Department of Health

From Nicola Blackwood MP
Parliamentary Under Secretary of State for Public Health and Innovation

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[redacted]

Ms P A Schofield
Senior Coroner
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Dear Ms Schofield

Thank you for your letter dated 5 October 2016, following the inquest into the death of Amy Rose El-Keria.

I was very sorry to hear of Miss El-Keria's death. Please extend my sincere condolences to her family.

You have raised the following matters of concern:

- The staffing levels at Ticehurst House Hospital and availability of national guidance on staffing levels for inpatient Child and Adolescent Mental Health Services (CAMHS)
- An on-going shortage of acute mental health beds for young people close to the community where they live.

NHS England and Health Education England (HEE) are working to improve the capacity and capability of workforce delivering mental health care for children and young people, so that by 2020 an additional 70,000 receive effective treatment per year. This work extends to supporting training programmes for staff working in inpatient CAMHS to improve team functioning and delivery of evidence-based care.

I have been advised that in 2016, NHS England commissioned the Royal College of Psychiatrists and National Collaborating Centre for Mental Health (NCCMH) to develop guidance on the implementation of the staffing required to deliver safe, effective and compassionate care in inpatient and community mental health care for children, young people and adults. The guidance will be relevant to commissioners, providers, young people and parents, and will contain:

- A methodology for delivering safe, effective, compassionate and sustainable staffing;
- Guidance on staffing to support delivery of the evidence-based treatment pathways (these include pathways for children and young people);
- Recommendations on minimum staffing numbers and competences required across different mental healthcare settings;
- Positive Practice Examples and Helpful Resources pack

This programme is expected to be completed by December 2017 and will inform future revisions of the service standards for the Quality Network for Inpatient CAMHS (QNIC), which are reviewed every two years.

You have also raised concerns about the quality of care provided to Miss El-Keria whilst she was in Ticehurst House Hospital and in particular the ability of staff to mitigate risks of suicide and self-harm.

The Government revised the Mental Health Act 183 Code of Practice in 2015, which we expect all mental health providers to implement. The Code of Practice is clear that patients should have in place a robust care plan developed by a multi-disciplinary team and that this should include effective risk assessment.

The Department of Health published good practice guidance on assessing and managing risk in mental health in 2009. This can be accessed through the GOV.UK website at the following address:
https://www.gov.uk/government/publications/assessing-and-managing-risk-in-mental-health-services

You have also raised concerns about access to CAMHS inpatient beds close to where they live.

I am aware of instances where children have had to travel too far away from home to access care. The Prime Minister announced in January 2017 that by 2020/21 no child will be sent out of their local area for non-specialist care. You may also be aware that NHS England has reviewed CAMHS inpatient services nationally which has resulted in an additional 56 CAMHS inpatient beds being commissioned across the country to meet demand.

However, we should also be seeking to avoid unnecessary admissions to hospital wherever possible. That is why the Government is developing a comprehensive set of community-based mental health service pathways and standards so that more people can be treated in the community closer to home. We have also invested £400 million to improve crisis care services in the community so that people receive the right care

in the right place when they experience a mental health crisis. Every local area now has a mental health crisis care action plan in place.

This Government is committed to achieving parity of esteem for mental and physical health. We have invested £1.4bn over the course of this Parliament in children and young people's mental health and we remain committed to delivering the vision set out in the *Five Year Forward View for Mental Health* and *Future in Mind* to transform mental health services. Every area in the country now has a children and young people's transformation plan in place to achieve this and every area has developed a sustainability and transformation plan to deliver long-term improvements to health services.

Every death of a person in a mental health setting is a tragedy and every patient has the right to expect high quality and safe care. This is why we commissioned the Care Quality Commission (CQC) to review the way in which deaths of people in NHS settings are investigated and learned from to avoid further tragedies.

On 13 December 2016, the CQC published the findings of its review in a report titled *Learning, candour and accountability: A review of the way NHS trusts review and investigate deaths of patients in England*. It concluded that learning from deaths is not currently being given sufficient priority within the NHS and that bereaved families and carers have poor experiences with providers.

The Secretary of State accepted the CQC's recommendations for improvement and a programme to deliver his commitments is underway. The first stage will be the delivery this year of a National Framework on Learning from Deaths for NHS providers. The aim is to standardise and improve practice across providers by providing clear expectations in relation to identifying, reporting, reviewing, investigating and learning from deaths, and significantly, engaging with bereaved families and carers. From April 2017, Trusts will be required to publish specified information on deaths each quarter, including estimates of how many deaths were judged more likely than not to have been associated with problems in care. Trusts will also be required to publish evidence of learning and action as a result of the information. This increased transparency, through improved data collection and reporting, is about supporting a systemic, NHS-wide approach to learning from deaths. The CQC will also strengthen its assessment of providers by covering learning from deaths.

In addition, as a result of cases such as that of Miss El-Keria's, earlier this year I set out measures for how we will improve the recording and monitoring of deaths of patients under the care of inpatient child and adolescent mental health services, with every death now directly reported to Ministers.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Miss El-Keria's death to my attention.

Yours sincerely

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NICOLA BLACKWOOD