to have understood their safety priorities and have made a measurable improvement in at least one key area of mental health safety by 31 March 2020.

In order to meet this aim, the programme will work to:

- Align Arm's Length Bodies (ALBs) understanding and resources relating to safety, assurance and improvement culture
- Create sustainable mental health improvement resources
- Map existing networks, resources, and best practices relating to safety across mental health services
- Work with the Department of Health and Social Care to ensure its approach is aligned to national policy

The programme's underlying approach to safety is one that addresses leadership, capability and culture. The key areas of focus are:

- Safety on mental health wards (including restrictive practice, violence and sexual safety)
- Medications management
- Use of informatics to support safety at all levels
- Environmental awareness
- Safe management of referrals and waiting lists
- Increase in knowledge and expertise at a regional level
- Plus, any key areas agreed by individual trusts and the Mental Health Safety Improvement Programme.

In addition, the Five Year Forward View for Mental Health set out clear recommendations on suicide prevention and reduction, and made a commitment to reduce suicides by 10% nationally by 2020/21. Alongside this, the Secretary of State announced a zero suicide ambition for mental health inpatients in January of this year and NHSI is working closely with other ALBs to help services achieve this aim. The approach includes supporting trusts to develop a clear understanding of the definition and practical implementation of the ambition including processes to support the identification of patients who present as a high risk of self-harm or suicide.

In addition to these points relating to improving patient safety in mental health, I outline below our regulatory and oversight approach with system partners to provide assurance that appropriate action is taken to address the serious failures identified through this, and other Coroner's reports.

As you may be aware, the original incident was recorded as a Serious Incident (SI) on the Strategic Executive Information System (known as StEIS) in accordance with the Serious Incident Framework. Under the Framework, a trust's CCG (in this case Wiltshire CCG) oversees its response to an SI, both the immediate action required through to undertaking the investigation and producing a final report and action plan. If there is a Coroner's inquest the SI is not closed until the outcome from the inquest is known and a satisfactory response/action plan is developed.

When the Regulation 28 letter was received by Wiltshire CCG in September 2018 it did raise concerns similar to the themes previously identified by the Trust's 'root cause analysis' (that was undertaken as part of the investigation into the SI) particularly around reducing the number of suicides. These concerns led to the system partners setting up a quality improvement summit to focus on suicide prevention, with its first meeting being held in September. The follow up is planned for December 2018. NHSI, NHS England, Wiltshire CCG, Swindon CCG and Bristol CCG are participating in this.

In addition, the system partners have been working together to review the co-ordinated regulatory/oversight approach to the concerns and failings identified by the Coroner. NHSI has discussed with the Trust the Coroner's report and the key changes that have already been put in place. It has also commented on the Trust's response to the Coroner and action plan to address the issues raised. We will continue to oversee and hold the Trust to account for its actions at our monthly oversight meetings and through regular calls with the Trust's Director of Nursing and Medical Director. NHSI is also working with the Trust and key partners on a support package for the Trust as it reviews and strengthens its governance arrangements for quality.

I trust you will find this information of assistance and should you require any further detail please do not hesitate to contact me.

Yours sincerely

Dr Kathy McLean OBE
Executive Medical Director and Chief Operating Officer
NHS Improvement