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Dr Shirley Radcliffe
HM Assistant Coroner
Inner West London
Westminster Coroner's Court
65 Horseferry Road
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5th April 2019

Dear Dr Radcliffe,

Re: Regulation 28 Report to Prevent Future Deaths – Miss Sophie Holman, 13.12.2017.

Thank you for your Regulation 28 Report (hereinafter the 'report') dated 29th January 2019 concerning the tragic death of Miss Sophie Holman on 13th December 2017. Before seeking to respond to your report I would like to first express my deep condolences to Sophie's family.

Your report concludes that Sophie's death was as a result of an asthma attack. Following the inquest, you raised concerns regarding the care Sophie had received across both primary and secondary care, and you also urged the National Health Service to take action and revisit national policy around asthma for children, particularly in light of the NHS Long Term Plan.

From the information you have provided, it is apparent that Sophie's condition was not managed in accordance with published asthma guidelines. Tragically, I note we can draw comparison to Michael Uriely and Tamara Mills whose deaths were also associated with treating asthma episodes separately rather than managing their asthma as a long-term condition.

For this case I can confirm Barking, Havering and Redbridge University Hospitals NHS Trust ("Trust") have been contacted directly and they have assured us that they have taken very seriously the findings of the inquest and have held internal meetings to review the troubling concerns raised. I understand that the Serious Investigation Report as presented to the Coroner has also been shared with the Clinical Commissioning Groups (CCGs) covering the Barking, Havering and Redbridge health system who are now working closely with the Trust to develop more extensive local system plans to improve services and share learning. They have assured us that immediate actions have been taken to improve the quality of their asthma care pathways to prevent future deaths.

In terms of national policy, I note that in previous communication to you we detailed steps NHS England were taking in working with the wider NHS with a view to improving asthma care for children. However, despite our ongoing efforts, child asthma deaths still occur and we recognise that much more needs to be done. Sadly, a new study[1] published in February this year, from the Nuffield Trust think tank and the Association for Young People's Health, found that young people in the UK are more likely to die from asthma than those in other wealthy countries. It is very clear that we must change this, and I can confirm we are determined to do more to ensure that the NHS appropriately manages and improves the care of childhood asthma across England, with a view to preventing further asthma related deaths.

NHS England published the NHS Long Term Plan[2] in January 2019. Within the plan we committed to focusing on the health and care of children and young people, and to launch a 'Children and Young People's (CYP)Transformation Board'. As part of this we will work to develop new models of integrated care that will bring together services and connect vital information for children and young people. We are particularly keen to focus on continuing healthcare needs and from Autumn 2019 we will roll out CYP clinical networks for long-term conditions focusing on asthma, epilepsy and diabetes. These CYP networks will link to primary care networks[3] whilst focusing specifically on the needs of children, young people and their families and the improvement of services by sharing best clinical practices and supporting the integration of paediatric skills across services.

I can confirm that improving the quality of care will be a key focus for the new CYP Transformation Board, and we will prioritise action on conditions such as asthma where our clinical outcomes are unacceptable. This work will start from April 2019 and bring together key stakeholders from across the NHS and the wider public sector. The board will be led by the Chief Executive of Birmingham Woman's and Children's Hospital I can confirm that we will include a review of national asthma policy and existing clinical guidelines, including the 2014 NRAD (National Review of Asthma Deaths) report[4], in order to determine appropriate actions to be taken on both a national and local level to establish better consistency. This may include but will not limited to:

- a national recommendation for appropriate asthma management plans;
- development work to enable systems alerts and follow ups;
- safety netting and self-care advice for patients and parents; and
- the promotion of educational material for professionals.

We will also be working to improve access to specialist paediatric care in the community, as we know this will have a positive impact. Also through the clinical networks we will continue to share examples of best practice from areas that are

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[1] https://www.nuffieldtrust.org.uk/research/international-comparisons-of-health-and-wellbeing-in-adolescence-and-early-adulthood

[2] Published in January 2019, https://www.longtermplan.nhs.uk/

[3] Primary care networks are based on neighbouring GP registered lists, typically serving natural communities of around 30,000 to 50,000. They should be small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system. https://www.england.nhs.uk/gp/gpfv/redesign/primary-care-networks/

[4] https://www.hqip.org.uk/former_programmes/national-review-of-asthma-deaths-nrad/#.XKRhaTaouYM

delivering asthma services well, such as: the community Paediatric hospital at home service at the Whittington Hospital where a single named point of contact is assigned to each child and follow up appointments with a GP after any hospital admission are organised within a given timeframe; the work of Health London Partnerships (HLPs) who have pioneered developing local asthma standards, digital support tools and enlisted pharmacy help to improve inhaler techniques which was shared at NHS England's Quality Assurance Group (QAG)[5] in June 2017.; and from Connecting Care for Children (CC4C) who have developed integrated and joined up care from the hospital ward to GP centre.

In addition to the CYP Transformation Board and Programme being established shortly, I can confirm we will also contact the Royal College of General Practice and the Royal College of Paediatrics and Child Health, to discuss what more can be done to raise awareness amongst healthcare professionals about the need to actively manage childhood asthma and the importance of asthma care plans.

In addition, within your letter you also ask about the possibility of preventable paediatric asthma deaths being classified as a 'Never Event'. As stated previously the National Clinical Lead for children and young people and clinical advisers with in the Healthy London Partnerships reviewed this possibility. They concluded that as Never Events usually only apply to in hospitals care not the wider NHS system and that not all asthma deaths are preventable that this might not be the best driver to enact the major system change we need. We hope that the urgent work we are taking forward now on paediatric asthma, though a combination of interventions driven by the CYP Transformation Board, will go some way in preventing future child asthma deaths.

Thank you for bringing this important patient safety issue to my attention again, we will endeavour to do more on childhood asthma. Please do not hesitate to contact me should you need any further information.

Yours sincerely

Professor Stephen Powis
National Medical Director
NHS England and NHS Improvement

[5] The QAG brings together all of NHS England's Regional Medical and Regional Nursing Directors to discuss and address quality and safety issues within each region.