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29 September 2022

Dear Ms Wharton

Re: Regulation 28 Report to Prevent Future Deaths - Dean Ryan Crossman who died on 18 June 2019.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 7 June 2022 concerning the death of Dean Ryan Crossman on 18 June 2019. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Dean's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Dean's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to the Repost, and I apologise to the family for the delay, as I appreciate this will have been an incredibly difficult time for them.

Following the inquest, you raised concerns in your Report regarding:

1. Evidence was given at the inquest that at the time of Dean's passing, there were issues accessing second (s.12) doctors out of office hours for the purpose of carrying out a Mental Health Act (MHA) assessment, resulting in delays to MHA assessments being carried out. The Emergency Duty Team (EDT) explained that since Dean's passing, a "s.12 Solutions" App has been introduced, and although this had made a significant improvement, issues still exist trying to access a second doctor out of hours, as the EDT is still wholly reliant on second doctors making themselves available after midnight (with no fixed rota).

2. Evidence was given at the inquest that at the time of Dean's passing, there were issues securing the timely attendance of the private ambulance service (ERS Medical) to transport patients after a MHA assessment had taken place, potentially resulting in an increased risk to both the Approved Mental Health Professional (AMHP) and the patient for MHA assessments in the community. The EDT advised that since Dean's passing, despite spot purchasing of private ambulances being introduced, issues still exist trying to get the private ambulance to attend a MHA assessment in a timely manner.

3. Evidence was given at the inquest that both of the above matters of concern are on-going national issues.

It is critical that when a MHA assessment is required it is undertaken in a timely manner. The issues regarding availability of s.12 doctors are widely recognised and, as a result, the Independent MHA Review (2018) recommended that the Government review and address the factors that affect the timely availability of these clinicians. Section 12 doctors are approved by the Secretary of State under section 12(2) Mental Health Act 1983 and, in recognition of the national staffing issue, the Government confirmed in the White Paper, 'Reforming the Mental Health Act' (August 2021), that it has commissioned research to explore the factors promoting and inhibiting the accessibility of s.12 approved doctors to participate in MHA assessments in England and Wales.

The Department of Health and Social Care commissioned the National Institute for Health and Care Research (NIHR) to carry out a study of the reasons for and nature of reported difficulties in accessing s.12 doctors for MHA assessments. The NIHR published the outcome of their study in September 2021 in the report "*The availability of section 12 doctors for Mental Health Act assessments: Interview perceptions and analysis of the national MHA Approvals Register Database".* A link the report is : here

The study had two main findings:

- Firstly, the main problem is the availability of s.12 doctors, rather than overall numbers. This suggests a need to focus on encouraging psychiatrists and other s.12 doctors to make themselves more available for doing MHA assessments.
- Secondly, there is currently no real way to tell how many s.12 doctors are needed without better information about the numbers of MHA assessments attended by different doctors, in what circumstances.

The Department is working with regional approval panels to increase the number of s.12 doctors and consider what more can be done to improve availability, alongside the Mental Health Act reforms.

Integrated care systems (ICSs) are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. Each local system has responsibility to ensure that the section 12 rota for their area is adequately managed, to ensure 24/7 availability of s.12 doctors. NHS England recognise that, while doctors may indicate their availability for certain times and days on local rotas, this does not obligate them to accept a request to attend and undertake a MHA assessment. The National NHS England Mental Health Team will review this issue via our regional NHSE teams to understand if there are any local areas where this is a particular concern, and if there is anything further that can be done nationally to help mitigate the issues. This may include sharing and promoting best practice approaches from areas that are successfully ensuring s.12 doctor availability, including after midnight / out of hours.

It is also critical that appropriate transportation is commissioned and is available to transport someone to the appropriate setting, to meet their needs in a timely manner.

This is particularly important after a MHA assessment has taken place, and is the responsibility of Integrated Care Boards (ICBs) who commission services for their footprint. Integrated Care Boards replaced Clinical Commissioning Groups (CCGs) as the **statutory NHS organisation** which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in a geographical area.

In recognition of the significant role the ambulance service plays in responding to mental health calls, the NHS Long Term Plan, published in January 2019, stated that "Ambulance staff will be trained and equipped to respond effectively to people in a crisis", alongside a programme of investment (£70 million by 2023/24) to improve the capacity of ambulance services to respond to urgent and emergency mental health needs.

There are three key strands to the NHS Long Term Plan work programme on improving the mental health response of ambulance services:

1. funding of mental health nurses and other mental health professionals working alongside colleagues in integrated urgent care clinical assessment services (CAS) and ambulance emergency operation centres (EOC) and providing on-the-scene response;
2. training for ambulance staff to improve skills and competencies in relation to supporting patients with mental health needs; and
3. capital funding for **dedicated mental health response vehicles** to increase capacity to respond in a more timely manner, in a more suitable vehicle. A vehicle specification has been developed with patients, clinicians and fleet experts.

   One of the aims of the Long Term Plan ambition is to provide timely assessment from trained mental health staff. For patients detained under Section 136 of the Mental Health Act, ambulance services have committed to an average 30-minute response and this is reflected within ambulance quality indicators (AQIs).

   The NHS England Ambulance Quality Indicators (AQIs) were first introduced in 2011 to drive strong performance and identify areas for improvement across the sector. The data includes, for example, call answer and response times, and clinical outcomes of patients treated by the ambulance services for a number of presentations.

   The AQI system indicators specification has recently been updated (and will apply to data from 1 October 2022) to support improvement in mental health response, and advises that services should aim to achieve the measure of a mean (average) Section 136 response time of 30 minutes or less.

As set out above, this investment is largely intended to support emergency response and conveyance but, where appropriate locally, it may also help to alleviate pressure on critical transportation requirements after planned MHA assessments, as in this case.

I would also like to provide further assurances on the national NHSE work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by a Regulation 28 Working Group, comprising Regional Medical Directors and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Dean Crossman, are shared across the NHS at both a national and regional level, and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

National Medical Director