Department of Health & Social Care

From Nadine Dorries MP
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Suicide Prevention and Mental Health

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Mr Nigel Parsley
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16 December 2020

Dear Mr Parsley,

Thank you for your letter of 12 October to Matt Hancock about the death of Piotr Kierzkowski. I am replying as Minister with responsibility for mental health and suicide prevention and I am grateful for the additional time in which to do so.

I was saddened to learn of the circumstances of Mr Kierzkowski's death and wish to offer my sincere condolences to his family and loved ones. We must do all we can to take the learnings from Mr Kierzkowski's death to improve the safety of NHS care for others.

Your report raises matters of concern relating to the availability of mental health beds for patients who require informal admission to hospital in a crisis; and alternative provision where an inpatient bed is not immediately available.

In preparing this response, my officials have made enquiries with NHS England and NHS Improvement (NHSE/I) to understand the action taken locally to improve the provision of mental health emergency care.

Local bed capacity and crisis care

I am advised by NHSE/I that the Norfolk and Suffolk NHS Foundation Trust has increased capacity through the opening of four crisis house beds in Norwich, with plans to open two additional crisis houses in the coming months, as well as extra ward capacity for older people. This is expected to significantly enhance local bed capacity.

I am further advised that the Trust has reviewed its bed management processes to ensure they facilitate clinically-led admissions; make use of every available alternative to out of area placements; and support safe discharge. In line with national policy, I am assured that the Trust is developing its community mental health services so that safe and effective care can be provided as close to home as possible.

I am encouraged by these developments locally. However, it is important that the Trust and local commissioners ensure that they reflect carefully on the circumstances of Mr Kierzkowski's death and identify any opportunities for further learning. To support learning at a national level, my officials have brought your report to the attention of the Care Quality Commission (CQC), as the independent regulator of quality, and NHSE/I, as system leader of NHS-funded care.

National improvements to mental health provision

At a national level, I would like to assure you that the overarching aim of the NHS Long Term Plan[1] ambitions and new investment in mental health services, is to ensure that people can access the appropriate service for their needs in a timely way, preventing further deterioration and allowing the least restrictive care. This means caring for people outside hospital where it is safe to do so, but ensuring that when admission is required, it can be arranged immediately and as close to home as possible.

There are a number of key commitments that support this aim, most notably the national policy to end reliance on adult acute out of area placements by April 2021. This commitment aims to ensure that all local mental health systems are operating effectively, with sufficient local bed capacity so that everyone can be admitted close to home and at the right time.

However, patient safety is the first priority and NHSE/I, as system leader, is clear that if an urgent admission is required and a local bed is not available, mental health providers should seek and secure a placement out of area. You may wish to note that it is not the case that detention under the Mental Health Act is required to access a bed quickly.

National and regional support has been provided to mental health services working to reduce out of area placements, with a particular focus on those areas that have been the most challenged. This includes clinically-led, bespoke improvement support and ensuring that strategies are in place to invest in community services and alternatives to admission.

To deliver early and effective intervention for people in mental health crisis, the NHS Long Term Plan focuses on:

- Transforming and expanding community mental health services for adults and older adults with severe mental illnesses. By the end of 2023/24 every local health system will have at least one new community service model in place, giving patients greater choice and control over their care, and supporting them to live well in their communities; and,
- Delivering 100 per cent coverage of 24/7, age-appropriate crisis care, via NHS 111, by 2023/24.

In recognition of the additional service pressures this winter resulting from the COVID-19 pandemic, an additional £50million is being provided to deliver strengthened support for mental health patients following their discharge from inpatient care over the coming months. This will be used to ensure that patients who are ready to leave inpatient facilities

[1] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

have the community support they need and will improve the availability of inpatient care for those who require it.

Suicide prevention

I would also like to explain the important work being taken forward on suicide prevention.

In 2018, we launched a zero-suicide ambition for mental health inpatients which means that every mental health NHS trust now has a zero-suicide ambition plan in place.

In January 2019, we published the first Cross-Government Suicide Prevention Workplan[2], which sets out an ambitious programme across national and local government and the NHS and will see every local authority, mental health trust and prison in the country implementing suicide prevention policies.

I am pleased to say that every local authority now has a multi-agency suicide prevention plan in place and we are working with local government, including investing almost £600,000 to assure the effectiveness of those plans.

We have made further investment of £1.8 million to support the Samaritans helpline and £2 million for the Zero Suicide Alliance, which aims to achieve zero suicides across the NHS and in local communities by improved suicide awareness and prevention training and developing a better culture of learning from deaths by suicide across the NHS.

From 2019/20, the Government has been investing £57 million in suicide prevention through the NHS Long Term Plan. This will see investment in all areas of the country by 2023/24 to support local suicide prevention plans and establish suicide bereavement support services. We have ensured that the suicide prevention funding for local areas includes addressing self-harm as a priority focus.

The NHS Long Term Plan also commits to developing integrated models of primary and community care to support people with complex needs, including self-harming.

In addition, we have:

- Invested £249 million to ensure every Accident and Emergency department has a mental health liaison team in place by 2020/21; and
- Committed to ensuring that 70 percent of liaison mental health teams meet the 24 hours a day, seven days a week standard by 2023/24 and 100 percent thereafter, in the NHS Long Term Plan.

Commenting on the wider aspects of your report, you may wish to note that in 2018, the Healthcare Safety Investigation Branch (HSIB) undertook an investigation and produced a report Provision of mental health care to patients presenting at the emergency department for wider learning within the NHS. HSIB's report reinforced the need for improved access to emergency mental health care and made four safety recommendations.

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2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/772210/national-suicide-prevention-strategy-workplan.pdf

A summary of responses to the recommendations is available online[3].

As already outlined, NHSE/I is working to expand the provision of urgent and emergency liaison mental health services across England in line with commitments made in the NHS Long Term Plan. This includes expanding the provision of services for people experiencing a mental health crisis and increasing alternative forms of provision.

In addition, the CQC has made changes to its assessment of the quality and safety of care in its inspections of acute hospitals. This includes that mental health inspectors now routinely participate as part of the inspection team, and there are new key lines of enquiry focused on mental health provision in its inspection framework.

You may wish to note that in October 2020, the CQC published a report on the Assessment of Mental Health Services in Acute Trusts (AMSAT) that highlighted issues around access to and provision of mental health services in acute trusts, including in Emergency Department (A&E) settings. While CQC found some progress, it identified that there is a need for improvement across AMSAT mental health provision and for better access to mental health care and support.

CQC's AMSAT report found that while staff were working hard in difficult circumstances, the system often limited their ability to provide the best possible mental health care to patients. CQC recommended steps that providers, clinical commissioning groups and local authorities can take to improve the quality of care for patients.

In summary, this Government is committed to improving mental health provision across the country and there is a particular focus on suicide prevention in the NHS Long Term Plan for Mental Health, which includes improving access to emergency mental health care for those who need it.

I hope this response is helpful. I am grateful to you for bringing these concerns to my attention.

Yours sincerely,

NADINE DORRIES

MINISTER OF STATE FOR PATIENT SAFETY, SUICIDE PREVENTION AND MENTAL HEALTH

[3] https://www.hsib.org.uk/investigations-cases/provision-mental-health-services-emergency-departments/