NHS England

Mr John Taylor
South London Coroner's Court
2nd Floor, Davis House
Robert Street
Croydon
CR0 1QQ

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

26 June 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Mr Samuel Thomas Howes who died on 02 September 2020

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 24 April 2023 concerning the death of Mr Samuel Thomas Howes on 02 September 2020. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Samuel's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Samuel's care have been listened to and reflected upon.

This response focuses on the national NHS policy and programmes relevant to the matters of concern you have identified in your Report. Most of the matters of concern raised in your Report are in respect of the provision of local support and the actions taken in providing that support to Mr. Howes and his family. These local concerns would need to be addressed by the relevant local commissioners and providers.

Your Report however does raise a matter of concern that is relevant to national policy and service delivery, which we would like the opportunity to address:

1) Samuel's case should be a stimulus for some level of Child and Adolescent Mental Health Service reflection of how different Child and Adolescent Mental Health Services (CAMHS) are organised and work together.

Improving mental health support for children and young people is a priority for NHS England. The NHS Long Term Plan (LTP) sets an ambitious commitment that access will increase, with 345,000 more children aged 0-25 accessing support in 2023/24 compared to 2019. We have made significant progress towards this commitment with a record of 720,817 children and young people receiving support from the NHS in the 12 months to February 2023. This has been achieved through investment in the children and young people's mental health workforce, which has increased by 46% since the start of the LTP, and by 70% since 2016. However, the prevalence of mental health need has also increased following the pandemic in 6-16 year olds from 1 in 9

to 1 in 6, and in 17-19 year olds from 1 in 10 to 1 in 6. Many services face significant demand and, therefore, increasing access to support continues to be a priority.

We also accept that alongside increasing capacity across services, there is a need to ensure Children and Young People's services are integrated with support across the whole system – including mental health support as part of the transition from child to adult services for adults, physical health needs, social care, education and health and justice. This includes integration with drug and alcohol services, which are largely commissioned by Local Authorities. Oversight of drug and alcohol service policy rests with the Office for Health Improvement and Disparities within the Department for Health and Social Care, who are copied into the Report.

While local commissioners are responsible for ensuring services are integrated, NHS England has a role to support this at national and regional levels. We have established Clinical Networks and regional delivery groups for mental health across NHS regions to support commissioning of effective services. We have ensured the leadership in these networks and groups are aware of the findings of this Report. NHS England commissioned the National Collaborating Centre for Mental Health to review models of care for young adults aged16 - 25. Their report published in 2022 highlighted examples of positive practice in terms of integration including and set out principles and considerations to inform the development of support, care and treatment for young people. This includes considerations where young people have co-existing mental health and substance abuse needs.

In terms of care for the most complex needs:

The **Framework for Integrated Care (Community)** ("Framework") is the evidence-based response to the NHS LTP commitment to invest in additional support for the most vulnerable children who have complex needs. These are young people who could be described as presenting with high-risk, high-harm behaviours and high vulnerability.

The Framework is now well established, and following expressions of interest, 12 vanguard sites have been selected with one in each of the seven NHS England regions, plus additional vanguard sites in the Midlands and in London.

The vanguards are required to demonstrate partnership working across multiple agencies including health, local authority, education, and youth justice agencies demonstrating how they will deliver the Framework and the outcomes within it. All vanguards have been brought together at shared learning events to collaborate and update on progress as well as highlighting areas of good practice and overcome any challenges together.

Vanguards started to submit quarterly data to the national dataset from October 2022. The dataset aims to collect information on the needs of and outcomes for children in the community, evidence that key objectives of the Framework are being met and enable national and regional commissioners to identify and target improvements in health inequalities.

In addition to the Framework, NHS England is working with partners across Government including the Department for Education, Department for Health and Social Care and key stakeholders, such as the Association of Directors of Children's Services and the Local Government Association to consider how we can better work together to deliver children's social care and health services for children with the most complex needs, including those with significant mental health challenges.

A Task and Finish Group is in the process of being set up and will examine the barriers to commissioning and providing joint care and health provision, and how to support the sector to better this deliver in future. It has been confirmed to the House of Commons by the Department for Education Minister. Link here. This will be achieved through implementing the recommendations in 'Stable Homes Built on Love', the government's strategy for transforming children's social care, and building on other ongoing programmes, such as the NHS LTP.

Finally, whilst this is not listed in the matters of concern, your Report also refers to issues relating to information sharing between agencies. The NHS Shared Care Records (SHCR) programme is working to enable the safe and secure sharing of an individual's health and care information as they move between different parts of the NHS and social care. Information on this programme is published in the NHS England website:

NHS England » Joining up and sharing health and care data

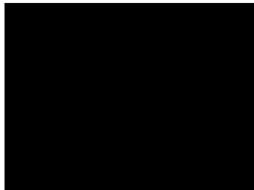
We have also liaised with South London and Maudsley NHS Foundation Trust who have advised us that the following actions have been completed since the death of Samuel.

- Dual diagnosis leads have been identified in each borough across the directorate and they have all either attended or booked dual diagnosis training appropriate to their role.
- Dual diagnosis has their own CAMHS Dual Diagnosis forum and a representative then which then feeds into the physical heath forum as well as the trust wide Dual diagnosis forum.
- Learning from Serious Incident (SI) and policy are standing agenda items at the team's business meetings, CAMHS SI panel and the monthly Dual Diagnosis forum.
- AUDIT appears on the "My Ward" dashboard; please note is it is only expected to be completed for 16 years and above and therefore does not appear as 100% on the "My ward tool" this is sent out weekly to highlight any gaps.
- CAMHS Data Managers have been holding briefing sessions across our services and part of the session includes AUDIT completion requirements.
- Key Performance Indicators (KPI`s) are standing agenda items teams monthly P&Q meetings and CAG wide monthly P&Q meetings.

I would also like to provide further assurances on national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the 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 preventable deaths are shared across the NHS at both a national and regional level and helps us 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