

Extraordinary Meeting of the Health Overview and Scrutiny Panel

Monday, 1st February 2016
at 6.30 pm

PLEASE NOTE TIME OF MEETING

Conference Rooms 3 and 4 - Civic Centre

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor Furnell
Councillor Houghton
Councillor Noon
Councillor Parnell
Councillor Tucker
Councillor White (Vice-Chair)

Contacts

Sue Lawrence
Democratic Support Officer
Tel: 023 8083 3569
Email: susan.lawrence@southampton.gov.uk

Mark Pirnie
Scrutiny Manager
Tel: 023 8083 3886
Email: mark.pirnie@southampton.gov.uk

PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have six scheduled meetings per year with additional meetings organised as required.

- To discharge all responsibilities of the Council for health overview and scrutiny, whether as a statutory duty or through the exercise of a power, including subject to formal guidance being issued from the Department of health, the referral of issues to the Secretary of State.
- To undertake the scrutiny of Social Care issues in the City unless they are forward plan items. In such circumstances members of the Health Overview and Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.
- To develop and agree the annual health and social care scrutiny work programme.
- To scrutinise the development and implementation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy developed by the Health and Wellbeing Board.
- To respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises.
- Liaise with the Southampton LINK and its successor body "Healthwatch" and to respond to any matters brought to the attention of overview and scrutiny by the Southampton LINK and its successor body "Healthwatch"
- Provide a vehicle for the City Council's Overview and Scrutiny Management Committee to refer recommendations arising from panel enquiries relating to the City's health, care and well-being to Southampton's LINK and its successor body "Healthwatch" for further monitoring.
- To consider Councillor Calls for Action for health and social care matters.
- To provide the membership of any joint committee established to respond to formal consultations by an NHS body on an issue which impacts the residents of more than one overview and scrutiny committee area.

Public Representations

At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

Mobile Telephones: - Please switch your mobile telephones to silent whilst in the meeting.

Use of Social Media: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting

COUNCIL'S PRIORITIES:

- Jobs for local people
- Prevention and early intervention
- Protecting vulnerable people
- Affordable housing
- Services for all
- City pride
- A sustainable Council

CONDUCT OF MEETING

The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution).

Business to be discussed

Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, **both** the existence **and** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

- (i) Any employment, office, trade, profession or vocation carried on for profit or gain.
- (ii) Sponsorship:

Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

- a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
- b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council
Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

Dates of Meetings: Municipal Year 2014/2015

2015	2016
23 July 2015	28 January 2016
1 October 2015	24 March 2016
26 November 2015	28 April 2016

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 INDEPENDENT REVIEW OF DEATHS OF PEOPLE WITH A LEARNING DISABILITY OR MENTAL HEALTH PROBLEM IN CONTACT WITH SOUTHERN HEALTH NHS FOUNDATION TRUST APRIL 2011 TO MARCH 2015

Report of the Chair of the Health Overview and Scrutiny Panel relating to the recently published Mazars report commissioned by NHS England, attached.

NOTE: Appendix 3 of the report has been updated following the meeting of the Panel to reflect information omitted in error from the original table.

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Agenda Item 6

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:	INDEPENDENT REVIEW OF DEATHS OF PEOPLE WITH A LEARNING DISABILITY OR MENTAL HEALTH PROBLEM IN CONTACT WITH SOUTHERN HEALTH NHS FOUNDATION TRUST APRIL 2011 TO MARCH 2015		
DATE OF DECISION:	1 FEBRUARY 2016		
REPORT OF:	CHAIR OF THE HEALTH OVERVIEW AND SCRUTINY PANEL		
<u>CONTACT DETAILS</u>			
AUTHOR:	Name:	Mark Pirnie	Tel: 023 8083 3886
	E-mail:	Mark.pirnie@southampton.gov.uk	
STATEMENT OF CONFIDENTIALITY			
None			
BRIEF SUMMARY			
<p>NHS England commissioned Mazars (an independent auditing firm) to conduct an investigation of the deaths of all patients of Southern Health who had been in receipt of mental health or learning disability services since 2011 following the avoidable death of Connor Sparrowhawk in Oxfordshire. Connor was a patient in the care of Southern Health NHS Foundation Trust.</p> <p>The Mazars report was published on NHS England's website on 17th December 2015 and highlights a number of actions for the Trust, commissioners and regulators.</p> <p>The Mazars report and the responses to the reports' recommendations from Southern Health NHS Foundation Trust, NHS Southampton City Clinical Commissioning Group and NHS England are attached as appendices.</p> <p>The Panel are requested to consider the appended documents and discuss the key issues, focusing on outcomes for the residents of Southampton, with the invited representatives.</p>			
RECOMMENDATIONS: That the Panel			
	(i)	Consider the Mazars report and appended documents and discuss the key issues, focussing on Southampton, with the invited representatives from Southern Health NHS Foundation Trust, NHS Southampton City Clinical Commissioning Group and NHS England (Wessex).	
	(ii)	Consider and agree if there are any matters arising from the discussion that the Panel would like to receive further information on as part of its future work programme.	
REASONS FOR REPORT RECOMMENDATIONS			
1.	To enable the Panel to effectively scrutinise the issues impacting on health services in Southampton raised by the Mazars report.		
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED			
2.	To not discuss this issue at a meeting of the Southampton Health Overview and Scrutiny Panel. This was rejected because the Mazars report identifies a		

	number of issues relating to service providers and commissioners operating within Southampton that require discussion at the Panel.
DETAIL (Including consultation carried out)	
3.	NHS England commissioned Mazars (an independent auditing firm) to conduct an investigation of the deaths of all patients of Southern Health who had been in receipt of mental health or learning disability services since 2011 following the avoidable death of Connor Sparrowhawk in Oxfordshire. Connor was a patient in the care of Southern Health NHS Foundation Trust.
4.	The purpose of the Mazars report was to identify any common themes and trends in terms of unexpected deaths, any lessons to be learned for providers, commissioners, and/or regulators, and any common contributory factors. The team reviewed deaths that occurred in the period between April 2011 and March 2015 for people who had been in receipt of the Trust's mental health and/or learning disabilities services, either at the time of their death or within the twelve months preceding their death. The report did not consider the quality of care provided by the Trust to the people the Trust serves.
5.	This report was published by NHS England on 17 th December 2015 and highlights a number of actions for the Trust, commissioners and regulators. The final report by Mazars is attached as Appendix 1.
6.	Southern Health are commissioned to provide mental health and learning disability services in Southampton. Therefore, following the publication of the report, to enable the Panel to effectively scrutinise the provider and commissioners of these services in Southampton, representatives from Southern Health NHS Foundation Trust, NHS Southampton City Clinical Commissioning Group and NHS England (Wessex) have been invited to attend the meeting to discuss the report and the subsequent responses to the reports' recommendations produced by their respective organisations.
7.	In addition to the Mazars report, to help inform the discussion the following documents have been appended to this report: <ul style="list-style-type: none"> • Southern Health NHS Foundation Trust – Statement; Action Plan for Mortality and SIRI Improvement; Gap Analysis Mortality Review • The Commissioners' response to the Mazars report • The joint response from NHS Improvement, NHS England and the Care Quality Commission to the Mazars report.
	Monitor
8.	Following the publication of the joint response from NHS Improvement, NHS England and the Care Quality Commission NHS England forwarded the report to Monitor, to consider whether regulatory action was required.
9.	On 12 th January 2016 Monitor, as the regulator of Foundation Trusts, announced that it would take regulatory action against Southern Health NHS Foundation Trust.
10.	The Trust will receive expert support to improve the way it investigates and reports deaths at the Trust, particularly among people with a learning disability and/or those who are experiencing mental illness. Monitor also announced that they will appoint an Improvement Director for the Trust, who

	will use their expertise to support and challenge the Trust as it makes the necessary changes.
	Care Quality Commission (CQC)
11.	In addition, on 17 th December the CQC, the independent regulator of health and social care in England, announced that it would be undertaking a focused inspection of Southern Health NHS Foundation Trust early in the new year, looking in particular at the Trust's approach to the investigation of deaths.
12.	The CQC commenced their inspections on the week commencing 18 th January 2016 focusing on improvements within mental health and learning disability services, in particular acute mental health inpatient wards, learning units for people with learning disabilities, crisis/community mental health teams and child and adolescent inpatient and secure services.
RESOURCE IMPLICATIONS	
<u>Capital/Revenue</u>	
13.	None.
<u>Property/Other</u>	
14.	None.
LEGAL IMPLICATIONS	
<u>Statutory power to undertake proposals in the report:</u>	
15.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.
<u>Other Legal Implications:</u>	
16.	None
POLICY FRAMEWORK IMPLICATIONS	
17.	None
KEY DECISION	No
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report
<u>SUPPORTING DOCUMENTATION</u>	
Appendices	
1.	Mazars Final Report - Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015
2.	Southern Health NHS Foundation Trust – Statement
3.	Southern Health NHS Foundation Trust – Action Plan for Mortality and SIRI Improvement
4.	Southern Health NHS Foundation Trust - Gap Analysis Mortality Review

5.	Commissioners' response to Mazars report	
6.	Joint response from NHS Improvement, NHS England and the Care Quality Commission to Mazars report	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		No
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No
Other Background Documents		
Equality Impact Assessment and Other Background documents available for inspection at:		
Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	Easy read version of the Mazars report https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-er-rep.pdf	

Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015

December 2015

FINAL VERSION FOR PUBLICATION



Acknowledgements

This report presents a lot of numbers. The team recognise that each number represents a loved one and would like to give their condolences to the families of every person referred to in the following chapters.

The team worked with an Expert Reference Group convened by NHS England to agree and develop the approach in the most appropriate manner as the work progressed. The original scope has been refined and extended as a result of early findings.

We reviewed patient confidential information relating to many unexpected deaths as part of this work. We have used the information therein to help inform our conclusions. It is not appropriate to share any of this information in the report in order to respect confidentiality. The detailed patient information is available to the Trust for further review. However, we have provided some anonymous information by way of illustration.

We would like to thank everyone who assisted in the production of this review.

Mazars is an integrated, international audit, tax and advisory firm with a presence in 69 countries. We have over 130 partners and over 1,600 employees working across the UK.

Review team:

Bob Green (CPFA)- Partner

Mary-Ann Bruce (RGN, RSCN, RHV, MBA) - Director

Peter Finn (MSc) - Senior Manager

Alison Wright - Manager

David Daniel (BSc, FRSS) - Associate, Fellow of the Royal Statistical Society

Dr Jane Povey - Associate, GP and Medical Manager

Dean Repper (RMN, MSc) - Associate, Independent Health Care Consultant and Clinical Director, Mental Health Matters

Membership of the External reference group:

Anne Richardson, Independent Chair

Members:

Beverly Dawkins OBE, previously of Mencap, now Chief Executive, Generate

Dr George Julian, Family representative

Julie Kerry, Associate Director of Nursing, NHS England (to September 2015)

Karen Lascelles, Suicide Prevention (part)

Dr Justin Wilson, Medical Director, Berkshire Healthcare NHS Foundation Trust

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Introduction

The preventable death of Connor Sparrowhawk in July 2013 led to a number of investigations and enquiries into practice at Southern Health NHS Foundation Trust in whose care he died.

This is a review of all deaths of people in receipt of care from Mental Health and Learning Disability services in the Trust between April 2011 and March 2015. It is not a clinical case review of each service user and we have therefore not tried to identify clinically unavoidable deaths. It does seek to establish the extent of unexpected deaths in Mental Health and Learning Disability services provided by the Trust and to identify any themes, patterns or issues that may need further investigation based on a scope provided by NHS England.

We were asked to benchmark this Trust with other similar organisations where this was possible.

In the report, we focus on the responsibilities as they impact on the Trust to report deaths and then to secure the right level of review, enquiry or investigation. However, the responsibility for investigating deaths lies with a number of organisations across the area and we refer to these responsibilities where appropriate.

The scope of this independent review was to help secure:

- a shared view across all the key players of risks within Southern Health NHS Foundation Trust services, of improvement action required, and plans to deliver change.
- advice to the Clinical Commissioning Groups (CCGs) about Learning Disability commissioning, data management and analysis, and adverse events indicators.

The outputs would:

- summarise the findings with respect to all deaths in the Mental Health and Learning Disability services provided by Southern Health NHS Foundation Trust and to contextualise these.
- provide a set of recommendations and/or a framework for ongoing assurance.
- feed in to the work of the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD).
- feed in to the Equalities and Human Rights Commission Inquiry into the non-natural deaths of people with Mental Health conditions in state detention.

The purpose of reviewing the circumstances of or investigating a death is:

- to establish if there is any learning for the Trust, the wider NHS and its partners around the circumstances of the death and the care provided leading up to a death;
- to learn from any care and delivery problems or system failures that need to be addressed to prevent future deaths and improve services;
- to identify if there is any untoward concern in the circumstances leading up to death;
- to be in a position to provide information to the Coroner if requested;

- to be able to work with families to understand the full circumstances and answer questions; and
- to have the full detail of the events available for any subsequent complaint or legal investigation.

National reports and research¹ indicates to us that best practice would be that:

- there are thorough and challenging reviews undertaken when the death of a service user happens unexpectedly – regardless of the location of the death;
- these are not necessarily serious incident investigations but occur in a range of ways including clinically led mortality reviews;
- the learning from national reports is applied when making decisions about local investigations;
- there is an open, transparent and independent approach to investigations with the intention of securing all the evidence needed;
- families and carers are involved where at all possible;
- reviewers are trained and investigations are of a high standard;
- lessons are shared widely between providers, commissioners and other agencies; and
- that organisations investigate incidents of unexpected deaths jointly where appropriate.

Deaths of users of the Trusts' services occur in a wide variety of settings - as an inpatient on a Mental Health or Learning Disability ward or unit, as an acute hospital inpatient or in the community. The nature of the way Mental Health and Learning Disability care is provided by the Trust and nationally means that most care is provided in community settings.

The actual location of a death can be any home, supported living environment, residential or nursing home setting or on occasion abroad or in a different geographical location from that covered by local services. Some deaths occur in acute hospital settings. We found that the location of a death is an important factor in determining who, and if anyone, leads a review or investigation.

Determining the cause of death and the need for an investigation can be complex as a result of this variety of care delivery settings and can involve a wide number of agencies. It is therefore important to have clear protocols in place for prompt decision-making about who should investigate.

In the main report, we highlight a number of service and statistical issues which mean that such "headline findings" need very careful interpretation. Variation in death rates, for example, will be determined by a range of factors and are not necessarily a consequence of any particular aspect of the Trust's approach: they do, however, provide an important context to the review and a starting point for further investigation to identify areas of potential improvement.

Throughout this report we refer to a number of systems and types of reports - these are explained below:

¹ See national context section at the end of this report

Reporting deaths - information systems and types of report

The information systems - RiO, Ulysses and StEIS

RiO is the Trust's patient administration and clinical information system. All health service user information is recorded here by clinical staff. It serves two purposes – predominantly it is the clinical information system through which all staff record care plans and clinical information relating to service users, including its use as a communication tool and recording risk assessments. It can be interrogated to secure information at all levels and for this review has been used to identify deaths of all Mental Health and Learning Disability health service users since April 2011 by age, date and the division stated as providing the care.

It therefore contains all the necessary details about service users for a wide range of service user administration needs and forms the Trust's Patient Administration System (PAS) linking to the national spine - the NHS service user administration system². It does not include all social care service users or users of substance misuse services.

Ulysses is the Trust's risk and incident management system. It is a system in common use in the NHS. All incidents relating to staff, visitors and service users should be recorded here. It has been used for this review to identify all deaths reported as incidents by staff responsible for the care of Mental Health or Learning Disability service users. It should therefore be a sub-set of the information provided by RiO. It isn't always as not all services use RiO in the Trust. However, all services do use Ulysses. The system is also used to manage risk within the Trust at all levels.

StEIS is the Strategic Executive Information System which is a national system for capturing all Serious Incidents Requiring Investigation (SIRI). The Trust (sometimes in conjunction with the commissioner) will decide whether an incident is reported onto StEIS according to its interpretation of national guidance. The information on StEIS should therefore be a sub-set of the Ulysses incidents. Throughout the period of this review the 2010 National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (NPSA/NRLS 2010) guidance was relevant and the Serious Incident Framework March 2013 reflected the new commissioning system but did not fundamentally change the guidance. New guidance (The Serious Incident Framework: Supporting Learning to prevent recurrence (NHS England, 2015) is in place from April 2015 which is outside the scope of this review.

² <http://systems.hscic.gov.uk/spine>

Types of report - IMA, CIR and SIRI

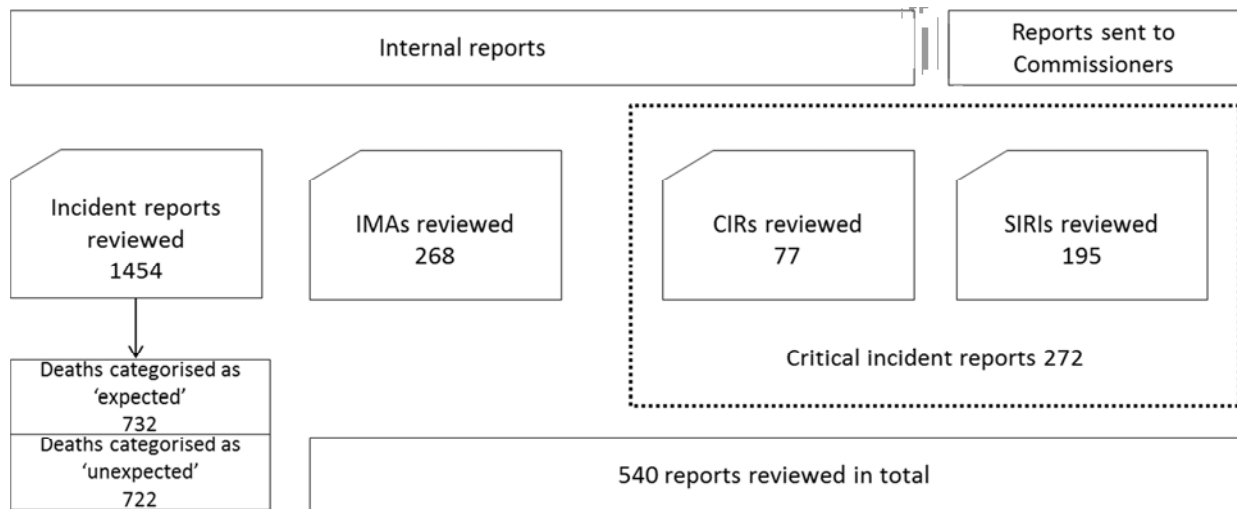


Figure 1: Types and numbers of reports reviewed.

IMAs are Initial Management Assessments which are undertaken within 24-48 hours of an incident being reported to determine whether further review or an investigation is required. They are usually written by the team or team manager, involved in the care of the service user. The Trust's 2014 procedure also suggests that someone with a more objective view may be appropriate to do these reports.

CIRs are Critical Incident Reviews which are undertaken if an incident is considered to be untoward. They are full investigations as distinct from the brief review of an IMA.

SIRIs are CIRs (see above) which are considered to meet the criteria for reporting onto StEIS and differ only in that there is a requirement to report externally and for the investigation to be reviewed and closed by the relevant commissioner. They are usually of the most serious nature.

Terminology used in this review

The scope of this review is all deaths of people with a Mental Health or Learning Disability problem who had one or more contacts with Southern Health NHS Foundation Trust in the 12 months preceding their deaths and who died between 1st April 2011 and 16th March 2015. Where we refer to deaths we refer only to those of people receiving care/who had received care in these services and not from community or 'physical care' services.

'Service user' refers to all people who meet the above criteria and will include both health and the Trust's social care services.

Reports to Ulysses - incident reports (1454)

We reviewed 1454 incident descriptions relating to deaths. We have taken these to be a reliable description of the incident which forms a record at the time of notification.

The Trust's 2011 policy on Managing Incidents (effective April 2011) states:

"Using the Trust's Incident Report Form, give as much information as possible about the incident using Sections A to H. This will include name, address, and status of the individual, any witnesses, location of the incident and when it happened. Only factual information and not statements of opinion or assumptions, is required at Section C."

The Trust's 2014 policy (issued September 2014) states:

"The Incident description must give a clear, concise description of the incident (including key events leading up to and immediately after the event) – bullet points are encouraged if this makes the account clearer. All free-text boxes in the form must be anonymised (P1, P2; S1, S2 and V1, V2 should be used in place of names). The account should be factual and should include any relevant clinical judgement, key risks, contributory factors or causes of the incident. "

Initial Management Reports/Assessments - IMR/A (268)

For the purposes of our analysis, we refer to an IMA - we class these as a initial review or assessment process and we do not consider an IMA (or IMR) as an investigation. Whilst IMAs may have been completed for all the investigations of CIRs and SIRIs, 268 is the figure relating to where only an IMA has been completed (and we have reviewed it) and did not proceed to CIR or SIRI. Trust Policy 2011 states:

Initial Management Report (IMR) – The IMR should be a report which provides information about the incident and the care that the service user received prior to the incident. All sections of the IMR should be completed electronically and include as much information as is available from the records. It is used by Directors of Operations to identify whether further investigation of the incident is required. The IMR is to be sent electronically (via NHS mail) to the distribution list on the basis of the report within 24hrs (next working day if out of hours) of incident (inpatient) or within 3 days of notification of the incident (community team).

Critical Incident Reviews (CIR):

A CIR for the purposes of this review is used to mean a CIR which remains internal to the Trust and is not shared externally with commissioners (although families and coroners may be sent them).

Critical Incident Review (CIR) - "The CIR process uses root cause analysis principles to investigate the organisational and managerial systems underlying the provision of care to identify the root cause/s of the incident and improve systems and processes to reduce the likelihood of incidents occurring again. CIRs are not part of the investigation process into individual staff member/s performance, nor do they form any part of a disciplinary process. The CIR investigation is to be completed, with action plan agreed by the Directorate(s), within 45 working days of notification of the incident."

For the purposes of this review we distinguish between a CIR as above and a SIRI. A SIRI is when a CIR is reported on to the national reporting systems through StEIS and becomes part of national intelligence and statistics. When we refer to 'investigations' we consider both CIRs and SIRIs as investigations.

Comparative data uses the denominator 'per 1,000 Mental Health Service users'. This is because it is a way of comparing providers for this review. The alternative of Occupied Bed days (OBD) or Finished Consultant Episode (FCE) would not be appropriate given the large proportion of community based services in Mental Health provision.

Time periods for reports relating to deaths:

The review requested information for all deaths in Mental Health and Learning Disability services from April 2011 to 16th March 2015.

Learning Disability deaths that occurred prior to the merger in November 2012 were not in the scope of the review.

Southern Health NHS Foundation Trust services

Southern Health NHS Foundation Trust provides Mental Health, Learning Disability, Community and Social Care services

The Trust states that care is provided to 250,000 people in all its services each year.

The Trust's Mental Health and Learning Disability services are provided to about 45,000 people each year including across Hampshire, Oxfordshire, Buckinghamshire, Berkshire, Wiltshire, Dorset.

The social care arm of the Trust - TQ21 - currently provides services to about 650 people including over 400 being cared for full time.

Services can be broken down as:

- **Physical health and older people's mental health community services** for adults & older people. This is delivered through in-patient community hospitals, outpatient clinics and musculoskeletal services and community services delivered in peoples' own homes.
- **Adult mental health and specialised secure services** for adults and young people in Community Mental Health Teams and Acute Care Teams. There is a range of in-patient facilities inclusive of forensic services some of which are highly specialist.
- **Health visitors & school nurses** providing public health services for children and families.
- **Specialist support to adults with learning disabilities** in the community and inpatient settings.
- **Social care services (known as TQtwentyone)** for people with learning disabilities or mental health needs, and for older people.

These services are commissioned by a number of different CCGs locally, NHS England directly and local authority commissioners.

Executive Summary

People die for a variety of reasons – both expectedly and unexpectedly. Not all deaths require an investigation and just because someone dies does not mean that the quality of services is poor. What is important though is that when someone does die unexpectedly this is identified so that the correct processes and appropriate levels of enquiry are made with a view to learning and taking preventative action in future.

Southern Health NHS Foundation Trust (the Trust) sees about 45,000 Mental Health and Learning Disability health service users every year as well as 655 social care service users currently on caseloads in TQ21 (the Social Care arm of the Trust) - 390 with full time care. On average 2600 deaths from a variety of causes are recorded on RiO per year of people who were in receipt of Mental Health or Learning Disability services from the Trust, or who had been in receipt of these services within the 12 months prior to their death. Most people are very elderly and many of the deaths were expected. However, some people die earlier than expected and it is important that these deaths are identified correctly. It is important that the right level of review or investigation is undertaken to improve services, identify any service failure, learn from any mistakes and to provide families and stakeholders with relevant information.

Through an analysis of 540 individual reports of deaths of service users occurring between April 2011 and March 2015, reviewing documents relating to all deaths and an analysis of a wide range of data we have identified a series of key messages which result in recommendations for the Trust, its commissioners and nationally.

Key findings:

- There was a lack of leadership, focus and sufficient time spent in the Trust on carefully reporting and investigating unexpected deaths of Mental Health and Learning Disability service users.
- Despite the Board being informed on a number of occasions, including in representation from Coroners, that the quality of the SIRI reporting processes and standard of investigation was inadequate no effective action was taken to improve investigations during the review period.
- There were at least 10,306 deaths of service users in the period and most were expected. 1454 deaths were reported to Ulysses as death incidents. Not all were unexpected deaths - but 722 were categorised as unexpected. Of these 272 (37.5%) deaths were investigated as a CIR of which 195 were reported as SIRIs. This analysis is based on the Trust's categorisation of unexpected deaths. It was outside the scope of the review to verify whether all unexpected deaths were reported as such.
- 30% of all deaths (those reported as expected and unexpected) in Adult Mental Health services were investigated as a CIR or SIRI, less than 1% of deaths in Learning Disability services were investigated as a CIR or SIRI and 0.3% of all deaths of Older People in Mental Health services were investigated as a SIRI. We observed that the numbers of deaths reported as incidents in the first place amongst Older People Mental Health (OPMH) service users significantly decreased over the period of the review such that for the last 2 years an average of only 30 deaths of people over 65 years were reported to Ulysses (approximately 1%).

- In terms of deaths ‘categorised as unexpected’: within Adult Mental Health services, 60% (237 out of 394) of all unexpected deaths were investigated as a CIR or SIRI; in Learning Disability only 4% (4 out of 93) of all unexpected deaths were investigated as a CIR or a SIRI and in Older Peoples’ Mental Health services 13% (30 out of 235) were investigated as a SIRI.
- It should be noted that there was no statutory requirement for Trusts to report or investigate deaths except for reporting under Regulation 16/17 and 18 to the Care Quality Commission. The Trust did meet its responsibilities under Regulation 17. It was outside the scope of the review to examine whether they met the Regulation 16 and 18 requirements. There is only national non-statutory guidance in place for serious incident reporting which allows Trusts to exercise considerable discretion. The Trust adopted a practice which was in line with supporting guidance issued by the National Patient Safety Agency in 2010 which they have not followed their adopted practice.
- During the period of the review the Trust had a policy that all deaths reported to Ulysses as incidents - expected or unexpected - should be subject to an IMA (with the exception of expected deaths in 2011/12 for OPMH Community patients). The table below shows the breakdown of the number of death incidents reported that should have been subject at least to an IMA (for a decision to be made on investigation or not) based on the policies in place throughout the period.

The breakdown of death incidents reported to Ulysses and assessments/investigations held is in the table below:

Service division	Death incidents reported to Ulysses	IMA/CIR	SIRI	No of death incidents not assessed	% of death incidents not assessed
Adult Mental Health (AMH)	464	276	161	27	6%
Learning Disability (LD)	157	66	2	89	57%
Older People Mental Health (OPMH)	831	60*	30	741	**
Specialised Services (SS)	2	-	2	-	0%
Totals	1454	402	195	857	-

* this is the number estimated by the Trust but we have not reviewed the majority of these.

** OPMH - under the 2011/12 policy expected deaths in the community were to be reported onto the system but did not require an initial management assessment (IMA) unless there were identified issues of concern. Therefore, not all death incidents in OPMH services need to have been subject to an IMA. During the period we estimate that there were 300 OPMH deaths (unexpected and inpatients) which should therefore have been subject to an IMA. This figure is based on all unexpected deaths reported and all inpatient deaths. This is shown below:

Service	Death incidents reported	IMA/CIR	SIRI	Not assessed	% not assessed
OPMH	300	60*	30	210	70%

- As stated in the introduction to this report, the nature of Mental Health and Learning Disability service provision means that the majority of care is provided in the community. It is clear that there is a need for full protocols across the health and social care system to determine when and which agency should investigate these deaths.
- There was no effective systematic management and oversight of the reporting of deaths and the investigations that follow - it is reasonable to expect the Trust to properly review the need for a further investigation into all deaths when staff have been sufficiently concerned about something which they have then reported to their incident management system. This review needs to be of a high quality against a clear rationale and decisions to proceed to fuller investigation or not to be made by a suitably senior independent member of the Trust and with a clear audit trail as to the reason for their decision.
- Timeliness of investigations is a major concern - on average it took nearly 10 months from an incident to 'closing' a SIRI relating to deaths (those heard in West Hampshire CCG closure panels in 2014/15).
- The Trust could not demonstrate a comprehensive, systematic approach to learning from deaths as evidenced by action plans, board review and follow up, high quality thematic reviews and resultant service change.
- The average age of death of the 337 service users who died with a Learning Disability was 56. The median age was 59. Further investigation must be undertaken to review the comparability of this finding with that of the CIPOLD inquiry.
- The involvement of families and carers has been limited - 64% of investigations did not involve the family.
- Initial management assessments and investigations did not involve other service providers where this would have been appropriate.
- Despite the Trust having comprehensive data relating to deaths of its service users it has failed to use it effectively to understand mortality and issues relating to deaths of its Mental Health or Learning Disability service users.
- Commissioners have a role in demanding better information relating to deaths and using it to seek improvement.
- If the Trust determine that another part of the system should undertake an IMA it has a responsibility to ensure the incident is reported to the commissioners for them to ensure that an appropriate review and potential investigation is carried out. This is crucial because 90% of this vulnerable cohort of patients die in other places outside of Southern Health Institutions.
- National data is available that would enable benchmarking of Trusts' reporting and aspects of mortality. We have identified a number of issues that need further investigation.

There is a range of national data available which, if combined with other local and service data, could help provide an effective dashboard to identify issues relating to deaths and how service improvements may impact on unexpected and premature deaths. Consideration should be given to the development of a data set/ dashboard of data that will allow providers and commissioners to readily identify issues and which (through publication) will enable greater transparency.

In the period covered by our review there were at least 10,306 deaths of service users - most of which were expected. There were 1454 deaths reported to the Trust's incident management system (Ulysses) (722 were unexpected) and of this number 272 were investigated as a CIR (of these 195 were SIRIs). There were 128 inpatient deaths identified by the team of which 24 resulted in SIRIs.

There was a high level of attrition, from the level of deaths initially recorded on the Trust's systems to those subsequently reported and investigated. This attrition varied across care groups (for instance, there was a greater likelihood of a Mental Health death which was a suicide being investigated than the death of someone with a Learning Disability due to the interpretation of national guidance). It is also reflected in the fact that the Trust reports a low number of deaths to StEIS under death and suicide categories in comparison with other regional NHS Mental Health provider Trusts and in absolute terms to the National Reporting and Learning System (NRLS) under 'degree of harm death'.

From our review of the evidence, too few deaths were investigated in Learning Disability and Older People Mental Health services. It is not possible to determine a precise figure of how many deaths should have been investigated that weren't. This is because the national guidance for reporting and investigating deaths in these services is open to significant Trust discretion. National guidance is not statutory and therefore relies upon the implementation of good quality governance and assurance frameworks.

Our review of initial management assessments highlighted cases which should have been investigated further but which were not and, in our view, should have been. Some Critical Incident reviews should also have been reported as Serious incidents to StEIS. There are a number of consequences of the issues described in the report but they include:

- Insufficient transparency around investigations into deaths;
- The information reported within the Trust and through national systems does not present a comprehensive picture and analysis of the unexpected Mental Health and Learning Disability deaths amongst the Trust's service users; and
- Missed opportunities for learning.

When an investigation did occur, the report identifies the overall poor quality of these investigations and of the subsequent reports. These issues mitigate against the learning that is possible especially given the limited evidence of thematic reviews looking specifically at deaths and follow up of these commissioned by the Trust Board or in divisions. We have identified in the detailed report some of the common themes that emerged from our review.

Leadership and Board oversight of deaths

The failure to bring about sustained improvement in the identification of unexpected death and in the quality and timeliness of reports into those deaths is a failure of leadership and of governance.

In our view there has been a lack of leadership, focus and sufficient time spent on reporting and investigating unexpected deaths of Mental Health and Learning Disability service users at all levels of the Trust including at the Trust Board. Due to a lack of strategic focus relating to mortality and to the relatively small numbers of deaths in comparison with total reported safety incidents this has resulted in deaths having little prominence at Board level.

The systems in place provide no evidence that the Trust has fully reported or investigated unexpected deaths or taken remedial action where appropriate. This is also evidenced by the inconsistent and incomplete nature of the data supplied.

There are a number of facets to this poor leadership which we describe further in the detailed report but which include:

- a failure to consistently improve the quality of investigations and of the subsequent reports;
- a lack of Board challenge to the systems and processes around the investigation of deaths including how decisions are made on whether to investigate deaths;
- a lack of a consistent corporate focus on death reflected in Board reports which are inconsistent over time and which centre only on a small part of the available data;
- an ad hoc and inadequate approach to involving families and carers in investigations;
- a lack of focus on deaths amongst the health and social care services caring for people with a Learning Disability;
- limited information presented at Board and sub-committee level relating to deaths in these groups. SIRI numbers are reported on and only unexpected deaths that are investigated as a serious incident are presented; and
- a lack of attention to key performance indicators (KPIs) indicating considerable delays in completing death investigations.

Despite the Board being warned on a number of occasions including from Coroners that the quality of the SIRI reporting processes and standard of investigation was inadequate no effective action has been taken to address these weaknesses. The incidents are highlighted below:

- In April 2012, an inpatient suicide occurred. The likely criticism of the poor quality of the CIR by the Coroner was noted at the Trust Board meeting in July 2013. The minutes note that reassurance was given to the Quality and Safety Committee that all SIRIs like this are heard at Corporate Panels but nearly two years later reports remained of a poor standard. Corporate Panels for Mental Health were only in place from early 2015 and started to begin to challenge the quality of reports.
- In October 2012 a service user committed suicide. The July 2013 coroner conclusion was discussed at the September 2013 board meeting. Two CIRs had been written due to the first CIR being inadequate. The second CIR was dated as being finalised on the day of the start of the inquest. The January 2014 board minutes contain the minutes of the October 2013 Quality and Safety committee where the quality of the CIR was raised.
- In December 2013 the Quality and Safety committee's attention was brought to the internal auditors RSM Tenon findings that a sample of cases showed there was no evidence that action plans from SIRIs were being monitored or implemented

- In October 2014, West Hampshire CCG returned a SIRI that was of poor quality (again 10 months post incident) and it was finally approved in April 2015 some 18 months post incident.
- In January 2015, West Hampshire CCG re-opened a May 2014 SIRI when it became clear that a report had said there were no care problems yet the safeguarding report gave a conflicting account. It was closed by the CCG panel in September 2015.
- In April 2015, West Hampshire CCG wrote to the divisional director expressing considerable concern at the quality of SIRIs and one in particular that had to be returned. The response from the Trust stated that the divisional panel process was now being instigated more formally and that the SIRI in question had been returned by the Corporate Panel in February 2015, approved virtually 2 weeks later but it was still not adequate such that the CCG wrote a letter.
- There have been at least 14 cases reported in the media during the period of the review
- In August 2015, the coroner criticised the Trust for failing to produce a CIR for an April 2015 death in time for an inquest hearing and a further inquest had to be postponed.

There was no corporate list of deaths of service users subject to the Mental Health Act (MHA) 1983 or of all inpatient deaths and as such a specific exercise was needed to pull both these lists together. 24 people died who were subject to detention under the MHA 1983. After investigation we concluded that the Trust met its obligations to notify deaths in detention to CQC under Regulation 17. This also required a specific exercise to confirm and we can only conclude that there is not a corporate overview of either all inpatient deaths or those subject to the MHA – whether detained or not.

A culture across the Trust has developed that means there was an absence of mortality review in Mental Health and Learning Disability which results in lost learning, a lack of transparency when care and delivery problems occur as well as a lack of assurance to families and commissioners that a death was not avoidable and has been properly investigated.

In early 2015 the Trust was planning to develop a Mortality Review Group and to review every death of its service users. This will be led by the Medical Director and the Terms of Reference for this are being agreed. We have not seen any relevant documents relating to this group but understand the meetings commenced in August 2015. The Trust states in December 2015 that the draft Terms of Reference for these meetings are available.

Management and oversight of death investigations

There was no effective systematic management and oversight in reporting deaths and the investigations that follow.

There was a limited amount of corporate oversight at all stages of reporting and investigating deaths. The classification of deaths and whether they were unexpected was left largely to local area teams and divisions, with the SIRI reporting team latterly providing further challenge. This has resulted in inconsistent decisions about when a death is unexpected and therefore the level of investigation required. There was a lack of corporate challenge about whether the right level of scrutiny was applied. We have seen no evidence that the divisional and corporate oversight panels have taken place in a robust manner and it is only since April 2015 that effective challenge is beginning to take place.

We note that fewer deaths were reported to Ulysses over the four years of this review against a background of increasing patient safety incident reporting. The number of deaths being reported to Ulysses and subsequently investigated has steadily reduced in a way which cannot be easily explained given the total number of deaths have remained constant. The re-categorisation of incidents with the development of the Ulysses system has classed greater numbers of incidents as patient safety related but unexpected deaths incidents have reduced. The board and committee papers show no evidence that this trend was identified or reported on.

The decisions about whether deaths are unexpected or not are made using a range of different criteria – including national, local and coronial system guidance. However, whilst these criteria provide sufficient latitude for the Trust to report and investigate any death, a large number of decisions to not investigate further has been explained by the Trust in that the incident did not meet SIRI criteria.

Learning from deaths is presented as a priority in the Annual Report 2013/14 but the Trust has not met its stated aims of ‘a thematic review of all deaths with a thorough, open and transparent process of investigation, reporting and acting on learning to arise.’ This is also reflected in the 2014/15 Annual Report, published in July 2015, as ‘learning from deaths.’ This focuses on suicides and ‘physical health service’ deaths only and does not refer to other Mental Health or Learning Disability deaths. We have little confidence that the Trust has fully recognised the need for it to improve its reporting and investigation of deaths of people with a Mental Health (in particular Older People) or Learning Disability need.

The role of Commissioners

The review and investigation of deaths is usually left to the Trust to undertake and commissioners become involved in cases when these are determined to be serious incidents by the Trust.

There are instances where commissioners have tried to secure improvements in the quality of reports but they have been unable to effect change in reporting and investigation practice throughout the period despite raising concerns directly with directors in the Trust.

There has been insufficiently strong enforcement or attention paid by a variety of commissioners in requiring improvement by accepting poor quality investigations and the considerable delays in receiving reports across the last four years. As a result the average time to close a SIRI in our sample was nearly 10 months. This needs to change.

The role of the CCG in creating an environment in which providers work together across health and social care to ensure pathway reviews is critical. The inclusion of local authority commissioners and primary care leads would add a whole pathway dimension in an environment where there is an increasing move towards multi-speciality provision.

A regular joint review of mortality and unexpected deaths across Mental Health and Learning Disability is needed to provide transparency and assurance to commissioners to learn from unexpected deaths to inform service improvement and commissioning intentions. This would provide greater accountability for the quality of service provision across both provider and commissioner. The inclusion of primary care input to this activity would be particularly beneficial.

Over 90% of the reports we reviewed were deaths which occurred in the community or other non-Trust premises. As institutional care is now less common it remains imperative that the quality of care in community and residential settings is monitored and of a high standard. Investigating deaths appropriately in all settings is crucial to ensuring care in the community remain high quality.

Attrition from unexpected deaths to investigations

There were at least 10,306 deaths of Mental Health and Learning Disability service users between April 2011 and March 2015 - most were expected. The investigation of Older People Mental Health and Learning Disability deaths was markedly more limited than those of Adult Mental Health service users between the age of 18 and 65.

In Adult Mental Health services 56% of all deaths were subject to an IMA, 30% of total deaths were investigated as a CIR/SIRI; whilst for Learning Disability 20% were subject to an IMA and 1% investigated and amongst Older People Mental Health services only 0.3% of deaths investigated as a SIRI.

Nearly 60% of all SIRIs were suicides. Non-suicide deaths are less likely to be reported as SIRIs. Some unexpected deaths clearly did not meet serious incident criteria but the Trust's lack of review has resulted in clear groups of deaths not being investigated at all, learning lost and limited assurance that criteria are being applied correctly.

Of 337 deaths of people with a Learning Disability recorded over the four years, two resulted in a SIRI despite at least 47% being reported to Ulysses. Not all of the service users will have been on the Trust's caseload at the time of death, although 70% had been seen within the preceding 91 days before death. Of the total, 68 had an initial management assessment and there was an absence of subsequent investigation by the Trust in all but 4 of these cases.

There were 9190 deaths of Older People in Mental Health services (9173 deaths over 65) in the period. Not all will have been current service users at the time of death but 81% were seen during the preceding 6 months. 57% of these service users were very elderly (over 85 years). In total, 30 deaths of service users over 65 were classed as SIRIs (0.3%). In 2014/15, there were 2322 (2314 over 65 years) deaths in Older People Mental Health services, three were investigated as serious incidents by the Trust (0.13%) - the least amount across all four years.

The diagram below shows the total attrition of all deaths in the Trust over the four years of this review including those reported to StEIS.

We mapped all deaths through all reporting systems.

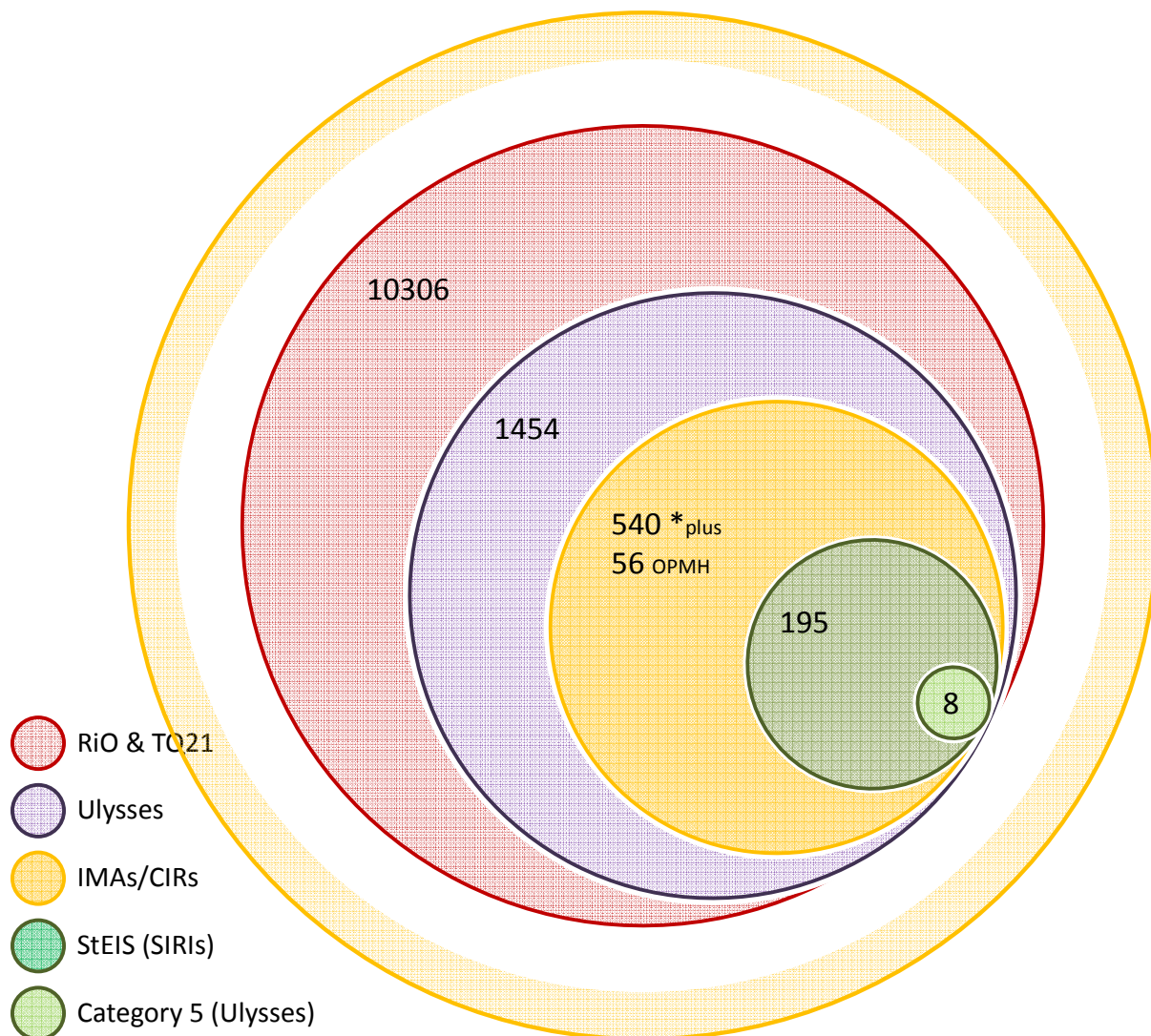


Figure 2: The attrition of all deaths April 2011 to March 2015 to those reported to StEIS and considered Category 5 by the Trust as at August 2015. (Category 5 deaths are those in the highest category of patient safety incidents recorded on the Ulysses system - Catastrophic/death)

*The figures above for IMAs reflect the 540 IMAs and CIRs provided to us for Adult Mental Health and Learning Disability as we requested all of them. The 56 OPMH IMA figure has been provided to us by the Trust as those readily identifiable as having been undertaken for Older People across inpatients and community (that were not SIRIs or CIRs).

Only 195 deaths were reported in the Trust’s Annual Reports or at Board level as Serious Incidents. This will ultimately result in the public and other stakeholders not being properly informed about unexpected deaths so that as well as the missed opportunity for learning, there is limited oversight and scrutiny and a risk of poorly informed decision-making.

The Trust reported relatively few unexpected deaths of service users to regional and national systems. It reports fewer deaths to StEIS under unexpected death and suicide categories compared to the other Mental Health Trusts in the region per 1,000 Mental Health service users. Published national data indicated that the Trust reported 111 deaths under the National Reporting and Learning System (NRLS) “degree of harm death” category for the period. We anticipated that this

number would reduce further due to concluding investigations and updating categorisations. On further interrogation, the Trust stated that current NRLS figures should reflect 11 deaths (8 for Mental Health and Learning Disabilities) which the Trust consider meet the NRLS definition in this category for the whole period. Current NRLS figures show that the figure is 48 deaths reported in the “degree of harm death” category (figures taken at 27th October 2015) of which we can match 34 to Mental Health of Learning Disability by using the reference number of each case to directly map to the Ulysses extract provided to us. These 34 cases do not all reflect those, as represented on Ulysses or in CIRs/SIRIs, that we would have expected to be reported to NRLS under the degree of harm death category. This is summarised below:

- 10 were subject to a SIRI
- 12 were logged on Ulysses as unexpected death - natural cause
- 11 were subject only to an IMA
- Only five of the eight Category 5 Ulysses deaths were included in the NRLS dataset
- There were cases from the 540 reports we reviewed that, in our view, would have been considered as suitable for reporting as ‘degree of harm death’ that were not.

We conclude that the Trust reports a very small and reducing number of deaths under the “degree of harm death” category. We are also concerned about the inconsistency in reported figures and the lack of apparent logic of those cases in the NRLS figures. The numbers reported reduced over the last three years, so that in the last published reporting period no deaths were reported under the “degree of harm death” category. This is the subject of one of our recommendations.

This is likely to mean that strategically and externally with commissioners and regulators, decisions on risk and safety are made which may be based on incomplete or inaccurate data.

Southern Health appears to report fewer deaths of mental health service users than other mental health trusts in the region, and when compared to the national ‘average’. The age-standardised death rate for the Trust is very similar to the national average at 57 per 1,000 mental health service users. Therefore it is likely that the low level of reporting is a function of the Trust reporting practice.

Report quality and timeliness

There was a very poor quality of written investigations at all stages. At least 30% of the reports were of a poor standard; some would cause further distress to families if they were shared due to the carelessness with which they have been written; some had to be returned by commissioners for review and there is little evidence that there was any effective effort to improve the quality of the reporting until very recently.

The reports were not reviewed with any significant challenge or rigour; had they been, this would have helped improve the standard of the report writing itself. We assessed 20% of the reports we reviewed as being good or better including all of the external investigations undertaken by other agencies.

There were 110 different lead investigators identified for 195 SIRIs. This decentralised model was intended to help spread learning. The Trust has now decided to move to a more centralised model with dedicated investigators paired with clinical staff from divisions.

Timeliness is a major concern. Timeliness of reporting to StEIS and getting reports to closure panels was particularly weak. Deaths were not reported to StEIS in a timely manner and it could be months or in some cases years before they were reported. The Trust's 2011 policy expected initial management assessments to be produced within one working day of notification. In 2014 this changed to two working days (three for the community). On average these took 14 days (10 working days) to produce.

Reports were being written ready for divisional review in an average time of 84 days (60 working days/3 months) and delays in signing reports off internally took the total elapsed time to an average of 127 days (90 working days/4 months) - far exceeding the 45 days needed to meet the SIRI guidance. This took the average time to close a serious incident relating to death at CCG closure panels to nearly 10 months. SIRI reports are expected to be completed within 45-60 days depending on grade. 90% of SIRIs were not completed within 45 days.

The diagram below summarises the key timescales involved in completing SIRIs once reported.

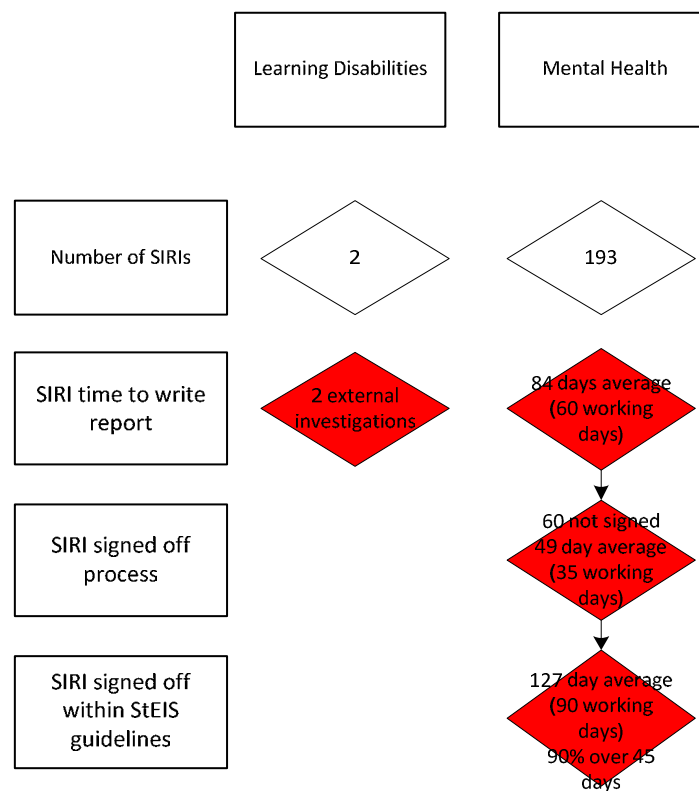


Figure 3: Time in days for SIRIs to be signed off within the Trust ready for CCG closure panel (Information based on data where dates were available)

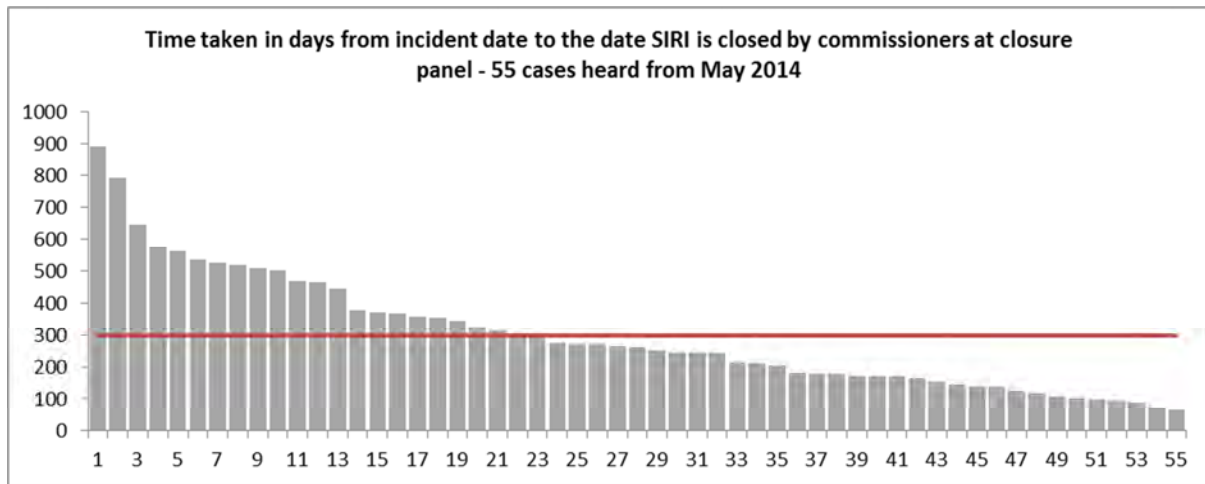


Figure 4: Time taken in days from incident to SIRC closure for 55 cases reviewed at closure panels in 2014/15

Learning from deaths

The Trust could not demonstrate a comprehensive, systematic approach to learning from deaths as evidenced by action plans, board review and follow up, thematic reviews and resultant service change.

There were three examples of thematic reviews related to unexpected deaths, other than annual analysis of suicides, during the period of the review. However, these were:

- of a poor quality
- were not drawn from a corporate approach to looking at themes arising from death SIRIs
- did not evidence learning
- did not all identify common themes across the period
- did not demonstrate what happened as a result
- did not demonstrate robust action plans.

Action plans in SIRIs could not always be linked to the evidence in the SIRC reports and the recommendations being made.

In Mental Health IMAs, action plans were produced in 12% of cases. An 'extended IMA' appears to be an option developed in the Mental Health division which differs little from a CIR but which is less robust and also not monitored. There were 24 'extended IMAs' where actions were identified but some of these simply referred to sharing learning. In CIRs, 88% of reports did have action plans. But these actions are not logged corporately and similar actions recur throughout them suggesting that lessons are not being learned.

In contrast, of the IMAs in Learning Disability none had any action plans. This means that in four years only four cases that were investigated (2 CIRs and 2 SIRIs) would have expected to have action plans formulated - two cases were subject to independent investigation, of the two CIRs one action plan is inadequate and the other is blank. Without clear action planning or the logging of lessons learned it is hard to see how learning from these deaths can be demonstrated or how it is being embedded within the Trust.

Learning from deaths, done well can be powerful and can lead to improvements in patient care. The Trust provided evidence to us in October 2015 of the learning relating to epilepsy which we believe was instigated by Connor Sparrowhawk's death in 2013. The toolkit and training resources are of a high standard. They were still being more widely disseminated in the summer of 2015. 128 deaths occurred whilst service users were inpatients of the Trust. 24 were investigated as SIRIs. There was no corporate approach to reviewing inpatient deaths.

The failure to implement a systematic process of reviews has meant that the Trust has not been able to comprehensively identify appropriate areas for further review - some of which we highlight for the Trust later in this report as a result of our review of all reported deaths.

High quality, timely investigations are crucial for learning, for families, for service improvement, for commissioners and to provide inquests with accurate information. These were not being produced.

Themes

Our review of over 540 reports and a review of all reported incidents of deaths showed there was a potential to understand care and delivery problems in clear groups of people even if they were not SIRIs.

In Mental Health very distinct groups of service users emerged for which limited review and investigation took place. Nationally Mental Health service users suffer worse health and die earlier than the general population. Reviewed together, the IMAs provide significant insight into care and service delivery problems for people with alcohol dependency and drug addictions. In particular, we identified a lack of adherence to the Trust's Difficult to Engage Policy and the management of care across voluntary services was inadequately investigated.

The management of people with severe and enduring mental illness is a priority for mental health services. Over a quarter of the IMAs and CIRs in Adult Mental Health involved people with a diagnosis of paranoid schizophrenia. Our review of these assessments and investigations identified repeat themes of isolation, self-neglect, safeguarding and poor physical health but no thematic review of this group of service users was undertaken.

There were Critical Incident Reviews that would have benefited from being reported as SIRIs if only to alert commissioners to problems with service provision - this was particularly the case with two deaths resulting from eating disorders.

A case study of a death reported in a Mental Health initial management assessment which was not considered to be a serious incident requiring investigation. The Trust agrees this case should have been reported as a SIRI. It shows a range of typical issues facing service users:

Case study:

There were missed opportunities to engage a service user, with a lack of communication between services. There was a lack of a plan following a Mental Health Act assessment. The referral process to the acute mental health care pathway was not followed by staff. There was disagreement between different services about who should look after the service user. The chair of the CIR panel found that the service user underwent a number of assessments but little effective treatment happened. It appears that although it was assessed that the service user needed more intensive input, the transfer process was not followed. The case was not reported as a SIRI.

In Learning Disability initial management assessments, there were clear themes which highlight the need for further investigation on a multi-agency basis.

There were particular concerns regarding dysphagia assessments and the management of swallowing and helping people eat and drink safely. A significant number of people with a Learning Disability experience difficulty with this and in several cases there was delay in decision-making at all levels, including in acute care, to provide hydration and nourishment by alternative means. In particular, decision-making about inserting PEG feeding systems. A multi-agency Hampshire publication on choking as a result of five cases between 2005 and 2010 is a good example of learning. However, this was based on deaths before the period covered by this review.

Hospital liaison services are an important aspect of ensuring reasonable adjustments are made to make acute care a safe place for people who cannot communicate and whose behaviour can become challenging when either in pain or in a strange environment. A number of cases highlighted the role of this service and the need to ensure joint decision-making including when making best interest decisions.

People with a Learning Disability were often being cared for in residential care settings with health professionals visiting for care. A number of these cases highlighted the need for identifying and managing the early signs of deterioration and responding promptly by the care home or service team. Delayed decision-making in some extreme cases led to deterioration to the extent that further treatment was not possible.

Best interest decisions made on behalf of patients are common for many Learning Disability service users but we were concerned that on at least two occasions concerns raised by staff were not fully investigated or escalated

The multi-agency nature of care is described below in the case studies to demonstrate the need for a joined up approach to investigating the experiences of vulnerable people.

Case study of an IMA which the Trust did not escalate:

Case study:

A service user was seen by the GP but care home staff took him to A&E. He was turned away from A&E and sent back to the care home. The service user was admitted shortly after and died of a terminal illness. It was reported by Trust staff that no painkillers were given on the acute ward as the service user did not appear in pain. There was no further investigation or escalation by the Trust which, whilst not directly responsible, did not act on the incident report.

A case study which raises concerns about reporting processes and escalation:

Case study:

A service user with a Learning Disability was admitted from a social care setting into a Mental Health ward environment temporarily where the care provided caused concern to the person reporting the incident. The care involved specific dietary arrangements. The service user was found deceased. An IMA was completed in the January (the month of death). No CIR was provided to the team initially. Subsequently, the Trust stated this was a SIRI – but provided us with a CIR. This CIR was signed off in the May but there was a blank action plan. The Trust in December 2015 stated there was a SIRI uploaded in July of the same year but has not provided it and we cannot verify its contents. The inability to provide accurate and timely information relating to individual deaths is of considerable concern to the review team.

There are deaths which do not proceed to SIRI status which would benefit from being investigated and we believe should be reported as SIRIs. The Trust is notified of these incidents and should discharge its responsibilities under its own policy to ensure that at least another provider is informed or the commissioner is notified.

The reporting of deaths of people with a Learning Disability

There were 327 Learning Disability health service users who died in this period and a further ten in TQ21 resulting in 337 deaths in total. TQ21 is the social care service that the Trust operates. Any service user receiving health care will be included in the above service user numbers on RiO. But there is no electronic system for keeping the details of 'social care only' service users for the Trust and spreadsheets are held locally in the north and south areas of the service. The number of Learning Disability deaths identified to us by the Trust for this period for people looked after 24/7 in the Trust's social care service was 14 in the north area and 24 in the south. The number for those cared for part-time has not been provided as the Trust systems cannot readily provide this information. Ten of the full time service users were identified as additional service users not found on the RiO system. This results in a total of 337 deaths of Learning Disability service users. 157 were reported as incidents to Ulysses and four were investigated as a CIR (two were SIRIs).

As part of our assessment of the reports into Learning Disability deaths we considered the findings from the CIPOLD inquiry. One of the major findings of this inquiry was the average age of death of service users. The Trust provided no evidence that it had considered the age at death of its service users or that it has undertaken a thematic review of the death of Learning Disability services users to identify any other themes highlighted by CIPOLD.

We therefore undertook an analysis of the mean and median age at death of all 337 service users identified. The mean (average) age of all 337 service users at death was 56 years old. The median age for all deaths identified by the Trust was 59 years. The mean (average) age of the 66 service users for whom we received an IMA/CIR was younger than this - 52 years. The median age was 55.

Mean and median ages at death of service users with a Learning Disability at the Trust.

	Number of deaths	Mean age (average)	Median age
Mazars review	337	56	59

Figure 5a : Mean and median ages at death of Learning Disability service users over 18 in the Trust

	Number of deaths	Mean age (average)	Median age
CIPOLD (over 18 deaths)	233	63.18	65

Figure 5b : Mean and median ages at death of Learning Disability service users over 18 in the CIPOLD cohort.

We consider that part of the explanation relating to the lower mean/median age may be a higher level of dependency but the review team did not have dependency level information available to them. We based this assumption on the degree to which the caseloads appeared active by looking at the last date of appointment before death.

The Trust subsequently analysed 174 cases as part of the fact checking process of this report to review the level of dependency and they provided a comparison with CIPOLD dependency levels. Based on this sample of 51% of the deaths, there is an increased level of dependency apparent with fewer cases in the mild category. However, the dependency levels of the whole cohort would need to be completed for the full picture. The table is provided below:

174 individuals were identified in the Trust’s audit and classified as mild, moderate, severe or profound:

	SHFT
Mild LD	27%
Moderate LD	43%
Severe LD	19%
Profound LD	11%

Figure 6a: Dependency levels of 51% of deaths of Learning Disability service users

Source: Southern Health NHS Foundation Trust September 2015

	CIPOLD adults
Mild LD	41%
Moderate LD	31%
Severe LD	21%
Profound LD	7%

Figure 6b: Dependency levels of the CIPOLD cohort

The comparability of the CIPOLD cohort with the Trust cohort cannot be determined. What is clear is that this is an area that needs further investigation and we recommend that the information gathered in this review is shared with the CIPOLD team.

The low average age of death of ALL Learning Disability service users had not been previously identified or analysed by the Trust. Further independent analysis of cases would be needed to examine this apparent low average age of death to provide a full picture of dependency levels of all 337 service users who died and any underlying reasons why the average age of death is lower than previous studies have highlighted.

The geographic analysis of reporting also suggests that there was variable reporting practice of unexpected deaths in Learning Disability health services in some areas – in particular in the Oxfordshire and Buckinghamshire areas (The Trust have only been responsible for the services since November 2012 and therefore the table below shows only deaths which have occurred since they became responsible for the services. *(Note: the geographic analysis has relied on best available information)*)

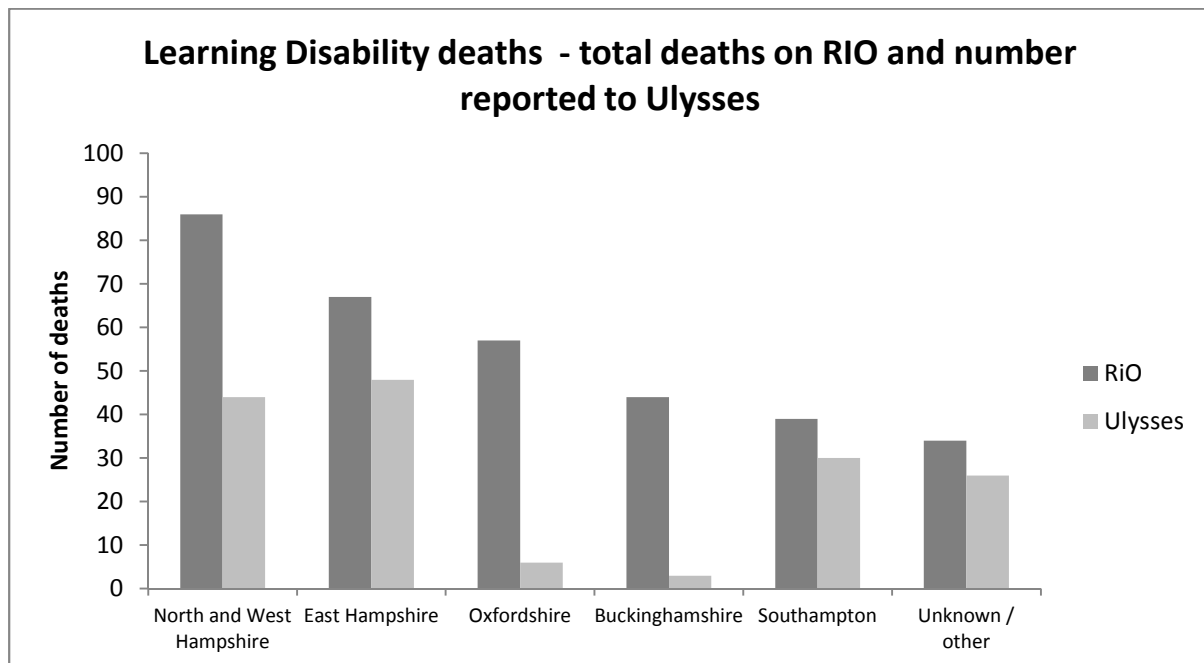


Figure 7: Reporting of Learning Disability deaths to Ulysses by area April 2011 to March 2015

We believe this review has identified that there has been inadequate investigation of Learning Disability deaths.

It was disappointing to see the CIPOLD³ and Death by Indifference⁴ findings reflected in the cohort of death reports we reviewed and a lack of anyone documenting that appropriate action to investigate if anything could be improved in future had been taken. We can only conclude that improvement actions did not effectively take place.

Whilst we have not reviewed specific practice in local acute trusts it has become very clear through reviewing investigation reports that a significant number of service users, in particular those with a Learning Disability, spend their last few hours, days or weeks in an acute hospital environment. 50% of the deaths we reviewed in Learning Disability occurred in an acute environment and a number should have been investigated further. We reviewed StEIS for ready evidence of investigation in acute providers regarding these service users and found two SIRI reports.

Family and carer involvement in investigations

The involvement of families and carers in investigations of unexpected deaths has been very limited - 64% of investigations did not involve the family based on our review of the evidence in SIRI reports. Not all families wish to be involved in investigations and, in a small number, it may not be possible or appropriate. When contacted only 4% of families declined any involvement.

There is evidence that individual teams were involved in providing support to families but this is confused with the involvement of the investigator in the written reports. There is a lack of separation between the clinical team supporting families clinically and with bereavement and the lead professional undertaking the investigation.

Our analysis reflects the lack of involvement measured in numbers and percentages but this cannot accurately reflect families' experiences. The need for families to be listened to and be involved if they wish, to have their concerns reflected accurately in reports, to get some answers, to have an accurate picture of what happened and for this to be done in a timely and open manner is critical to helping families.

Quotes below from the Making Families Count⁵ project, which is a project across the South, (see below for link) that records families' experiences of NHS investigations, demonstrates the impact of not involving families properly:

Involvement "...they had done an internal investigation. A decision had been made not to inform the family of this investigation and not to inform the family of the findings because they had decided that we would find it too upsetting, that she wouldn't reveal how or why he had died...."

Communication "...we wrote back and received another letter...the case was closed and any further queries could be addressed to the complaints officer."

Listening to concerns "...no mention of his concerns.."

³ Confidential Inquiry into Premature death of people with a Learning Disability 2013 <http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf>

⁴ Death by Indifference Mencap 2007 <https://www.mencap.org.uk/sites/default/files/documents/2008-03/DBIreport.pdf>

⁵ Making Families Count <https://vimeo.com/hundredfamilies>

Delay “...she gave a date the report would be published, as this approached - no report, I phoned...eventually the report arrived and it bore no resemblance to what had happened.”

Learning “..it would be useful to know that people actually learnt from these things - that’s the important thing.”

Preventing it happening again “...the report said there was nothing that could have been done to prevent his suicide....there is always something you can do, engage more, talk more...”

Our analysis of involvement reflected these concerns in the reports we reviewed:

- Involvement - our analysis shows that 64% of investigations at CIR or SIRI level did not involve the family. This means about two families per month over the period of the review were involved in CIR or SIRI investigations.
- Communication - the reports do not detail the exact nature of the involvement but very few cases involve a face-to-face meeting - of 77 CIRs, 12 involved the investigator meeting with the family on one occasion during the investigation. The remaining seven that were involved were by telephone.
- Not responding to concerns - we identified four cases where the family had set out questions which were not addressed in the report.
- Delay - the delays in producing reports are extensive.
- Quality of reporting - reports were often careless, lacking attention to detail with grammar, spelling and date errors that demonstrate a lack of quality review
- Lack of courtesy in naming - in cases that particularly stand out - a teenage son was called three different names in one report; in another the deceased was referred to in a variety of different forms; on another the name was duplicated as ‘find and replace’ had been used incorrectly.

In total, 36% of Mental Health investigations (all CIRs and SIRIs) involved families. In Learning Disabilities it is negligible. In 4% of cases it was considered inappropriate to contact families including a small number where police investigations required delay. In 40% there was no involvement offered or staff did not have the details of family members to contact them. The breakdown of reasons is below:

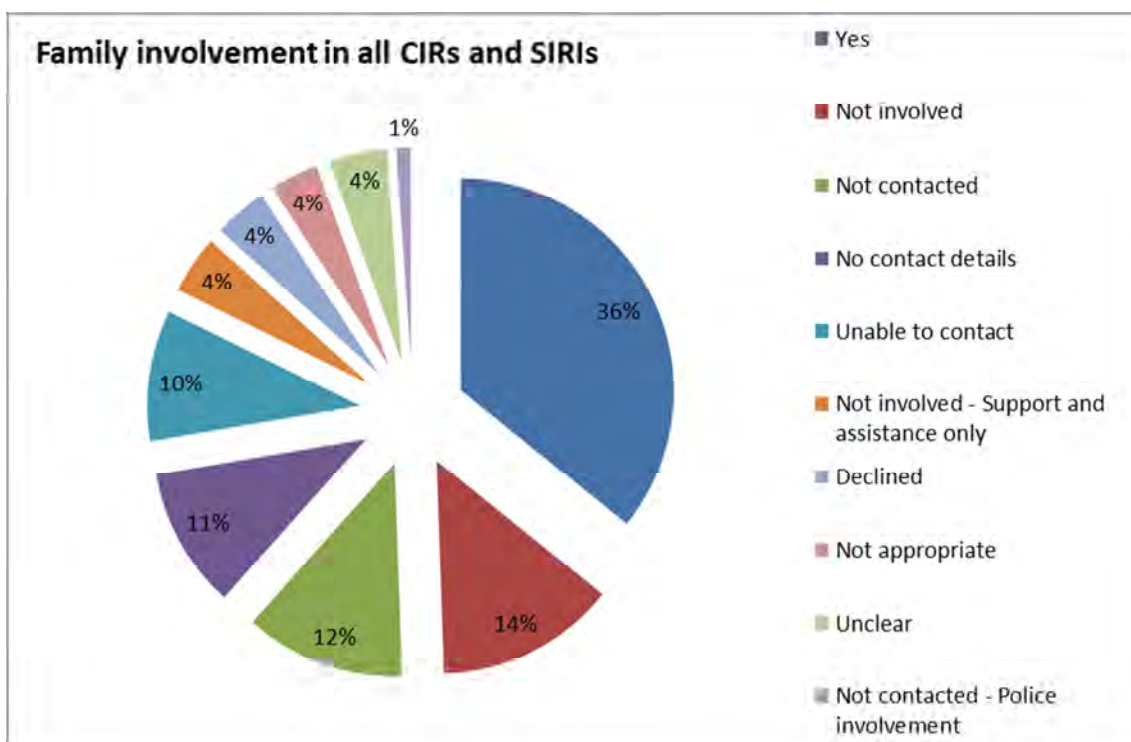


Figure 8: Family involvement in CIR and Serious Incident investigations April 2011 to March 2015.

Significant delays in completing reports also impacts on families who are often waiting for reports to be completed for inquests and for these reports to provide some answers to their questions.

Radically more effort needs to be made to develop the right culture across the Trust to engage with families when deaths occur and the Trust must continue to ensure systems to monitor Duty of Candour increase meaningful involvement, in particular, when unexpected deaths occur

Lack of system wide investigation and advocacy

Deaths were not investigated across the local health economy where this would have been appropriate. This is particularly stark in relation to deaths of service users with a Learning Disability. There is a joint responsibility for this but the initial incident reports were to the Trust and this is where the initial responsibility for ensuring escalation should come from. There was a failure to follow up on many of these reports and to share with commissioners or other care providers. This has meant there was a risk of, despite the well publicised CIPOLD report in 2013 and Mencaps Death by Indifference report, a perpetuation of the same issues being highlighted in these reports.

There has been a lack of system advocacy for service users across Adult Mental Health, Older People Mental Health and Learning Disability services. By system advocacy we mean compassionate enquiry, independent representation and investigation and transparency.

Compassionate enquiry requires investigators to review and challenge the incident from the service users' perspective, listening carefully to the experience of carers and families and seeking to learn from real experiences with an open mind. It requires all stages of the system to stand back and ask the questions from a professional stand point of the highest standard. There has been a lack of this standard of enquiry throughout the Trust's Mental Health and Learning Disability services.

Independent representation and investigation requires an investigator to be sufficiently independent to enable them to ask questions without fear or favour. It should enable them to review care across providers and not be confined to the episode of care provided only by one organisation. We saw very limited cross provider investigation in this review. The services across Hampshire are moving to a multi-speciality care arrangement and this appears to be an opportunity to look to investigate unexpected deaths across care pathways.

Transparency means sharing the information you have. The Trust failed to identify that it had information from which it could investigate deaths of people - in particular of Older People in Mental Health services and people with a Learning Disability. Detailed information is available on the Trust's systems but not interrogated by asking appropriate questions and therefore not used.

The Trust has a data set that provides detailed insight into incidents of deaths with which commissioners and other providers could work to improve care pathways. This was particularly relevant to Learning Disability services where there is still a limited ability in NHS systems to identify these service users.

The need to share information

Whilst there are some challenges with an apparent lack of information relating to Mental Health and, in particular, Learning Disability this review has demonstrated that the Trust has core information in a format that could be shared for research and review. Using and sharing the types of information we have highlighted here could have a significant impact on helping to understand local service provision and what needs to improve.

A transparent approach to sharing information on care pathways and multi-agency provision is crucial as more care is provided in independent living settings and are provided with a mix of personal budget and social and health care funding.

Despite the Trust having comprehensive data relating to deaths of its service users it has failed to use it effectively to understand mortality and issues relating to deaths of its Mental Health or Learning Disability service users.

Commissioners also need better information relating to Mental Health and Learning Disability users to inform commissioning decisions and to improve services. This information needs to be used and shared by the Trust and commissioners alike.

Information management and data provision

The Trust provided a range of information for this review. However, it is apparent that improvements are needed in how information is interrogated to help the Trust understand deaths better. The RiO extract has been largely reliable. However, RiO does not include TQ21 social care service users unless they are seen by other Trust services. Local spreadsheets are kept as a record of all service users in TQ21 being provided with 24/7 care but this is not a reliable way of identifying service users deaths information. TQ21 does use the same Ulysses system though.

The Trust had difficulty in accurately identifying inpatients and deaths of people in detention as well as Learning Disability service users without significant enquiry. Ways of readily identifying all inpatients, detained service users and Learning Disability service users need to be consistently and accurately produced. Learning Disability service users were missed in later data extracts produced

for this review due to the different teams involved in care and therefore patients being considered a 'physical health service user' only. The Trust must agree a protocol for ensuring it can extract data for these groups reliably.

The information on Ulysses, whilst comprehensive, needs to be reviewed specifically to ensure deaths are readily and accurately identifiable by location and by type of service user. Often inpatient units report deaths post discharge and so the system does not reliably identify all inpatient incidents without further enquiry. The way unexpected deaths are reported and how the data fields are used has not helped accurate interrogation.

Both these data sets can provide the basic underlying information needed to form the basis of a mortality review and for assurance purposes.

StEIS does not provide local reporting capacity to enable ready identification of unexpected deaths without further analysis. Comparative information is not easily provided either. In particular, it does not identify service users with a Learning Disability. Given the recognised challenge in identifying Learning Disability deaths nationally this would seem an area that needs addressing.

During the course of our review, we made a significant number of requests for information. The operational staff in the Trust provided a great deal of assistance, often at short notice. However, there was some difficulty experienced in providing the data in an accurate or timely manner. The mapping of service users through the above systems also relied on different reference numbers. The NHS number is not used in StEIS and so individual mapping had to take place to track service users through. This was a major barrier to undertaking this work.

Contextual and comparative information

As part of its brief, the review team was asked to: "provide a contextual view" using benchmarking data to compare death rates of people in receipt of services from Southern Health with comparable organisations. The brief noted that "While a benchmark only identifies 'norms' or 'averages' rather than best practice, it will be possible to identify whether Southern Health is an outlier".

There is a range of data available that might further investigations into unexpected deaths and their causes – see Appendix 4. We drew from the HSCIC experimental data link between ONS data on death and the Mental Health Minimum Data Set (MHMDS). This is the first time that this information has been presented and we recommend that there is a wider discussion about how the data can be analysed and then interpreted.

Undertaking a detailed statistical analysis of the significance of this data was not part of our scope and would be required before further action was taken. Statistical significance is not normally undertaken in benchmarking exercises. The findings shared below are intended to highlight areas for further investigation and to draw parallels with other findings in the report where this is relevant.

The report identifies some initial findings that warrant further analysis. These are presented in the detailed findings of this report but include the following:

- A relatively low level of reporting deaths under specific categories by the Trust compared to other mental health trusts regionally (on StEIS) per 1,000 Mental Health service users.

- The Trust states that there should be eight “degree of harm death” cases reflected on to NRLS for the period from April 2011 to March 2015 which it interprets as meeting the NRLS guidance. While we noted that the public data highlighted a relatively low reporting of death by the Trust to NRLS this figure differs significantly from the published data and that held by NRLS at present. We have been advised by the NRLS team not to use nationally published data to benchmark Mental Health Trusts including on numbers of reports in the ‘degree of harm death’ category as the information is dynamic and there is some over-reporting by some Mental Health Trusts. Our concerns about this data and the link between Ulysses and the NRLS are detailed in further chapters.
- A slightly higher than average level of unexpected or premature (under 75 years) deaths of mental health service users when compared to other mental health trusts.
- The low level of reporting appears to be reporting practice rather than arising from lower levels of unexpected deaths.

We analysed death rates against the diagnostic codes used by the CIPOLD team and sourced from the End of Life Care Intelligence Network as “unexpected deaths”. The proportion of service users deaths overall which are unexpected in these categories is the same as the average for England. This is likely to be because of the older average age of the Trust’s service users.

When we looked at causes of deaths by ICD10 Chapter, deaths amongst service users of the Trust were notably higher (in the upper quartile and higher than the adjusted crude death rate) in the following ICD 10 chapters:

- Chapter V - Mental and behavioural disorders e.g. organic, mood and behavioural disorders and dementia (which might be expected given the comparatively older cohort in the Trust)
- Chapter VI - Diseases of the nervous system e.g. Inflammatory and degenerative diseases of the central nervous system
- Chapter IX - Diseases of the circulatory system e.g. Pulmonary heart disease and diseases of pulmonary circulation
- Chapter XX - External causes e.g. injured in accidents, Intentional self-harm

A possible explanation for the higher rates in these chapters is the higher elderly population in the area. This needs further investigation including when the 13/14 data becomes available.

There were no chapters where the deaths were substantially lower. The chapter relating to diseases of the digestive system was marginally lower. The relevant spine charts for 2012/13 are in Figure 94.

Recommendations:

Trust recommendations:

Board Leadership and Oversight

1. The Board needs to address the culture of lack of review and reporting of unexpected deaths, ensure staff at all levels recognise the need for timely, high quality investigation, how to include families and to ensure learning is demonstrated.
 - a. The Board needs to ensure the processes of reporting and investigating unexpected deaths are consistent and robust throughout the organisation and to improve the quality of investigations and the involvement of families in those investigations. The Trust needs to prioritise the review of deaths as part of a wider mortality review process making better use of data available.
 - b. The Board needs to understand and make full use of the data available and the underlying information required for assurance that unexpected deaths are being properly identified and investigated.
2. The Board or its sub-committees should receive regular reports of all incidents of deaths. The report should:
 - a. provide data on all deaths of people using a Mental Health or Learning Disability service including service users of the social care service - TQ21.
 - b. outline how many unexpected deaths there have been and in which areas.
 - c. outline how many IMAs have been written as a result and how many have progressed to CIR and then onto being a Serious Incident under the 2015 Serious Incident Framework.
 - d. include a summary of how many deaths are 'pending' for the purposes of investigation with a reason why. This would make the decision-making more transparent as regards to delays in reporting to StEIS.
 - e. provide information to enable trends to be identified and for Board members to become familiar with the information
 - f. provide information which includes the categorisation of all deaths reported to Ulysses
 - g. provide data at least twice a year on all deaths. Themes should be reported on which covers at least the previous 6 quarters (or a sufficient number to provide a reasonable sample from which to identify themes). This is particularly important for the Learning Disability arena where numbers of deaths in each quarter will be low and in areas that may not be considered to meet Serious Incident reporting guidance e.g. non-suicide Mental Health deaths.
3. The 2015/16 Annual Report should provide a more transparent breakdown of deaths including an analysis of the themes that occur for people with Mental Health and Learning Disability challenges.
4. There is clear national and Trust policy guidance on reporting and investigating deaths. Trust policy includes a full set of templates and processes - the Board should ensure these policies are being followed and templates being used.

Monitoring mortality and unexpected deaths / attrition

5. Unexpected deaths should be defined more clearly. We suggest the Trust uses, as a starting point, the classification outlined in this report to identify the potential need for review or investigation in each case. In particular, the definition of an 'unexpected death' needs to be refined to be more applicable to the circumstances of people with a Learning Disability regardless of setting.
6. The Trust should develop a Mental Health and Learning Disability Mortality Review Group which includes reviewing unexpected deaths which do not constitute a serious incident. Clear terms of reference should be developed. This group should serve a number of purposes:
 - a. to provide oversight of all deaths occurring amongst the Trust's Mental Health and Learning Disability service users
 - b. develop a mortality dashboard which is provided to stakeholders and reported in the annual report, that provides a full picture of all deaths, themes, CIRs and serious incidents
 - c. monitor causes of deaths amongst its service users by using the 2013/14 MHMDS data release to see if the ICD 10 chapters show any trend
 - d. provide an evidence base to share with Local Authority commissioners and other providers highlighting themes that are arising relating to social care and other agencies issues
 - e. to ensure that liaison with acute provider colleagues can take place at a clinical and managerial level where the Trust has concerns raised with it about care in acute settings
 - f. should include a GP as part of its membership
 - g. the formation and progress of this new group should be monitored at Board level
 - h. the group must aim to improve the transparency of reporting levels of unexpected deaths in these service user groups.

Thematic reviews

7. A template for a thematic review should be produced. All thematic reviews should be undertaken in an agreed format which meets best practice standards and includes follow up, evaluation and demonstration of lessons learned and practice change.
8. There should be further work undertaken to establish whether all deaths of people over the age of 65 are being appropriately reported and investigated - in particular amongst inpatients.
9. The Trust, CCG and local authority should undertake a retrospective review of all Learning Disability unexpected deaths regardless of place of residence with particular reference to:
 - a. the quality, timing and follow up of dysphagia assessments
 - b. the level of support provided by hospital liaison services and the challenges faced in acute liaison
 - c. the decision-making process for PEG insertion
 - d. the hydration and nourishment of service users refusing to eat
 - e. delays in decision-making for treatment - including primary care, decisions by care staff and responses in A&E and on wards

- f. the inclusion of carers and families in investigations
 - g. waiting times for therapy services and community nursing
 - h. identification of early warning signs of deterioration through behavioural change
 - i. arrangements for attending appointments and seeing healthcare professionals
 - j. reporting and acting on safeguarding concerns.
10. The Trust and CCG should undertake thematic reviews in Mental Health on a number of the issues raised in this review, including:
- a. A joint review of the circumstances of death of people with serious mental illness on long term antipsychotic drugs encompassing a review of safeguarding alerts, self-neglect and physical health management.
 - b. A joint review of all deaths relating to people with a drug related death in conjunction with local providers encompassing a review of referral processes between agencies.
 - c. A joint review with the CCG of recent cases of death relating to serious eating disorders to understand how services need to improve by bringing both physical and psychological management together.
 - d. A joint review of alcohol related deaths in conjunction with local providers encompassing a review of self-referral processes.
11. The Trust should provide staff with regular training and guidance to help them manage physical health conditions of long-term mental health service users. Diabetes management stands out as an area for greater awareness from a number of cases we reviewed.
12. The Trust should undertake thematic reviews of the issues raised in this report, including:
- a. Medical input and senior medical oversight
 - b. The role of the care co-ordinator
 - c. The need for pharmacy colleagues to be more explicitly involved in cases involving drug toxicity and polypharmacy.
13. A regular review of all sudden deaths of OPMH inpatients should be carried out. This should include a review of whether care treatment decisions are taken quickly enough, whether co-operation and liaison with acute medical staff is adequate and whether staff feel confident in managing and identifying sudden physical deterioration including CPR.

Reporting and identifying deaths

14. The Trust should review the way that deaths are categorised under the incident reporting policy so that:
- a. All relevant deaths are re-graded accurately before and after investigations have taken place.
 - b. All relevant deaths are reported on regardless of impact grading to ensure that deaths have greater prominence in the Trust's reporting systems.
 - c. Accurate information is provided for future Trust Mortality Reviews.
 - d. That immediate work with the NRLS team is undertaken to ensure the changes to the local risk management system map as expected to NRLS and on to CQC.

Quality of investigation reporting

15. The Serious Incident investigation process needs a major overhaul in the Trust. Improvements are needed in:
- a. Separation of people responsible for quality assurance and those undertaking investigations. This would enable training in review processes and quality assurance to be targeted at senior staff and in investigation techniques at a dedicated group of investigators.
 - b. Quality assurance processes including independent review and sign off
 - c. Achieving high professional standards in written presentation

Timeliness of investigations

16. Reporting to StEIS should be undertaken within the 2 working days of notification as required by the national guidance.
17. There should be more explicit action to commence investigations promptly even when a coroner conclusion is not immediately available unless there is a specific reason to delay; any delay should have senior sign off.

Involvement of families

18. The involvement of families in investigations requires improvement. In particular, improvements are needed in:
- a. developing clear guidelines for staff, including expected timescales and core standards, which recognise the need for iterative engagement when the family is ready
 - b. ensuring that the investigation process is clearly defined and separate from the support and assistance offered by local treatment teams
 - c. the Trust should ensure that investigators talk to families as early as possible in the process to identify any concerns and take these into account in the ensuing investigation
 - d. provide reports to coroners in time for inquests
 - e. explicitly demonstrating why families are not involved
 - f. identifying next of kin details for all service users as part of a core assessment including where consent to share has not been provided to enable investigators to find relatives more easily.
 - g. working with primary care to identify family members
 - h. where the Trust delays the commencement of an investigation due to inquests or other investigations this should be made explicit to families and the reasons explained.
 - i. the performance of divisions in involving families and securing feedback.

Multi-agency working

19. The Trust Board should seek co-operation with other providers and commissioners to agree a framework for investigations in preparation for future incidents regarding escalation. Divisions should then apply this framework where the incident report suggests another organisation should review or investigate the circumstances of a death.

Deaths in detention and inpatient deaths

20. The Trust should retain a contemporaneous list of all inpatient deaths mapped to Mental Health Act status to enable Trust-wide overview of all inpatient deaths and deaths in detention
21. All deaths of service users in detention should be investigated, whether expected or not. These investigations should occur regardless of inquest conclusions. This will give assurance that the 24/7 nature of the care required has been of the highest standard. Specific issues addressed in the Terms of Reference for these investigations should include:
 - a. to ensure that physical health care symptoms are not dismissed where challenging behaviour presents;
 - b. that delays in seeking physical health care are not apparent;
 - c. that service users are fully aware of decisions regarding whether to treat or investigate chronic or acute symptoms and that these are made in an informed manner;
 - d. that access to full care and treatment is not restricted in any way;
 - e. that staff are adequately supported to provide physical health care and trained to do so.

Information management

22. The Trust should develop an agreed RiO extract and Ulysses reporting protocol to capture all deaths of Adult Mental Health, Older People Mental Health and Learning Disability service users including community and inpatient locations to form the basis of future mortality review.
23. The spreadsheet arrangement currently in place in TQ21 is insufficient to monitor deaths at corporate level as part of the whole Learning Disability service provision. TQ21 service users should be incorporated into Trust administration systems in a way which ensures their deaths are captured for reporting and investigation purposes.

Commissioners recommendations:

1. The CCGs should take action to ensure:
 - a. incidents are reported to StEIS within 2 working days as required
 - b. that reports are provided to closure panels within 60 days as required
 - c. that the quality of IMAs, Critical Incident Reviews and Serious Incident investigations improves radically
 - d. that Serious Incident investigations are completed within an agreed timeframe
 - e. that the data provided to them relating to deaths is accurate.
2. All Commissioners of services from the Trust should ensure that all unexpected deaths of people with a Learning Disability, inpatients on Older Peoples Mental Health wards and in cases of suicides of people in the period between referral and treatment are properly considered before a decision is taken not to report as a Serious Incident or report under CQC Regulation 16.
3. The CCGs, with CQC, should ensure that the Trust reports and investigates all deaths in detention to ensure that full learning is derived from this group of deaths.

4. The CCGs, with NHS England, should review whether GPs should be involved in initial management assessments of people with a Learning Disability and the extent to which GPs are sufficiently informed to talk with the Coroner if needed.
5. Commissioners should provide support to the mortality reviews in the Trust including agreeing appropriate independent representation and if possible co-ordinate between them to identify a GP member.
6. All commissioners should monitor and co-ordinate between them, the progress of the Trust in its improved use of mortality data and contract negotiations should reflect the changes required from this review.
7. The CCGs should discuss the implications of this review with acute care providers in the area and agree a protocol for ensuring joint investigation between NHS providers, in particular, for people with a Learning Disability.
8. The CCGs with local authorities should develop a detailed needs assessment of people with a Mental Health or Learning Disability in their area.
9. Commissioners should use the intelligence provided in this review to secure access to data on Mental Health and Learning Disability services to:
 - a. Develop investigation protocols that look across pathways more systematically including in primary care
 - b. Inform service developments
 - c. Ensure that general 'community physical care services' need to be accessible to all groups of patients

National recommendations (with basis for recommendation where relevant):

1. NHS England and its partners should facilitate the use of comparative mortality information relating to Mental Health and Learning Disability service users amongst Mental Health providers. This should include making use of the MHMDS experimental data linkage and the information contained in the new MHLDMDS.

There is a lack of readily available and comparative information on deaths of mental health and learning disability service users available to compare Trusts and services. The MHLDMDS and the work of HSCIC with the ONS, alongside information held in Trust's administration systems form the basis of comparative information. Through our work we identified no source of wholly reliable information to compare mortality in these fields on a Trust or provider basis. Data is available but is difficult to access locally.

2. NHS England should ensure that learning from this review of deaths into people with a Learning Disability informs the National Learning Disability Mortality Review programme.

The National Learning Disability mortality review programme is currently being implemented. Our current understanding of the programme through it's consultation programme is that it is being undertaken on a case by case basis using deaths reported individually. The ability to extract information on Learning Disability deaths from the Trust as part of this review demonstrates that there is the potential to secure this sort of information in an anonymised way to help underpin this important national programme. The themes reflect those identified in previous reviews of deaths of people with learning disability including the lack of carer and family involvement. Involvement of the views of carers and families should be part of the programme.

3. NHS England should highlight learning from this review for other NHS Trusts including the apparent low level of reporting and investigation of Learning Disability deaths and ensure improvement.
4.
 - a. The StEIS system should be reviewed to enable comparative information and easier analysis to be more readily able to identify where Mental Health and Learning Disability service users deaths are involved including the identification of cases in detention.
 - b. Whilst there is a move away from prescription of what constitutes a Serious incident the NHS England Patient Safety team should ensure that Mental Health and Learning Disability providers and Trusts are provided with focussed mental health or learning disability case examples or a specific framework to inform their own clear and transparent local policies for deciding what deaths to report and investigate. Without this national assurance cannot be secured that deaths are being correctly and consistently reported or investigated.

a) There was no ability in the StEIS system to identify Learning Disability deaths other than searching for the term in the text of individual reports. This makes it impossible to identify deaths that are reported across the wide range of providers that are related to a person with a Learning Disability. Compounded by the apparent low level of recognising deaths in Learning Disability service users as possible serious incidents it is important to introduce a facility that would enable these deaths to be identified for learning purposes.

It was easier to identify cases of people with a Mental Health need but this still required individual reviews of text to identify cases depending on which category the report was made under. The same issue as above arises when people die in other non-Mental Health organisations.

Deaths in detention could not be readily identified through StEIS as out of 10 Trusts only 1 death in custody was recorded.

b) The decisions about what a Serious Incident relating to death is in the Mental Health and Learning Disability arena, as a result of the way services are provided through community provision and multi-agency working, means that an open framework leaves considerable room for interpretation. This risks fewer cases being highlighted and thoroughly investigated. Whilst there is a balance required between prescription and flexibility, in the cases specifically of patients' deaths it would be advisable to provide case examples that would help guide Trusts. The national guidance used by the Trust does not appear to be recognised any longer as supporting guidance. There is therefore limited transparency and ultimately limited ability to hold organisations accountable without clearer local policies informed by national guidance.

5. Develop guidance on an assurance framework for Mental Health and Learning Disability mortality and deaths for NHS Trusts and require relevant Trusts to include this in their board assurance arrangements.

There was no assurance framework in place that could satisfy the Board at the Trust that mortality and service user deaths were identified and investigated accurately or consistently. Our meetings,

interviews and search for good practice in other Trusts suggest that there is a wide variety of practice nationally in this area with no consistent approach to assurance in mortality in this sector.

6. Regional data and national data should be interrogated to establish a better understanding of what might be expected as the ratio of deaths to investigations for Older People Mental Health services.

There was a significant difference between the number of deaths of Older People being investigated and those of people under the age of 65. There were many deaths of the very elderly but the causes of unexpected deaths in older people and the very frail and elderly were different from the younger population and were not being fully investigated for learning purposes. Despite the fact that death is increasingly more likely as people get older there was a marked difference that could not be fully explained. There was no benchmark against which the Trust could identify whether its performance varied significantly from others or that would inform a national perspective on deaths of older people. With such a small number of deaths being investigated in this age group there will be limited learning of how to improve care.

7. NHS England and its partners should provide further guidance for Mental Health Trusts on what should be reported to CQC under Regulation 16 and to the NRLS given both use the same system and have different purposes.

The guidance relating to what to report to CQC and what to report to NRLS is open to significant interpretation. Reporting to CQC is a statutory responsibility discharged through using the NRLS system; NRLS is a voluntary non-statutory requirement. This gives rise to potential conflicts in meeting the statutory requirement whilst also reporting to a system that is designed to promote and support learning. Guidance on both is open to wide interpretation.

Original scope of the review

The original specification drawn up by NHS England requested the following:

An independent investigation into the deaths of all service users who received Mental Health or Learning Disability services at Southern Health Foundation Trust since April 2011.

The outcomes and outputs from the independent review into Mental Health and Learning Disability service users who died while receiving care from Southern Health NHS Foundation Trust will include:

- A document summarising the findings with respect to all deaths in the Mental Health and Learning Disability services provided by Southern Health NHS Foundation Trust. This will be contextualised in relation to both national and local intelligence about correlates (e.g. of health risk) and local organisational issues in NHS and social care services.
- A set of recommendations arising including, as appropriate, action plans, briefing workshops, advice and/or a framework for ongoing assurance.
- Information to feed in to the work of the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD). In this way, the work will represent an early implementation of recent CIPOLD proposals.
- Information to feed in to the Equalities and Human Rights Commission Inquiry into the non-natural deaths of people with Mental Health conditions in state detention.
- Evidence on key data items that correlate with safe care and adverse care indicators.

Outcomes

- A shared view across all the key players of risks within Southern Health services, of improvement action required, and plans to deliver change.
- Advice to the CCGs about Learning Disability commissioning, data management and analysis, and adverse events indicators.

There were 4 aspects to the review:

1. User, family and carer input

As required further discussion with people who have used services, families and carers to identify areas of concern, types of incidents, categorisation by geography, services type and client group, and assurance that these continue to be identified, as required, throughout this piece of work.

2. Review of all deaths

Review of every serious incident leading to a death of whatever nature and however categorised since 2011. The aim of this element is to confirm that all such deaths were correctly identified, notified to the appropriate agencies and then to ensure that processes are in place to review, action plan and ensure lessons are learnt from them.

3. Benchmarking data

To provide a contextual view, key benchmarking data items will be used to compare death rates of people in receipt of services from Southern Health with comparable organisations.

While a benchmark only identifies 'norms' or 'averages' rather than best practice, it will be possible to identify whether Southern Health is an outlier. This information will be used to identify any common themes and trends and any common contributory factors.

4. Adverse events indicators

Information about patterns in these data may help to identify key indicators of risk for avoidable death (e.g., by suicide or from avoidable physical health-related causes). Such information, if available, will be summarised to inform service users, carers, commissioners and providers about care quality.

An independent panel will be established to assure the content and process of this third area of work. It will report to the Oversight and Assurance Group of the NHS England, Thames Valley and Wessex QSGs.

The arrangements for the independent panel changed given the complexity of the review. The original plans for membership and Terms of Reference were therefore amended and are attached in Appendix 1.

Outline methodology

The detailed methodology is described in Appendix 13.

Our approach had four main aspects:

- **To compile data, analyse and compare the Trust with others.** This involved securing a wide range of information in order to compare and benchmark the Trust regionally and nationally. We met with a number of organisations who had insight into relevant information including the Health and Social Care Information Centre.
- **To identify all Serious Untoward Incidents leading to a death and undertake a review of all Serious Incidents Requiring Investigation (SIRIs) involving a death.** This involved identifying from over 216 cases the relevant Mental Health Learning Disability cases and reviewing 195 SIRIs - recent cases were still at Corporate Panel stage. Extended work included a review of a further 345 reports which were either Critical Incident Reports or Initial Management Assessments. We also assessed 1454 entries relating to death on the Trust Incident system and tracked all coroner inquests on the Trust's inquest tracker to be confident that all unexpected deaths of service users were identified as far as possible.
- **To assess current reporting practice and processes at Southern Health.** This involved securing and reviewing over 100 further documents relating to policies, procedures, reports and reviews. We met with the Chief Executive, Executive Directors, 2 non-Executive Directors, central governance staff, and the SIRI and Ulysses teams at the Trust. We spoke with staff involved in the SIRI process at both Oxfordshire CCG and West Hampshire CCG. An additional set of documents was provided as part of the final stages of agreeing this report.
- **To assess current arrangements in order to make recommendations on future assurance frameworks and inform policy on the reporting of deaths in Mental Health and Learning Disability both locally and more widely if appropriate.**

The involvement of families and carers in the review was discussed on a number of occasions at the Expert Reference Group and at some length to establish if and how the team could speak with service users by experience and their families at the right time. NHS England and the Expert Reference Group assessed what the best approach would be at each meeting. It was considered inappropriate to meet with families or carers until the draft report was complete.

However, the family of Connor Sparrowhawk was represented at all the meetings of the Expert Reference Group. This has been useful in ensuring a balanced perspective to our work. It has also provided an opportunity for insight into the progress of the review and its findings, to comment and suggest further enquiry and, whilst confidential during the review has, we hope, demonstrated the rigour and determination of the team to provide an independent, transparent and balanced review.

Deciding which deaths are investigated

There is no clear single definition of either expected or unexpected death that is sufficient for classifying deaths. (There is no national guidance to help with this).

Within the Trust there is an inconsistent approach to deciding whether to report, review or investigate the circumstances of a death due to the reliance on staff to report unexpected deaths to Ulysses.

A death can be from natural causes and still be unexpected. It does not necessarily mean that there were no care delivery problems and that learning cannot be derived.

In national reports and guidance referred to in this report there are a number of terms used in association with deaths - expected, unexpected, avoidable and premature amongst others. There is no clear single definition of either an expected or unexpected death within the Trust or in associated guidance.

In this review we use the terms 'expected deaths' and 'unexpected deaths' are used. However, the decision about what constitutes either is defined by the Trust's own policy as shown below.

The Trust's Policy defines an **expected death** as *'for the purpose of this policy an expected death can be defined as a death occurring at a stage in the patient's disease pathway at which death is inevitable and no active intervention to prolong life is planned or ongoing'*.

An **unexpected death** in the same policy is defined as *'any death occurring where this has not been anticipated or predicted or where there is a similarly unexpected collapse leading to or precipitating the event that lead to the death'*. Care of a Patient After their Death (SHCP 145 December 2014)

The Policy requires all unexpected deaths to be reported to the senior unit manager and recorded as an incident.

Once reported, deaths that are classed as 'unexpected' initially can be recategorised as 'expected' throughout the decision-making process.

We reviewed 1454 instances of deaths reported to Ulysses. We then tracked whether these were then investigated as serious incidents and reported to NRLS. We concluded from these reports that deaths could be grouped into different types. Some types of death were far less likely to be reviewed or investigated.

If the death was classed as expected and from natural causes then there was a likelihood that no further investigation occurred within the Trust. If the death was classed as unexpected and sudden this increased the likelihood of investigation.

The framework at Figure 31 provides a suggested approach to developing consistency around whether an expected or unexpected death needs further review or an investigation.

Recording deaths on data and information systems - the process

Information systems contain detailed information relating to deaths including those that are reported as unexpected. The systems together collate a detailed data set from which the Trust could interrogate information if needed.

Deaths are reported to various systems. RiO contains a data set of all health related patients. It does not include all services of the Trust.

There are criteria for reporting an unexpected death onto Ulysses which are open to interpretation. There is no guarantee that all unexpected deaths will be reported as systems are dependent on staff to report an incident. All deaths reported to Ulysses are categorised as unexpected initially and subject to investigation and may be re-categorised as information becomes available.

There were a number of points where a death could be classed as 'expected' which can go unchallenged and risks unexpected deaths not being subject to an IMA or investigated further. There was no evidence of manager review processes provided during the period although we are informed that this occurs. Managers are required to close incidents on the Ulysses system when complete.

Unexpected deaths that are considered potentially SIRI reportable should be reported to StEIS within 48 hours of notification.

Deaths recorded through the RiO information system

When a death occurs patient administration and information systems at the Trust capture and record the death for all health service users - but not social care users. This is done through RiO. A death is noted immediately on RiO for inpatients. RiO synchronises regularly with the national spine which identifies all deaths from GP systems. This is how the Trust identifies all deaths on RiO. Sometimes the Trust is not aware of a death therefore until some time afterwards and it will only be validated on RiO when a member of staff goes into RiO to make the next entry in the system. The death will be recorded and various records closed and stored.

Reporting unexpected deaths to Ulysses

If a death is 'unexpected' then it should be reported onto the Trust's incident reporting system - Ulysses. This must be done within 24 hours of the incident. In TQ21, which is the social care arm of the Trust, there is a paper based system and the service manager is required to do an electronic entry within three days. An initial management assessment (IMA) is expected within 48 hours of the death being reported.

Ulysses is the first step of the investigation decision process: Ulysses records all patient safety and untoward incidents where harm has or might have been caused to a patient. It records any incident that a staff member considers is unusual or believes should be recorded in order that incidents are

monitored for trends, for action to be taken and so that a decision can be made about investigating further. All staff are strongly encouraged to report all incidents by the Trust.

The Trust's procedure for reporting and managing incidents was updated in September 2014. The relevant criteria for reporting deaths to Ulysses are in Appendix 5.

All deaths reported to Ulysses are categorised as 'Unexpected death under Investigation' unless and until the cause of death becomes clear. The Trust guidance requires 'impact grading' to occur at the time of incident and the majority of deaths are graded as Red - Catastrophic. The Trust's guidance states all 'unexpected deaths of a service user, suicide of a service user and significant abuse or neglect of a service user by staff employed to provide care, treatment or support' should be reported. The impact grading can be subsequently downgraded if the investigation shows there to be no untoward circumstances. Red graded incidents are all required to have an initial management assessment (IMA) within one working day. Ulysses is updated regularly as details become available.

Catastrophic incidents or incidents resulting in death are categorised as a 5. The Trust decides if a death is a Category 5 by determining if there is a service user safety element to it. Other deaths may be categorised differently depending on the circumstances.

There is no guarantee that every death that is unexpected is recorded through this system. It relies on staff following the correct procedure and the death being identified as 'unexpected'.

Once an 'unexpected death' is recorded onto Ulysses there is then a process that takes place to establish if any further investigation is required.

The staff member should discuss the incident with their team manager and a decision will be taken as to whether the death requires an IMA. This decision should be recorded on Ulysses. Some deaths are determined at this point as not needing any further investigation and therefore no IMA is completed. There is the risk at this stage that managers can wrongly decide an IMA is not required. The Trust cannot demonstrate confidently that all unexpected deaths are being reported into the system or that decisions on IMAs are consistent.

Guidance states that the IMA should be completed either by the clinician treating the service user or 'someone with a more objective view'.

StEIS

StEIS (Strategic Executive Information System) is the system by which NHS Trusts inform the rest of the NHS that an incident has occurred, that there will be an investigation (SIRI) and that others should expect the result of the investigation within a set timeframe. Some cases are discussed directly with commissioners before entry onto StEIS. Incidents must be reported within two working days and criteria for reporting are defined in the 2013 serious incident framework guidance. Investigations should have been completed and signed off by the Trust within 45 or 60 days depending on Grade, ready to go to the relevant commissioner.

A SIRI is an incident that fits within national guidance as set out in the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (NPSA/NRLS 2010) and the Serious Incident Framework March 2013. An extract of the precise guidance as relevant to deaths

that is used by the Trust - drawn from the Information Resource to support the Reporting of Serious Incidents 2010 (Gateway reference 2010/009 - is set out in Appendix 6. The national guidance has changed over the period to try to provide greater clarity and consistency. However, it is recognised that there are differing interpretations applied across the NHS. All sets of guidance have provided sufficient latitude to allow investigations to be reported as SIRIs if required.

The 2013 Serious Incident Framework highlights that initial incident grading should err on the side of caution, categorising and treating an incident as a serious incident if there is any possibility that it is. Providers should not wait for the outcome of full investigations before grading the incident.

All SIRIs go to a CCG closure panel. The Trust should demonstrate that actions have been implemented before the SIRI can be closed. CIRs that do not constitute a SIRI do not go through this panel.

Determining the level of investigation - types of reports

Initial Management Assessments, Critical Incident Reviews and SIRIs are all in use within the Trust for Mental Health and Learning Disability service user deaths.

The Trust introduced new procedures and policies relating to the conduct of these investigations in July and September 2014. However, these are not consistently followed.

Initial Management Assessments

For the deaths considered as 'unexpected' and needing further review, an initial management assessment (IMA) should be recorded and a report produced. These are produced to provide an initial insight into the circumstances of the death and help determine whether any investigation is required. The Trust's guidance is clear - an IMA should identify key learning and an action plan should be produced. It notes that all IMAs can be shared under the Freedom of Information Act (FOI) and as such is clear about the standards expected of the quality of writing. Trust policy also states that dates and spelling are to be checked and no cut and paste from patient notes is to be used. This is all required with 24 hours of the incident. No distinction is made between less major incidents and deaths.

The relevant divisional manager is required to review the standard of the report, determine action and a senior manager decides if the recommendation for further investigation or not (i.e. a Critical Incident review) is accepted.

In practice, this is done in a variety of ways across the Mental Health and Learning Disability divisions and Trust – sometimes 'virtually' by email and sometimes in panel meetings.

The Trust also produced 'extended IMAs' which were IMAs with an action plan. It is unrealistic for an action plan to be robustly produced within the expected 24-48hr timeframe and therefore if accepted that both types of IMA are appropriate then all initial IMAs should be completed and reviewed in 24 hours and then the decision to have an extended IMA should be made as an option (and produced within clear timescales) where a Critical Incident Review is not required. This might be appropriate where clear learning is apparent from the IMA but no service user safety incident is apparent.

Critical Incident reviews (CIR)

The decision to undertake a CIR requires a member of staff trained in Root Cause Analysis (RCA) to be allocated to lead an investigation - usually a person from outside the team. This decision has been taken locally within local areas of the divisions. A CIR looks at whether there are any care or service delivery problems, identifies any contributory factors and is expected to use a suggested set of tools to ensure the RCA is thorough.

The CIR is expected to identify lessons learned, make recommendations and identify actions.

The CIR should be submitted for sign off at a Divisional SIRI review panel prior to submission to the Corporate SIRI review panel.

Critical incident reviews and reporting to StEIS

If the death meets certain criteria it should be reported to the Strategic Executive Information System (StEIS) within 48 hours and therefore it becomes a Serious Incident Requiring Investigation (SIRI). This is standard NHS practice and is set out in the 2010⁶, 2013⁷ and 2015⁸ national frameworks for incident reporting. Incidents can always be removed if found to have been wrongly reported.

Final reports should be available to Commissioners (i.e. completed) within 45 days for Grade 1 and 60 days for Grade 2 SIRIs. Grade 2 SIRIs are those that were of the most serious nature and therefore were thought to require longer to investigate.

Decisions and investigations into a death are largely internal to the Trust. The Trust retains all evidence and investigation work is retained within the Trust until the final report is published anonymously for the CCG closure panel. We were initially informed by WHCCG that the SIRI reports could not be provided to us by them as the Trust had the full reports. The Trust would put information on StEIS and bring paper copies to the closure panel. The Trust now provides full reports and evidence to the closure panels one week in advance.

A SIRI investigation usually only involves internal staff to the Trust (the vast majority). Occasionally people from another Trust or an external agency undertake investigations. Homicides require a specific process and are always investigated by people external to the Trust and are managed by NHS England.

Commissioners are required to organise SIRI closure panels to review and close SIRIs. These are held regularly by different commissioners. There is a backlog of SIRIs being closed.

The Trust has produced a 'toolkit' for investigating incidents and for quality review. The template in the policy for the IMA, the CIR report, quality review and panel reviews were not being used. We saw only two reports written using a revised template in the Trust's updated policy.

Other reporting requirements

Reporting of unexpected deaths happen in at least three other ways for health service users:

- The coroner can be involved - anyone can report to the coroner and in many cases this will be the police. The Trust may be required to provide a report to the coroner and to provide witnesses at inquests.
- The number of deaths recorded on Ulysses through a batched upload (in most Trusts) is collated and submitted regularly and published nationally every six months through the National Reporting and Learning System (NRLS). The number of patient safety incidents of all degrees of harm is one of the indicators used by the CQC in its intelligent monitoring process of all NHS Trusts. Potential under-reporting of patient safety incidents of all degrees of harm combined is one of the indicators used by the CQC to prioritise Trusts requiring inspection.

⁶ 2010 national framework - National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (NPSA/NRLS 2010)

⁷ 2013 national framework - Serious Incident Framework March 2013

⁸ 2015 national framework - The Serious Incident Framework: Supporting Learning to prevent recurrence (NHS England, 2015)

- The Care Quality Commission (CQC) will be informed if the death meets a specific set of criteria - a death whilst in detention under the Mental Health Act 1983 (MHA)⁹ under Regulation 17 or under Regulation¹⁰ 16 which is the requirement to report deaths of service users. This is undertaken via the NRLS. The precise extract is below:

(2) Subject to paragraph (4), where the service provider is a health service body, the registered person must notify the Commission of the death of a service user where the death—

(a) occurred—

(i) whilst services were being provided in the carrying on of a regulated activity, or

(ii) as a consequence of the carrying on of a regulated activity; and

(b) cannot, in the reasonable opinion of the registered person, be attributed to the course which that service user's illness or medical condition would naturally have taken if that service user was receiving appropriate care or treatment.

(3) Notification of the death of a service user must include a description of the circumstances of the death.

(4) Paragraph (2) does not apply if, and to the extent that, the registered person has reported the death to the National Patient Safety Agency(2).

(5) This regulation does not apply where regulation 17 applies.

⁹ Appendix 11

¹⁰ Appendix 11

Main Findings

The attrition in the review and investigation of deaths: where deaths were reported for Southern Health service users between April 2011 and March 2015

There were 10,296 deaths of Mental Health and Learning Disability health service users during the period of this review. Most of these were expected. 57% of the Older People Mental Health deaths were very elderly - over 85 years. An additional ten deaths were identified in the 24/7 TQ21 service - the social care arm of the Trust.

1454 cases were reported initially to the Trust's incident management system - Ulysses.

Adult Mental Health - 60% of deaths in Adult Mental Health services were reported to Ulysses: most of these deaths (95%) were reviewed or investigated in some manner.

Older People Mental Health - 9% of deaths in Older People Mental Health services were reported to Ulysses: very few (3%) were investigated as Serious Incidents - a rate of 1 death every 6 weeks.

Learning Disability – of the 337 deaths, 157 (47%) were reported to Ulysses; 68 out of these 157 deaths reported were subject to an IMA but no further action was taken in 95% of the IMA cases. Two instances of unexpected death amongst those with a Learning Disability were investigated as Serious Incidents (less than 1%) - both of these were subject to further external reporting.

195 deaths were reported as Serious Incidents Requiring Investigation. This is a lower rate per 1,000 Mental Health service users than other Mental Health Trusts in the region report to the StEIS system. The investigations are largely driven by the requirement to investigate suicides which constitute 59% of all SIRI investigations into death.

The Trust has steadily reported and investigated fewer deaths each year over the period of the review.

The Trust stated that 307 deaths were reported to CQC via the NRLS for the period across all the Trust's services and across all harm categories - 275 (90%) related to Mental Health and Learning Disability.

111 deaths were originally reported as 'degree of harm death' incidents to NRLS. However, some of these were an administrative error and the Trust has undertaken a development programme on Ulysses and re-categorised some to another lower 'degree of harm' category. We have not seen any evidence supporting this re-categorisation and this level of change strongly suggests the system has not been accurately categorising deaths. As a result after further enquiries, regrading by the Trust meant that only eight Mental Health or Learning Disability deaths remained graded as Category 5 death on the Ulysses system based on the Trusts interpretation of NRLS guidance

One consequence of this reporting practice is to lessen the transparency around deaths of service users.

To establish how deaths were being captured in order to review and investigate we needed to understand the totality of deaths during the period. From this we could then understand the attrition to the numbers actually investigated and then reported externally.

The graphic below shows the total number of deaths through to how many were ultimately investigated as SIRIs. We have grouped the deaths into four categories:

- Adult Mental Health (AMH) - those upto the age of 65
- Older Peoples Mental Health (OPMH) - those over the age of 65
- Learning Disability (LD) - all ages
- Specialist Services (SS) - all ages

Some people over the age of 65 are still cared for by Adult Mental Health services so a breakdown by age means figures are not directly comparable to divisions. About 61 cases (ranging upto 91 years) were people over 65 years in Adult Mental Health services. 78 cases were categorised as Older People Mental Health services but were under 65 years - ranging from 44 years old.

Total deaths of people who had contact with Mental Health and Learning Disabilities within 12 months of their deaths

Between 1st April 2011 and 13th March 2015 there were at least 10,296 deaths identified on RiO and a further 10 in TQ21. These were deaths of any service user who had been in contact with Mental Health or Learning Disability services - in any setting in the previous 12 months.

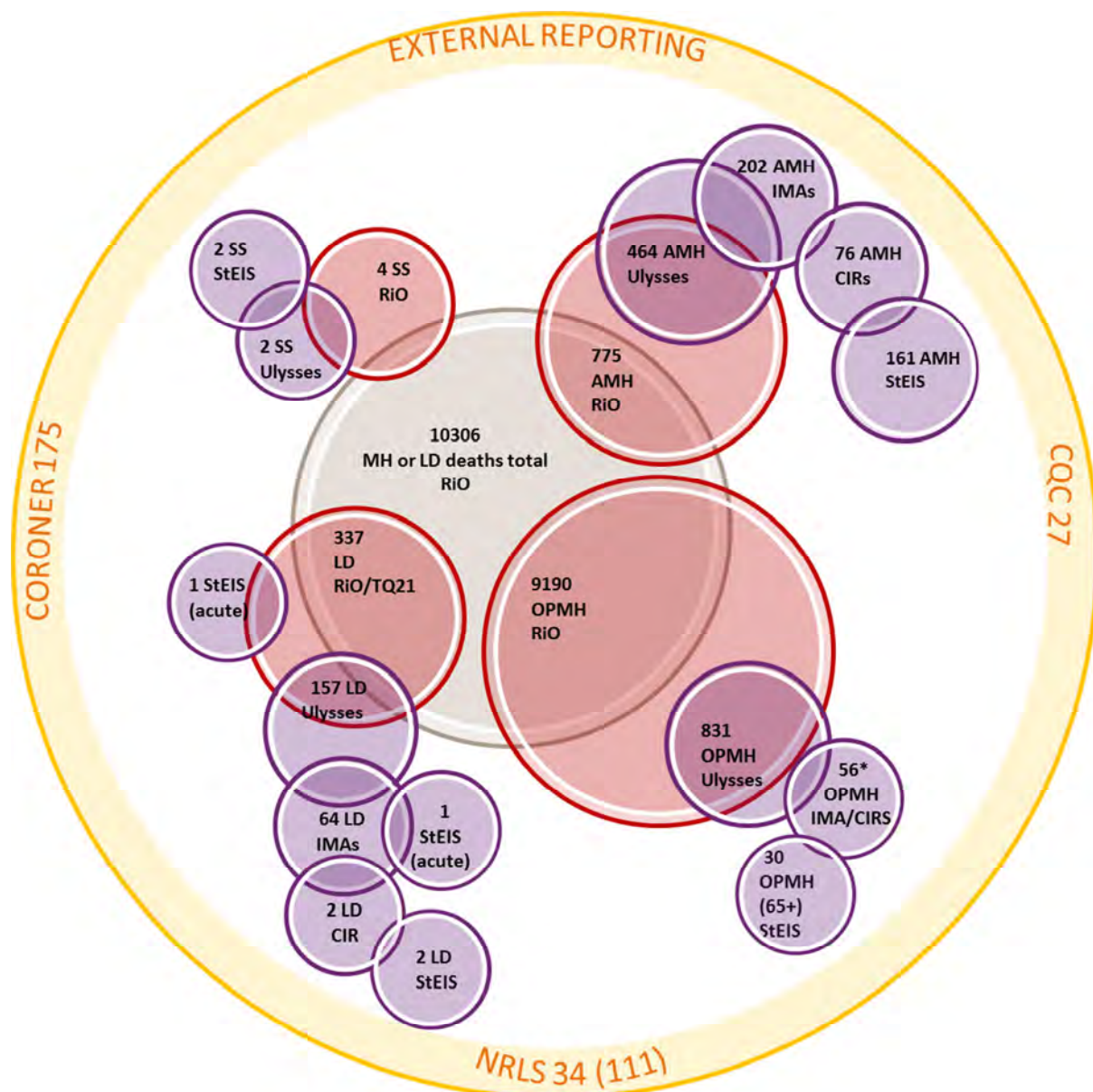


Figure 9: Attrition diagram of all deaths to those investigated as SIRIs to StEIS and external systems.

Abbreviation	Definition
AMH	Adult Mental Health - 18-64 years
OPMH	Older People Mental Health - 65 years plus
LD	Learning Disability - all ages
SS	Specialised Services

The figure reported to CQC in the above diagram relates to the deaths that must be reported under Regulation 17 (discussed in later chapter) for all deaths in detention and does not mean all deaths reported to CQC.

Total deaths can be broken down into three large groups - over 65 (Older people Mental Health - OPMH), 18-65 (Adult Mental Health - AMH) and all ages for Learning Disability (LD). A small number of deaths occurred in Specialist Services. The diagram below shows this breakdown

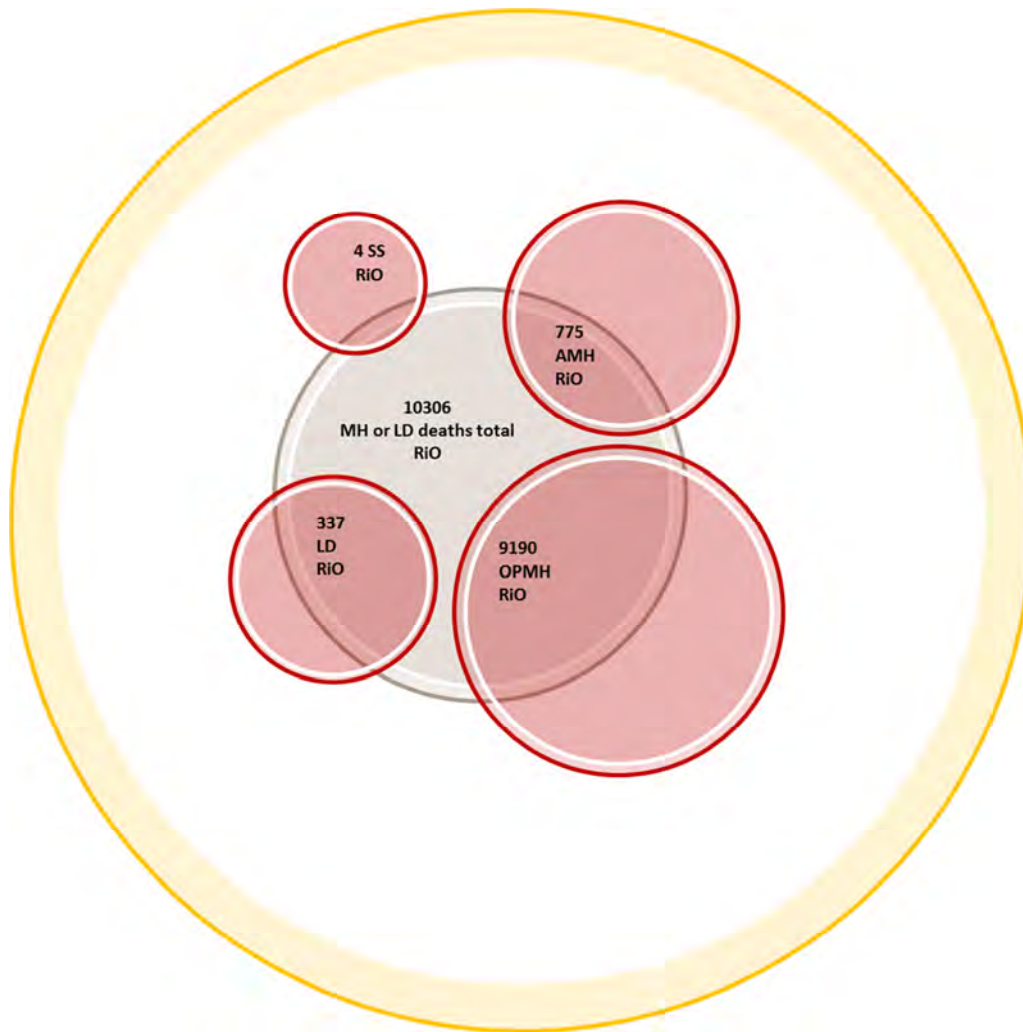


Figure 10: Deaths on RiO broken down by service user group

There were 9190 deaths of people in Older People Mental Health services (aged 44 and over), 775 people died in Adult Mental Health Services aged 18-91, 337 people died with a Learning Disability. Four died in Specialist Services. 89% (9173) of all Mental Health deaths were of people over 65 years.

Group	No of deaths recorded on RiO and TQ21	%
OPMH (over 65)	9190	89%
AMH (under 65)	775	7.5%
LD	337	3.5%
SS	4	-
Total	10,306	100%

Figure 11: percentage of deaths by service division

Reported deaths in Mental Health and Learning Disability divisions

We then examined how many of these deaths were reported as incidents. To do this we secured an extract from the Trust's Incident Management system (Ulysses) for all reported deaths and we were able to map these deaths back to RiO with a high degree of confidence. This means the Ulysses extract is largely a subset of the RiO extract.

The Ulysses extract reported **1454** deaths in the same period. This means that at least 8852 deaths were seen as 'expected deaths' and would not expect to be reported. It was not in the scope of this review to examine all these records or to establish that any of these were not expected and we have therefore concentrated on the analysis of all deaths that were reported onto the Ulysses system. Some unexpected deaths were not reported to Ulysses - there were also some deaths that were still investigated even though not reported onto Ulysses.

These reported deaths can be broken down into the same groups.

Group	No of deaths recorded on RiO and in TQ21	No reported on Ulysses	% reported on Ulysses
OPMH	9190	831	9%
AMH	775	464	60%
LD	327	157	47%
LD (TQ21)	10		
SS	4	2	50%
Total	10,306	1454	14%

Figure 12: percentage of all deaths reported to Ulysses by service

14% of all deaths were reported to Ulysses.

However, there is a marked difference between types of service user groups.

- At least 60% of Adult Mental Health deaths were reported to Ulysses.
- 47% of deaths with a Learning Disability were reported.
- Up to 9% of deaths of Older People with a mental health need were reported to Ulysses.

SIRIs

There were 195 Serious Incidents Requiring Investigation relating to death identified in total compared with the 1454 reported deaths to Ulysses.

There were 116 suicides with 79 non-suicide deaths investigated as SIRIs. Most (161) of the SIRIs were for Adults in Mental Health services under the age of 65 and of these 100 were suicides. The Trust mostly complies with the requirement to investigate suicides. This indicates that non-suicide deaths were less likely to be investigated. We are of the view that this is because the SIRI guidance is open to greater interpretation for non-suicide cases. 61 non-suicide Adult Mental Health SIRIs was a rate of just over one per month.

We were asked by NHS England to look at the reasons behind this to understand if all deaths were being reported as SIRIs correctly. We requested all IMAs for Adult Mental Health and Learning Disability services to understand the reasons behind the attrition noted above.

Investigated/reviewed deaths in the Mental Health and Learning Disability divisions

IMAs, CIRs and SIRIs in Adult Mental Health



Figure 13: Adult Mental Health deaths - the attrition in the investigation and reporting of all deaths.

Of the 464 deaths reported to Ulysses (60%) for Adult Mental Health, 237 were investigated as CIRs (161 as SIRIs). There were 202 subject to IMAs that did not proceed to further investigation. Therefore, only 5% of reported deaths in Adult Mental Health services were not subject to an IMA or investigation.

In Learning Disability services of 157 deaths reported to Ulysses (47%) only four deaths - less than 1% of all deaths - were investigated by the Trust as a CIR or SIRI.

There were 65 IMAs and one CIR provided to the review team. A further CIR (that was an IMA) was provided during the factual accuracy process. This means including the two SIRIs there were 68 deaths (43%) subject to an IMA and 4 subject to an investigation as a CIR/SIRI.

A high-level review of StEIS revealed that two deaths of service users with a Learning Disability were investigated as SIRIs by other acute Trusts as the deaths occurred within an Acute Trust setting. A more detailed review is needed to establish if other deaths were investigated as further work on this was outside the scope of this review.

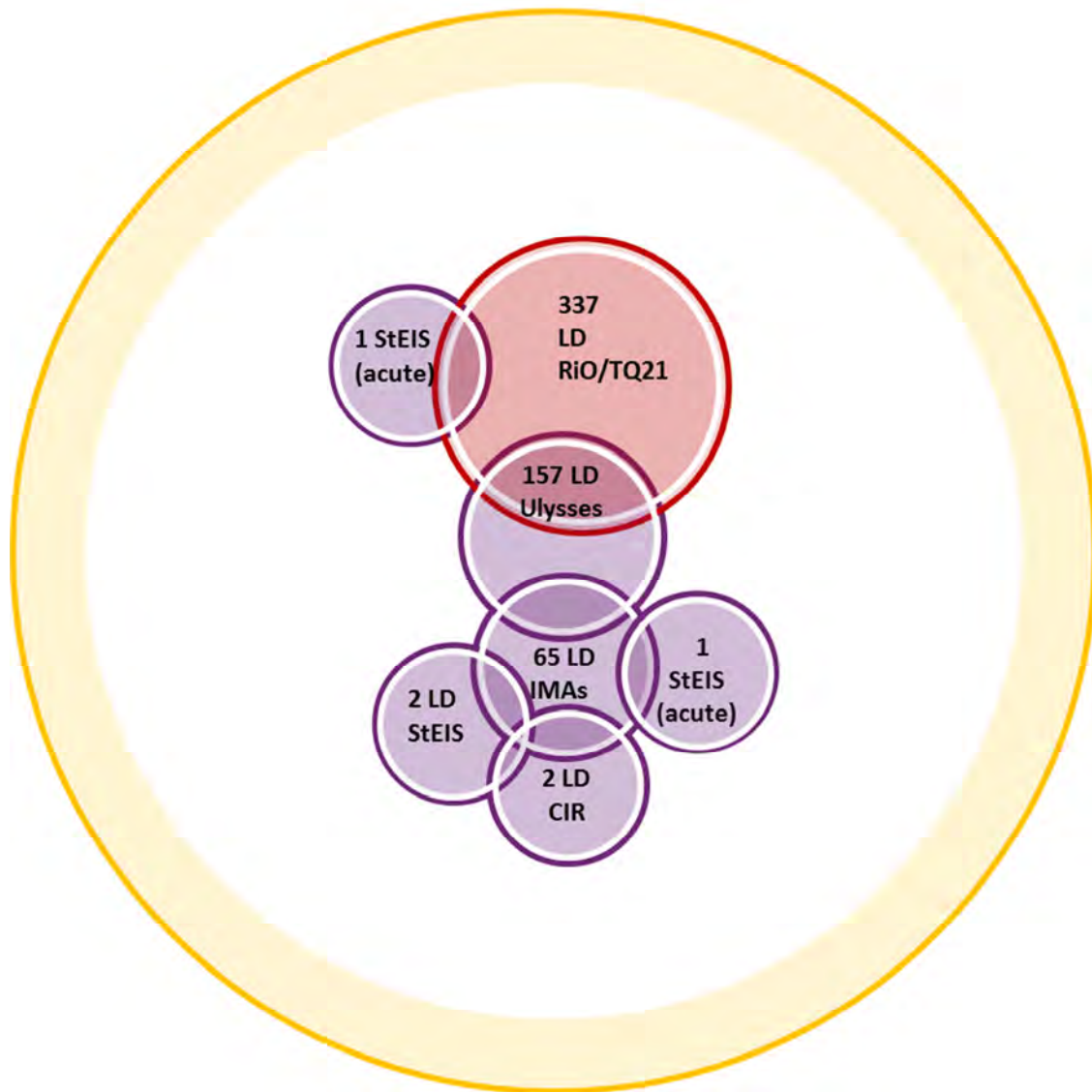


Figure 14: Learning Disability deaths - the attrition in the investigation and reporting of all deaths.

For Older People the attrition is also marked. The diagram below shows all deaths of service users in the Older People Mental Health services. This is slightly different to looking at this for service users only over 65 years of the Older People Mental Health service but has made the analysis more reliable. There were 78 cases included in this division that were under 65 years ranging from 44 years old.

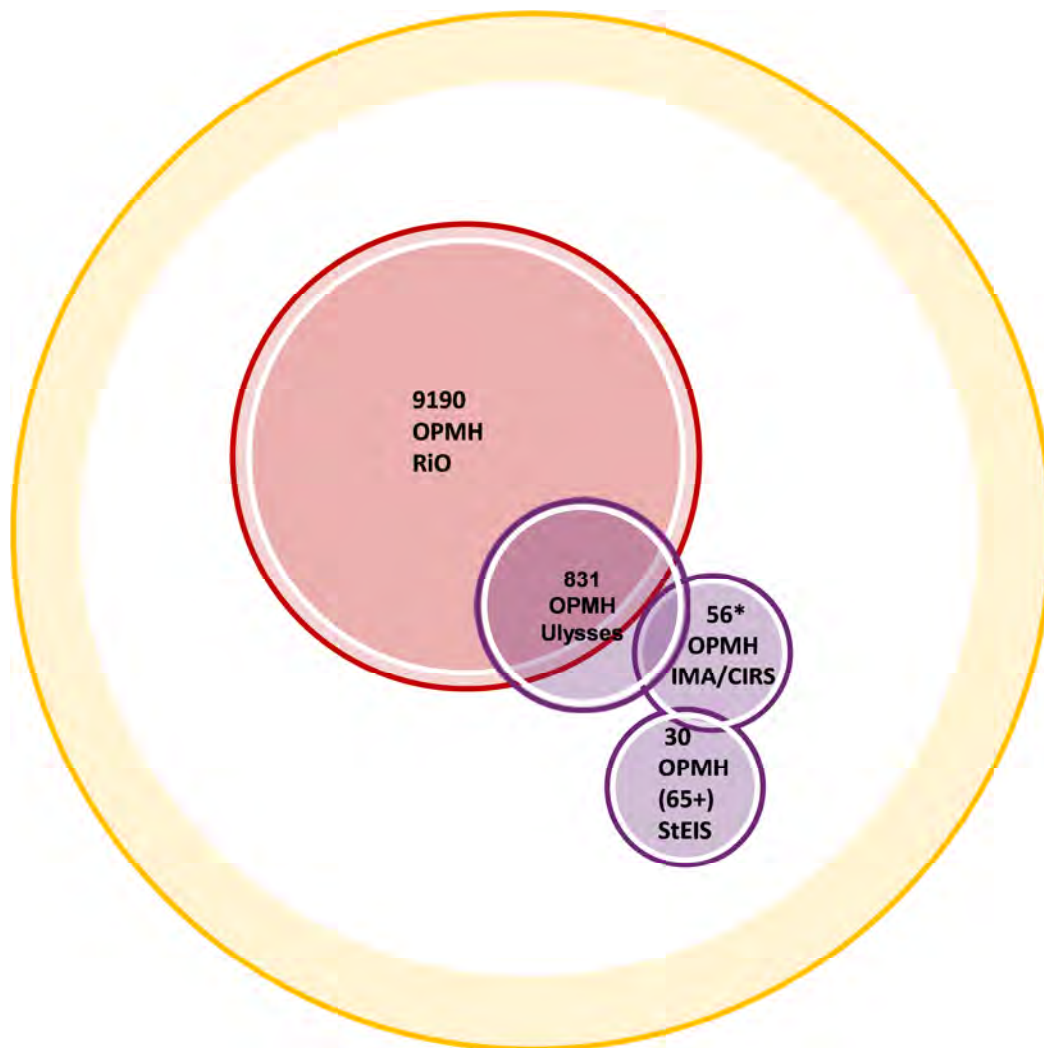


Figure 15: Older People Mental Health deaths - the attrition in the investigation and reporting of all deaths.

* It was not in the scope of the review to request all IMAs for OPMH services. The Trust state there were 56 IMAs. We have also established that there were at least 3 CIRs but we cannot verify this information. It would appear that the number of CIRs however are small.

The majority of deaths of service users occurred in this age group (89%). 831 (9%) of these were reported to Ulysses - 30 were investigated as SIRIs. The scope of the review did not extend to reviewing every IMA for people in Older People Mental Health services. However, we did search the Ulysses information to identify if the incident recorded an IMA being completed. Only 26 IMAs could be identified this way.

Our analysis of inpatient deaths (see later chapter) of Older People indicates that nine were investigated as a SIRI and a further three IMAs and three CIRs were completed but not recorded as such on Ulysses. The Trust has subsequently stated that 56 Older People Mental Health Inpatient and community cases were subject to an IMA only. The 56 is a minimum number as this was not in our scope and the Trust has not been asked to provide a final figure although it is reviewing this internally. This suggests that only a small fraction of Older People Mental Health deaths are reviewed reducing the likelihood of investigation and learning.

Summary of attrition

The table below shows the attrition of 1454 reported deaths to Ulysses to total deaths being investigated as a CIR or SIRI.

Group	Ulysses	IMAs only*	CIRs**	SIRIs	% reported deaths that are investigated as a CIR or SIRI
OPMH	831	56	3**	30	4.5%
AMH	464	202	76	161	51%
LD	157	65	2	2	2.5%
SS	2	-	-	2	100%
Total	1454	323	80	195	19%

Figure 16: Percentage of deaths reported to Ulysses that were investigated as a CIR or SIRI

* Figures as provided by the Trust

** The Trust state a further four inpatient OPMH deaths were investigated.

Reporting of deaths over the period

Total death reporting onto different systems over the four year period for Older People Mental Health, Adult Mental Health and Learning Disability deaths can be see in the following graphs:

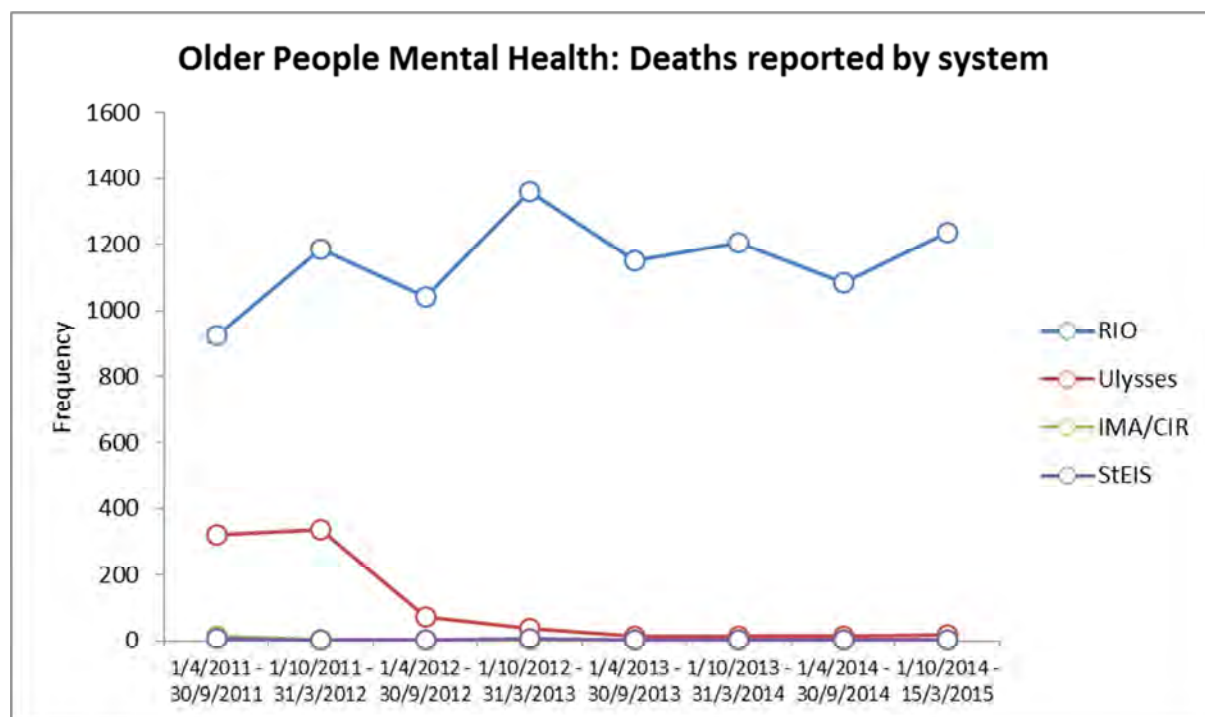


Figure 17: Older people deaths - attrition over four years

The number of deaths of people over 65 was the greatest proportion of all deaths. Despite a steady rate of deaths amongst this group a very small proportion of deaths were reported to Ulysses and this number was reducing over the period. At the end of 2011/12, the Trust states that it changed its policy so that palliative care/expected deaths were now not being reported.

The 2011 policy includes expected deaths in AMH, Specialist services, Learning Disability and OPMH inpatients. OPMH community expected deaths were not expected to be reported. The 2012 policy provided was effective August 2012 some six months after the sudden drop in reporting. It is apparent that there was a change in practice over this period but the documentation of this change is not clear.

By 2014/15, there were three SIRIs for people over the age of 65 out of 2314 deaths.

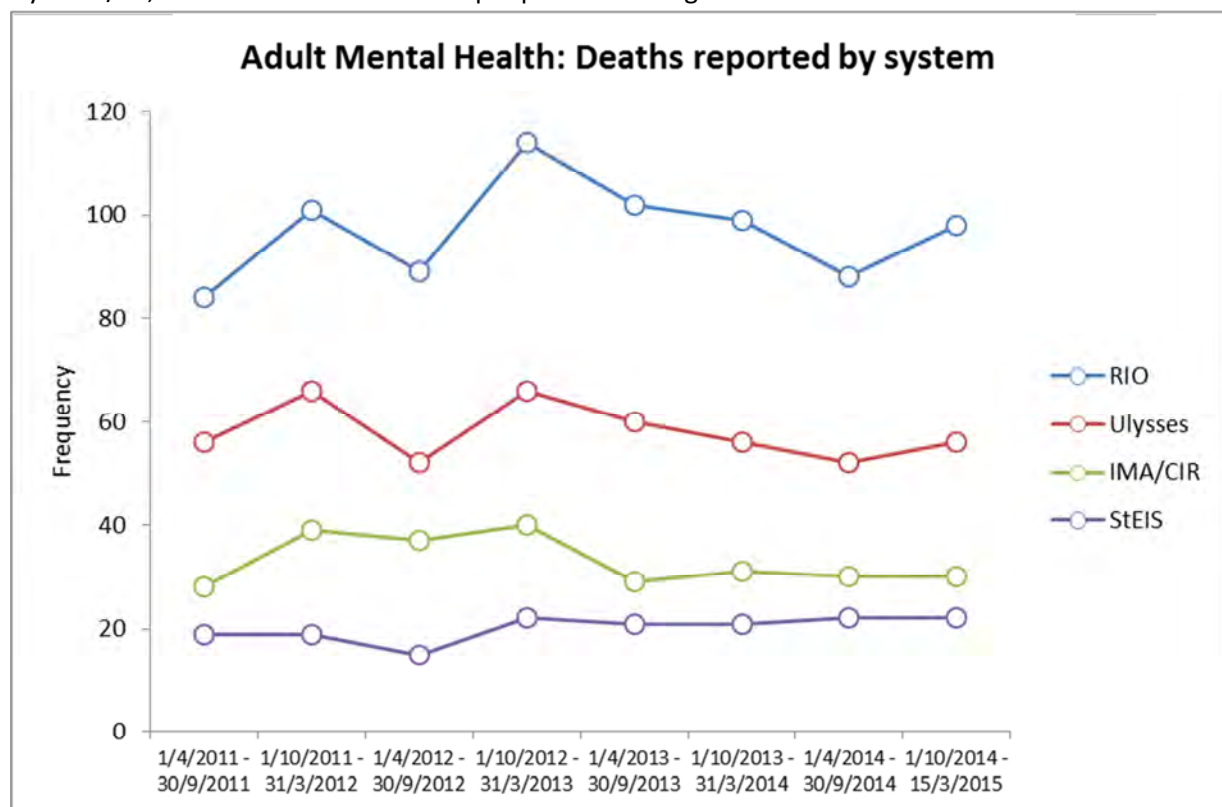


Figure 18: Adult Mental Health deaths - attrition over four years

In Adult Mental Health services a greater proportion of deaths were reported onto Ulysses. As a result, more of these deaths have an initial IMA and more are investigated. There has also been a steady number being reported to Ulysses over the period. The number being investigated has remained largely constant over the period driven largely by a constant level of suicides.

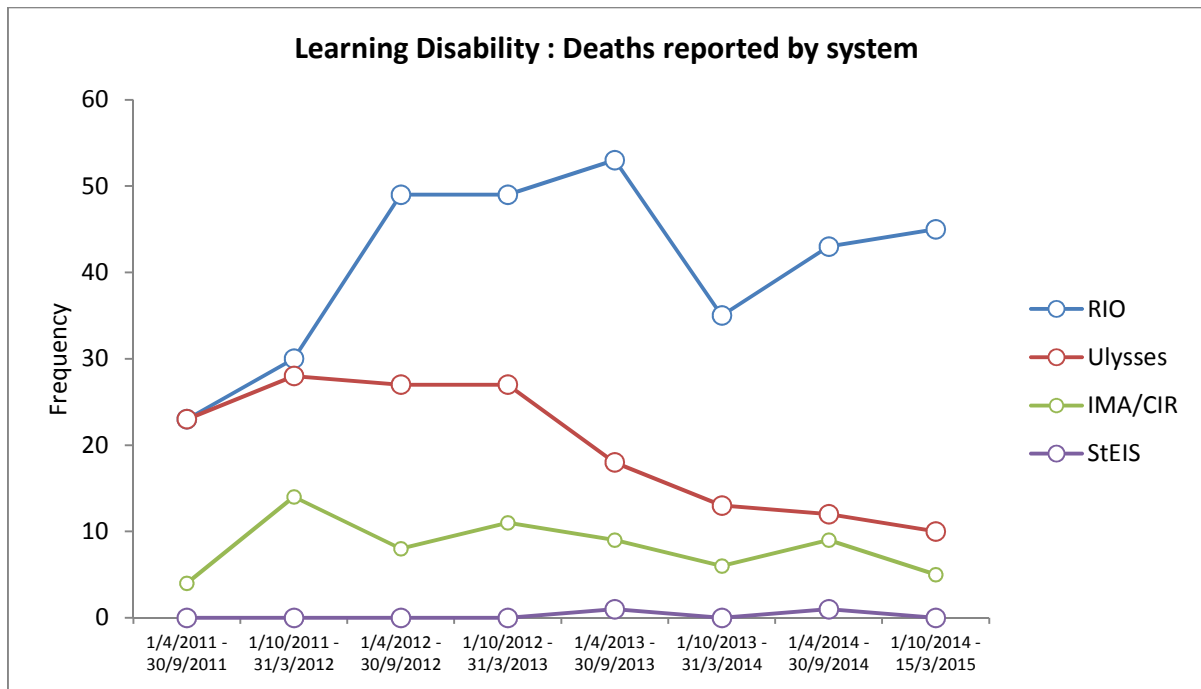


Figure 19: Learning Disability deaths - attrition over four years

In Learning Disability, there is a reducing number of deaths reported to Ulysses as a proportion of total deaths. Total deaths have also risen over the period. In 2014/15 there were 88 deaths of people with a Learning Disability to 16th March 2015 identified on RiO; 15 of these were subject to an IMA (17%) and one was investigated. There were a further three in TQ21 services in 2014/15 which were identified to us late in the review.

Reporting deaths by geography

We analysed deaths on RiO by geographical area for Mental Health and Learning Disability service users. Figure 18 below shows which areas the deaths occurred in. The majority are of Older People. The areas differ in geographical size and state only the absolute numbers of deaths in each of the Trust's areas.

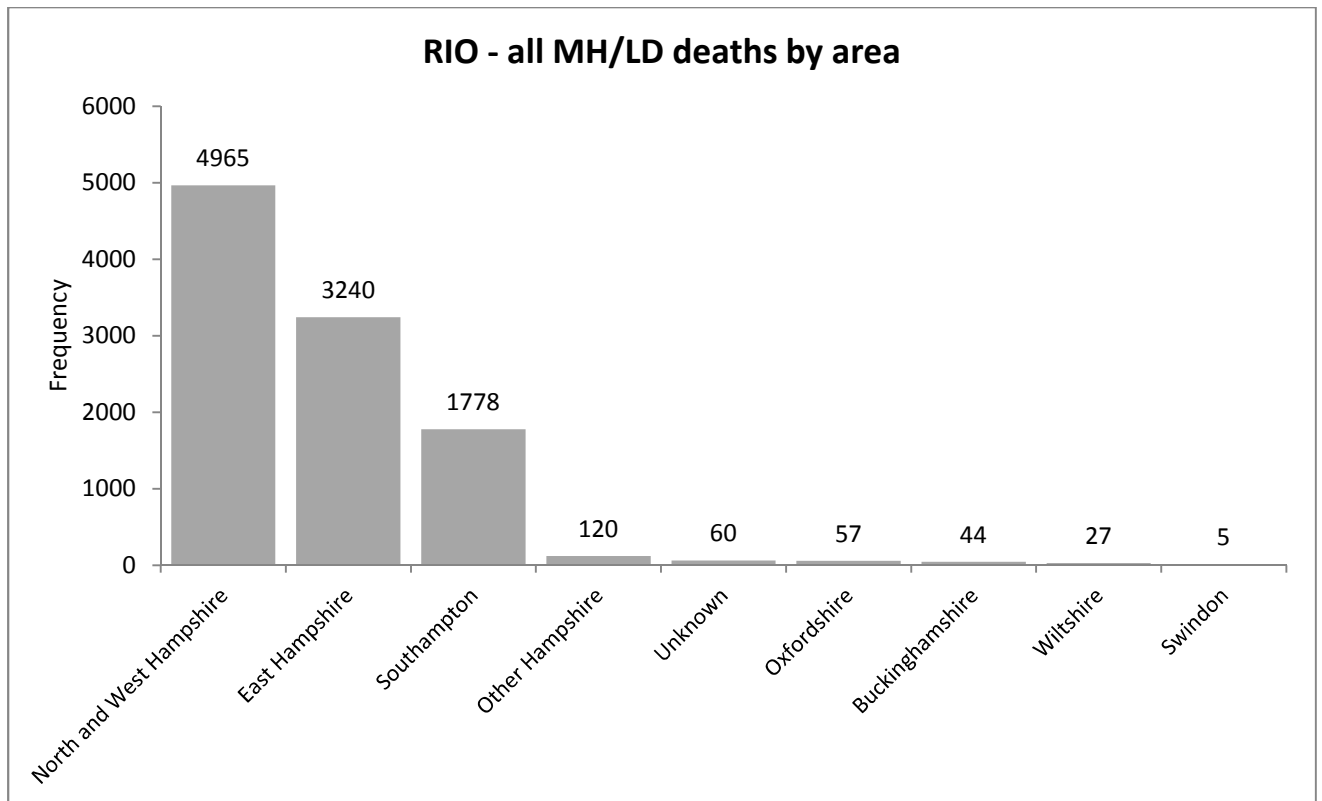


Figure 20: All deaths by geographical area

When we looked at Learning Disability deaths these are more evenly spread across the counties that the Trust serves¹¹ as Learning Disability services are provided across a wider geography than Mental Health services are. However, it would appear that in some areas there is markedly different practice in reporting Learning Disability deaths. Whilst in Hampshire a high proportion of Learning Disability deaths are being reported to Ulysses, in Oxfordshire and Buckinghamshire only 6-8% of deaths were reported. N.B. Ridgeway services were acquired in November 2012 and so reports in Oxfordshire and Buckinghamshire only relate to the period after this date to the end of our review period.

¹¹ The analysis on geography is based on best available information for the split between Hampshire and Southampton service users.

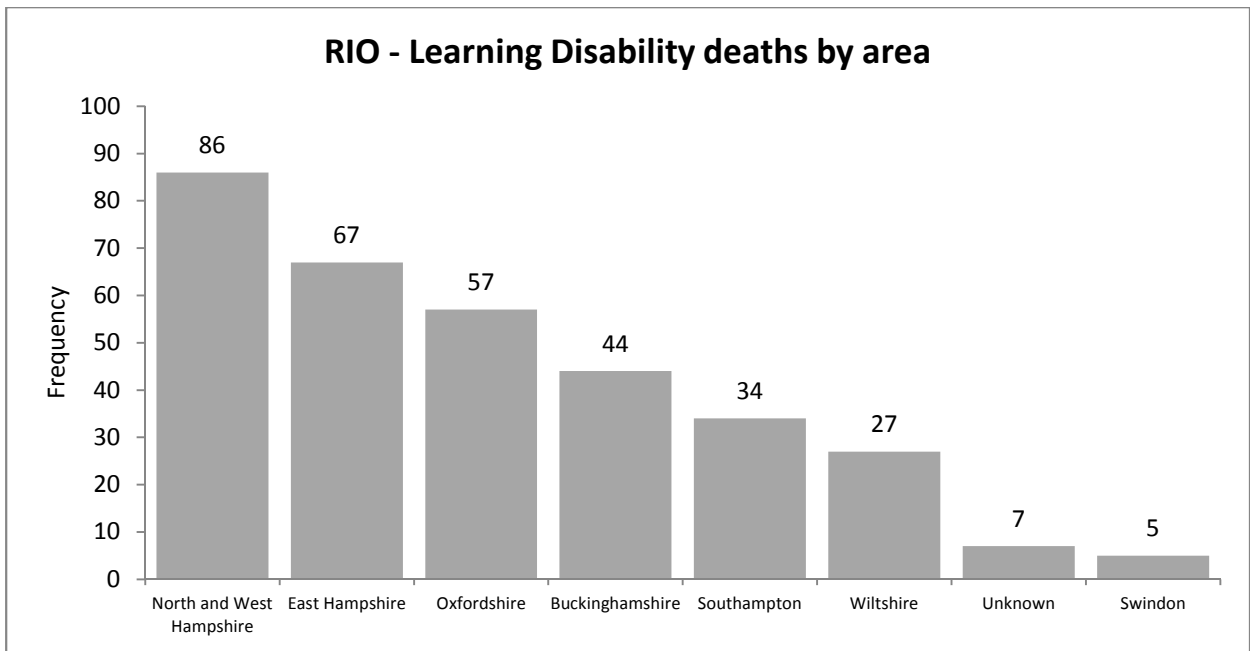


Figure 21: Spread of Learning Disability deaths across the counties the Trust serves

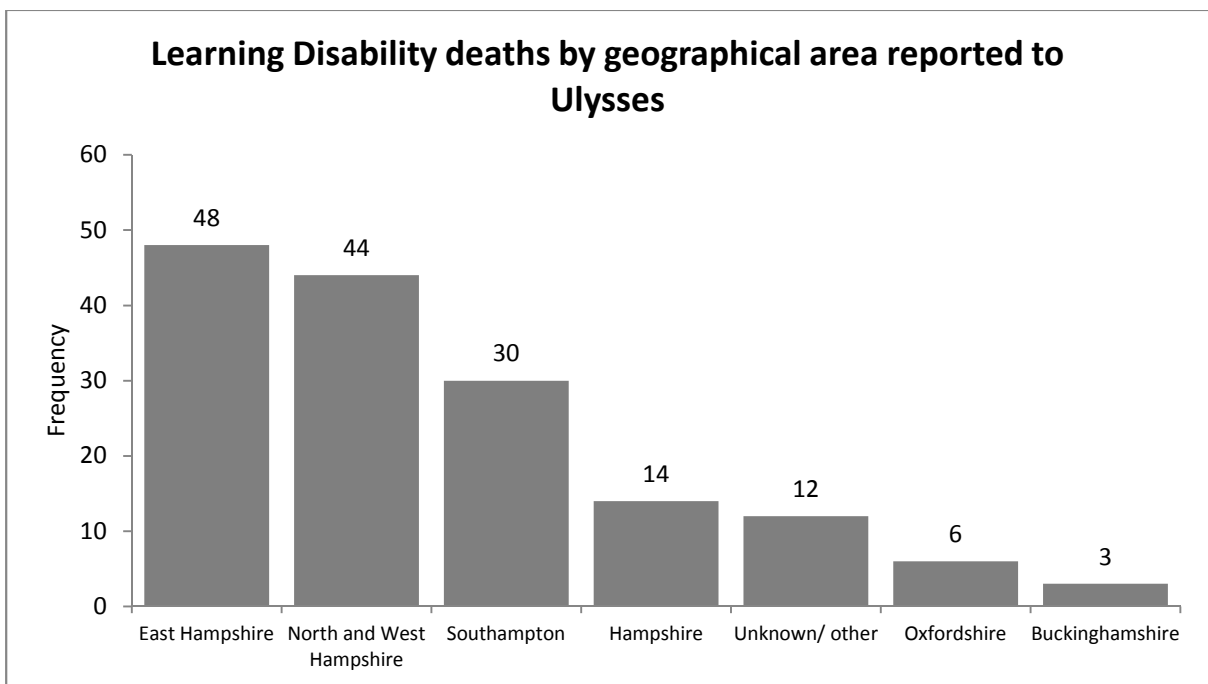


Figure 22: Learning Disability deaths reported to Ulysses as incidents

The National Reporting and Learning System (NRLS)

We looked to understand whether the number of deaths on the National Reporting and Learning System (NRLS) was in line (but not expected to be the same) with the number of SIRIs. The NRLS system is used to report patient safety incidents and compare Trusts of a similar type. Access to the full incident reporting information uploaded to the NRLS is available to CQC and forms part of the CQC intelligent monitoring system to determine risk. It serves a dual purpose of reporting deaths to

CQC under Regulation 16 (Registration) requirements (see Appendix 11) as well as being a patient safety reporting system.

This gives rise to different reporting practices, as Trusts are required to report deaths within CQC registration requirements as well as report patient safety incidents to the NRLS and the two are not necessarily the same. This situation exists to reduce the need to create a separate reporting system.

Summaries of the information submitted for NRLS purposes are publically available and published by the NRLS team. The Trust (along with 99% of other Trusts) uploads all patient safety incidents once they have been closed off by managers within the Trust directly from Ulysses. Ulysses categories are mapped directly to the NRLS categories. There are some difficulties with the system - namely interpretation of what to report, delays in reporting the information and the reports produced for benchmarking are fixed at a point in time and are not publically updated. Incidents are reported according to impact categories based on degrees of harm with the Trust's Category 5 of a 'catastrophic impact/death' incident mapping to the NRLS 'degree of harm' death category. Only deaths considered by a Trust where a patient safety incident was attributable to the death are graded as Category 5. Deaths can be graded as other categories of harm depending on the extent of the relationship between the Trust's actions and the actual harm. Reporting practice varies across Mental Health Trusts nationally.

The Trust has undertaken a 'development programme' for the local risk management system (Ulysses) which feeds both NRLS and Regulation 16 requirements. It is important that this information is reported accurately from notification of incident through to close off and final grading if it is to accurately feed NRLS and CQC requirements. This should ultimately provide transparent and accurate data to the public as well as inform risk assessments made by the CQC.

111 deaths over the four year period have been publically reported as 'degree of harm death' and therefore were originally graded in Ulysses as Category 5. Any other deaths reported as lower degrees of harm are not visible as deaths on the NRLS system publically. However, the Trust reports that there were administrative errors for one of the reporting periods and those incidents have needed re-categorising to a lower category. This would have artificially raised the overall total reported as 'degree of harm death'. The NRLS figures were updated but these are not published. Some of these deaths are for non-Mental Health and Learning Disability deaths.

We undertook further enquiry to establish exactly how many deaths were, in the Trust's view, categorised as Category 5 (and therefore 'degree of harm deaths' on NRLS). The extent of this was that 100 of the 111 were recategorised - some due to the administrative error which suggests they should not have been uploaded in the first place. That is, that there were 11: - of which three were non-Mental Health service users, seven were Mental Health service users and one was a person with Learning Disability - cases which the Trust believed were on NRLS under the 'degree of harm death' category. The Trust therefore states that it expects the NRLS system to reflect eight Mental Health and Learning Disability deaths in this category - much lower than reported publically and in absolute terms a very small number. No paper has been presented to the Board regarding the changes or extent of recategorising Category 5 deaths.

We cannot reconcile these figures with either the data provided by the Trust or the data provided by NRLS by matching the Ulysses references. We explain this below.

As stated by the Trust the total number of Mental Health and Learning Disability deaths reported to CQC via the NRLS for the period April 2011 to March 2015 (as at 2nd November 2015) are below:

Actual impact as per Ulysses*	All deaths	MH/LD deaths
1 No Harm / Damage / Loss	149	132
2 Low / Minimal Harm, On-Site First Aid	51	47
3 Moderate, Medical Treatment/Short Term Harm	52	47
4 Major, Permanent/long Term Harm	44	41
5 Catastrophic / Death	11	8
	307	275

*the full definitions are provided in Appendix 14

Figure 23: Deaths the Trust states were reported to CQC via NRLS for the period April 2011 - March 2015 (updated and refreshed as at 2.11.15 and provided by the Trust)

As can be seen the Category 5 deaths are reflected in the above table.

Following a request from the review team, the NRLS system produced the following number of reported 'degree of harm death' cases. The 48 deaths here are for all deaths and should directly relate to the 11 deaths in the table above.

Of the eight cases the Trust states are Category 5 on their system we cannot match three of these cases to the NRLS information below. These are deaths in June, July and October 2014.

On the NRLS system as at 27th October 2015 the following information was provided:

Financial Year	Number reported as 'Death'
2011/12	25
2012/13	12
2013/14	4
2014/15	7
Total	48

Figure 24: NRLS reported deaths under 'degree of harm death'

The above table shows there are currently 48 cases on the NRLS system relevant to the period. The NRLS provided the incident reference details for the death cases above. We matched these to our data on IMAs and SIRIs and to the Ulysses dataset provided to us in April 2015. We matched 34 to Ulysses and assume therefore that the balance are non-Mental Health or Learning Disability deaths.

Given the significance of the difference between the figures held locally and nationally and the importance of having accurate data, this clearly indicates either failings in the Trust's systems reporting to NRLS or in the NRLS system itself and further investigation should be carried out.

We have little confidence that the reported figures either by the Trust or those currently on the NRLS system accurately reflect deaths of the most serious nature i.e. those that might be expected to be in this category. Our direct mapping of the Ulysses reference numbers to reference numbers from NRLS has enabled us to establish exactly which Mental Health and Learning Disability deaths have been reported to NRLS. Ten of these were subject to a SIRI. Twelve of these cases were logged as unexpected death - 'natural causes' and eleven did not progress past IMA. This indicates that these are not the most 'serious patient safety related incidents'. Of the eight that the Trust considers as being in the highest patient safety categories only five can be matched to NRLS. This leads us to conclude that the deaths that the public might expect to be logged with the NRLS for further learning from deaths are not those that are actually logged for learning. We have not included specific examples of other cases we reviewed that we would have expected to be in this dataset, arising from our review of all 540 cases, from this report for confidentiality purposes.

These issues may be due to technical errors but appears to have been a problem since at least October 2011. This may also mean that deaths reported to CQC through the NRLS system are also not accurately categorised

We initially used public information to benchmark the Trust with other Trusts. We were told by the NRLS team on further enquiry that the public data could not be relied upon for comparative purposes due to different reporting practices and therefore no comparison against other Trusts can be made.

Given one of the stated aims of NRLS is to provide comparative information to help Mental Health Trusts we have recommended that the current variation in practice is addressed to provide more transparent information on deaths in Mental Health and Learning Disability to commissioners, regulators and provider Trusts.

Conclusions:

The attrition of death investigation is marked and varies considerably between service user groups.

We have not examined all 10,306 deaths and we therefore cannot determine whether all deaths that were unexpected were reported to Ulysses in the first place. We have therefore concentrated on the 1454 deaths that were reported.

The Trust does not have a standardised approach that is working in practice for deaths reported to Ulysses. Our analysis highlights that for example, Learning Disability reporting in Oxfordshire and Buckinghamshire shows a significant apparent difference in practice and this needs further investigation.

We can see that in Learning Disability only two deaths were visible through the StEIS system. The deaths of people with a Learning Disability are not made visible in the recorded data presented to

the Trust Board as SIRIs appear to be the only deaths reported in the period. This is a similar issue for regulators and commissioners whether expected or not.

Older Peoples' deaths are unlikely to be investigated (0.3%). Given that 89% of all deaths are of service users over 65 and 57% of those are over 85 years this would merit further investigation. Additional reporting is required to the Board for this group.

Adult deaths between the ages of 18 and 65 are most likely to have a further investigation - this is largely driven by the requirement for suicide investigations that are reported to and monitored by external agencies.

Over the four year period of this review there was a constant rate of deaths of service users overall. However, the reporting of unexpected deaths and the investigation into them has reduced in all categories. Older people's deaths (0.3%) and deaths of people with a Learning Disability (1%) in particular are very unlikely to be investigated. The reviews we have undertaken of the investigations that have taken place of Older People and Learning Disability service users indicates significant care issues and the Trust must ensure fuller investigations are undertaken in more cases to draw out learning and minimise risks to very vulnerable service users.

The need to re-categorise 90% of the reported Category 5 cases highlights that the systems in place were not fit for purpose. In order for the NRLS system to be comparable and provide accurate information it needs to investigate how to change practice and ensure accurate reporting and mapping for Mental Health Trusts.

We are particularly concerned that the information provided by the Trust and the cases highlighted by the NRLS under 'degree of harm death' cannot be matched and can only conclude that the NRLS figures do not reflect the deaths that might be expected to be in this category within the Trust (i.e. unintended or unexpected incidents that directly resulted in the death of one or more persons receiving NHS funded care). According to the NRLS team the Trust has not reviewed its mapping (a process which translates local Ulysses categories into NRLS categories on upload) with the mapping team since 2010 and has not requested advice. I was also not considered to be a Trust with obvious data quality issues. This requires urgent attention due to the implications of not ensuring the right categorisation and reporting of deaths is occurring - both to meet CQC Registration requirements and to ensure the voluntary scheme of the NRLS is accurate.

Board oversight

There has not been effective focus or leadership from the Board relating to the investigation and analysis of data relating to the deaths of its service users.

Insufficient time and attention has been spent on understanding deaths, using the information available to the Trust. Poor analysis and limited reporting has been a consequence while an opportunity of learning from deaths as distinct from other incidents has been missed.

Management information, investigation and quality assurance have been given insufficient attention and there was no evidence of the Board or its directors enforcing improvement, despite warning signs throughout the last four years.

Board reporting on deaths and mortality is minimal. The Board has not been provided with sufficient reliable information to enable it to secure an accurate picture of the performance of SIRI reporting relating to deaths.

There has been inconsistent use of indicators at Board level with regular changes of measures of deaths over the period resulting in a lack of long term trend analysis and limited challenge.

Suicide numbers are reported on a rolling basis but unexpected deaths are only reported when they are considered to be SIRI reportable.

Non-Executive Directors have requested more information and assurance relating to investigations over the period and have been assured as to the quality of investigations. Despite this, investigations are not always undertaken when they should be and many are not robust. The quality of investigations did not improve to any significant extent over the period despite reassurance to the Board.

The Board has not improved the timeliness of SIRI reporting.

Information in annual reports and the quality account was misleading in the presentation of unexpected deaths amongst service users by only reporting unexpected deaths when they are SIRIs.

The role of the Board, its objectives and the assurance framework

The Trust Board is responsible for overseeing the performance and effectiveness of its services. It has many statutory responsibilities e.g. to provide high quality care, improve care and protect its service users. The Board discharges its duties by securing assurance from inspections and external scrutiny as well as from information provided by Executive Directors and service managers through a system of controls and reports. These controls are outlined in the Board Assurance Framework, which is driven by the Trust's Objectives.

The first three Trust objectives relate to patient safety, patient outcomes and patient experience:

Strategic Objectives 1 - To deliver safe services - deliver a programme of patient safety initiatives that ensure the safety of our services is improved and the Trust does not fall below regulatory and internal standards

Strategic Objectives 2 - To improve clinical outcomes for patients, service users and their families - drive further improvements in the standards of clinical practice, customer services and outcomes across the organisation, so that all patients receive excellent care every time

Strategic Objective 3 - To improve the experience patients, service users and their families have of our services - improve how we listen and engage with patients and service users, fully involving them in service design, and systematically learning from and acting on the feedback we receive

The Trust's Strategic Plan 2014-19 sets out three enabling strategies:

1. To employ and develop talented, motivated staff

2. To develop our organisation and governance to ensure we are as effective and transparent as we can be

3. Building our infrastructure to enable us to deliver our visions

The Trust also recognises in the Strategic Plan the increased mortality and morbidity amongst people with a mental illness and the increasing complexity of caring for people with a Learning Disability meaning that integrated health and social care services are crucial within and outside the Trust.

The 2011/12 Annual report makes clear a priority for Mental Health services under Objective 1 is to prioritise avoidable deaths and this would be measured by unexpected deaths. It committed to reviewing the number of unexpected deaths in Mental Health and Learning Disability service users to better understand and respond to health needs. The report also notes the increase, in mental health units, of people with physical health needs and that this would be monitored through corporate panels.

The number of unexpected deaths (all causes) of people with serious mental illness under 75 years was being monitored and reported on until the end of 2011/12.

However, since this time unexpected deaths have not had the same focus and appear to have less prominence in objectives. Governors requested more detail on unexpected deaths in the 2011/12 Annual report.

The Board Assurance framework (BAF) is revised annually and updated to reflect current strategic risks - it is intended to be a comprehensive framework to assure the Board whether it is meeting the stated strategic objectives and to manage risk. The Trust's BAF relies heavily for its controls to manage risks on the SIRI process and learning from incidents.

The Board Assurance Framework is designed to provide the Board with assurance that all objectives are being implemented and to put in place a set of controls that help provide the assurance needed. The risks of not meeting strategic objectives are identified each year and controls put in place to mitigate them.

Neither the Strategic Objectives nor the Board Assurance Framework make reference to reducing unexpected deaths of service users. Whilst this can reasonably be considered part of the three strategic objectives outlined above (and was part of strategic objectives for Mental Health in 2011/12) the underpinning framework of controls does not include monitoring deaths of service users. The controls in place relating to SIRIs and learning from incidents are generic. The strategic or operational risks identified do not include unexpected and preventable deaths as a risk to the Trust, its services or service users. The 13/14 Annual report explains that the BAF was revised significantly but did not identify unexpected deaths of service users as a risk or area for specific focus.

Risks identified by the Trust - relevant to this review	Did the Trust address this risk in relation to deaths of its service users?
Risks relating to not providing safe care are identified as:	
1. Relevant safety policies & procedures are not clear and in place	Policies are in place for SIRIs and Incident reporting. The incident reporting policy is not clear in relation to reporting deaths.
2. Failure to follow proper policies and procedures	SIRI policies have not been followed. Incident reporting policies are not followed robustly The Board, subcommittees and directors do not monitor adherence to the incident and SIRI reporting processes adequately.
3. Lack of understanding of where risks are and what constitutes a risk	Risks relating to safety issues arising from and preventing Mental Health and Learning Disability deaths are not identified
4. Lack of identification and learning from incidents	The Trust is not identifying issues arising from incidents relating to death There are repeat issues arising in SIRI reports which do not have robust plans to address them
5. Inadequate or inappropriate funding arrangements to meet service need	A number of IMAs identify concerns about e.g. funding from social care, out of area placements, lack of beds, and lack of AMHPs available. The Trust has provided no evidence that it systematically logs incidents arising from its investigations or assessments of deaths relating to the funding related issues arising.
6. Inadequate processes in place to facilitate safe transfers of care	A small number of SIRIs highlight concerns of care transfers between acute and Mental Health units. This is particularly the case where very challenging behaviour presents a difficulty in caring for people in an acute environment. Whilst the Trust states that transfers of care are monitored it has provided no evidence that the lessons learned from these death SIRIs are being addressed across the health system through a lack of high quality investigation and clear actions arising. The Trust states it does

	monitor incidents relating to transfers of care. However, this is for all incidents not for issues affecting people who die.
Additional risks relating to not improving outcomes are identified as:	
1. Lack of understanding and definition of what comprises improved outcomes	The Board does not set the strategy for improving outcomes in relation to unexpected deaths and mortality and lacks information to do this
2. Inappropriate staff accountability, decisions and judgements	The Trust does not continually review incidents or SIRIs where staff capability or capacity is raised as a factor or where decisions have been made in error through thematic review as evidenced by the continuing recurrence of care co-ordination problems, sickness or staffing problems arising in 46 SIRIs reviewed. There is no accountability for the quality of SIRI investigations and the lack of improvement as SIRIs continue to be of poor quality.
3. Best practice knowledge and processes are not in place	The Trust has not applied best practice in relation to lessons and recommendations from CIPOLD . The Trust Board has not formally reviewed the learning from CIPOLD and many of the issues raised were occurring to service users throughout the period. The Trust has not applied best practice in relation to SIRI investigation The Trust has not applied best practice relating to investigating deaths in detention
4. Best practice is not followed	
Additional risks relating to not improving the service user experience are identified as:	
1. Complaint and stakeholder feedback processes are inadequate	Families are infrequently involved in investigations Responses to family concerns in investigations are not adequate
2. Inadequate or inappropriate management information to support better care	Information relating to lessons learned, monitoring action plans, quality of investigations is lacking. Management information does not focus on the right issues to monitor mortality or the quality of investigations
3. Difference between user expectations and what service is actually available	SIRIs, CIRs and IMAs highlight issues relating to expectations of service users in relation to input. This is usually in relation to referrals and keeping appointments and adhering to policies, These are not monitored.

The Board Assurance Framework relies heavily on learning from incidents and investigations and the serious incident reporting system to provide assurance for the above objectives and risks to

achieving them. The Board has no focus on deaths of service users or the systems for reviewing and learning from deaths through the above objectives and the assurance framework.

Information provided to the Board relating to death

The Board receives some data on deaths. We reviewed:

- all public Board papers from April 2012 to May 2015 for any information shared or discussed relating to deaths, investigations from deaths or learning from deaths. These included reports from Directors and minutes from Board sub-committees.
- all Part 2 papers (redacted) where deaths were discussed for the period September 2014 to February 2015.
- Annual reports and quality accounts 2012/13, 2013/14 and 2014/15

Our key findings are:

- Suicide data was provided consistently on a quarterly and annual basis.
- There was an inconsistent presentation of data relating to the numbers of other deaths at Board level over the four years.
- There was constant change at Board meetings with different measures of death being presented.
- Death information at Board level reduced over this time with reports only relating to all SIRIs.
- The unexpected deaths measure (including statistical process control limits) only includes SIRI deaths and not all unexpected deaths and is therefore largely suicides.
- Where death data is reported on a monthly or quarterly basis it was not possible to always reconcile this to the actual SIRIs incident date due to delayed reporting dates to StEIS.
- There was minimal discussion about the circumstances leading to death and what needed to change
- There was constant reassurance from executive directors to the Board that the SIRI reporting process was robust, investigations were thorough and action plans implemented. This is contrary to our findings (see below)
- As a result both individual cases and total mortality information are not given the attention at Board level that they should be
- Death information is lost in the totality of incident reporting
- The publically reported figures in the Annual report are not transparent and it is not possible to compare from one year to another because of the inconsistent presentation of the figures. The Trust reports unexpected deaths but does not qualify the limitations of these figures as they change each year.

The Board has not taken any effective action during the period of the review to improve the quality of investigations within the Trust despite a number of high profile incidents and warnings. This includes at least 14 deaths reported in the media highlighting concerns about care and involvement of the Trust including the failure to provide a CIR to an inquest in an April 2015 death as late as August 2015.

The poor quality of reports was highlighted to the Trust on a number of occasions – some examples are highlighted below:

- In April 2012, an inpatient suicide occurred. The likely criticism of the poor quality of the CIR by the Coroner was noted at the Trust Board meeting in July 2013. The minutes note that reassurance was given to the Quality and Safety Committee that all SIRIs like this are heard at Corporate Panels but nearly two years later reports remained of a poor standard. Corporate Panels for Mental Health were only in place from early 2015 and started to begin to challenge the quality of reports.
- In October 2012 a service user committed suicide. The July 2013 coroner conclusion was discussed at the September 2013 board meeting. Two CIRs had been written due to the first CIR being inadequate. The second CIR was dated as being finalised on the day of the start of the inquest. The January 2014 board minutes contain the minutes of the October 2013 Quality and Safety committee where the quality of the CIR was raised.
- In December 2013 the Quality and Safety committee’s attention was brought to the internal auditors RSM Tenon findings that a sample of cases showed there was no evidence that action plans from SIRIs were being monitored or implemented
- In October 2014 West Hampshire CCG returned a SIRI that was of poor quality (again 10 months post incident) and it was finally approved in April 2015 some 18 months post incident.
- In January 2015 WHCCG re-opened a May 2014 SIRI when it became clear that a report had said there were no care problems yet the safeguarding report gave a conflicting account. It was signed off in September 2015.
- In April 2015 WHCCG wrote to the divisional director expressing considerable concern at the quality of SIRIS and one in particular that had to be returned. The response from the Trust stated that the divisional panel process was now being instigated more formally and that the SIRI in question had been returned by the Corporate Panel in February 2015, approved virtually two weeks later but it was clearly still not adequate such that the CCG wrote its letter.
- In August 2015 the coroner has again criticised the Trust for failing to produce a CIR in time for an inquest hearing and a further inquest had to be postponed.

The table below summarises the board papers to the extent of reassurance provided by Directors as documented on any part of the process of incident and investigation reporting:

Summary of director assurances:

Date of board meeting	Commentary in Board or Board committee papers	Mazars observations
July 2013	Serious incidents are heard at Corporate Panels	No evidence provided that panels were documented or the process was effective until February 2015. There were Corporate Panels for physical health services and Corporate Panels were only introduced for MH/LD at the end of 2014.
October 2013	All suicides are reported to the Commissioners and the CQC	Our review highlighted that a number of suicides were not

		reported as some not considered to meet criteria
October 2013	SIRI audit - an action plan has been put in place to complete all the recommendations in the audit.	The recommendations were not enacted
December 2013 (September 2013 AAR Committee)	"No evidence of action plans from 5 selected MH/LD cases being implemented" (RSM Tenon auditors report). Discussed processes and learning from incidents reported through Q&S Committee.	Action plans not being implemented
December 2013	The Director of Nursing, AHP and Quality will have an increased focus on ...investigations and RCAs, SIRI reporting and management	This was not effective
January 2014	A thematic review had taken place and an action plan put in place	No thematic review provided to us and no clear action plan from CIR 2
January 2014	The action plan from the CIR had included the expected outcomes	There are some measures in both CIRs but these are not expected outcomes and there has been no evaluation since
January 2014	Unusual not to have family involvement at an early stage	Only 36% of families are involved in investigations
January 2014	The Director signs off all the CIRs	Not all CIRs were directly signed off and where they were then no proper Quality Assurance could have systematically taken place given the observed poor quality of the reports
May 2014	All probable suicides and near misses were subject to detailed investigations and are reported as SIRIs.	This does not always happen and the detailed investigations are not always adequate. At least 10 suicides were not reported as SIRIs and the Trust often waits for a suicide coroner conclusion before commencing a CIR. Probable suicides are not all investigated as SIRIs.
May 2014	Further work to improve engagement with families and their understanding	Family involvement is limited
September 2014	The committee discussed the detail of a specific SIRI in order to gain assurance that the processes and procedures remained effective and robust. Two key observations: <ul style="list-style-type: none"> • The use of family liaison ..was described... • The need for non-executive board members to be properly sighted on serious SIRIs at an early stage 	There has been no reference to any family liaison in relation to any death SIRI report (The Trust has subsequently stated that it did not take this suggestion forward)
November 2014	Thematic reviews highlighted issues of physical health conditions for mental health users	The thematic review provided to us was inadequate and not what we would consider a

		robust review and had no actions arising
February 2015	Every suicide is investigated using best practice with root cause analysis and shared across teams	Our review has indicated that the quality of a third of investigations is inadequate

Reporting of SIRIs relating to death to the Board

Throughout the papers we received, we could not reconcile the number of incidents to the reported figures. For example, we were unable to reconcile the reporting on SIRIs for Q3 2014 to the number of SIRIs relating to death provided to us by date of death and month of reporting. The actual number of deaths and those reported in the month are outlined in the table below. The difference is due to a delay in reporting deaths onto StEIS for weeks or months whilst a cause of death is established and it is only when it is reported to StEIS that it is reported in the SIRI figures. Whilst in some cases a delay may be inevitable, it provides an inaccurate picture of when deaths are occurring.

Month	Number of death SIRIs (Mazars database) numbers in brackets confirmed suicide	Number reported to QSC and Board
October 2014	4 (2)	8 (5)
November 2014	4 (1)	10 (10)
December 2014	3 (1)	4 (2)

Figure 25: Quarter 3 2014/15 report on SIRIs by month compared with actual month of death

The table below provides the detail behind these figures.

Case	Date of death	Date onto StEIS and therefore to Board and committees	Case	Date of death	Date onto StEIS and therefore to Board and committees
1	June 2013	October 2014	12	October 2014	November 2014
2	October 13 (notified March 2014)	October 2014	13	October 2014	November 2014
3	October 2014	October 2014	14	September 2014	November 2014
4	June 2014	November 2014	15	November 2014	November 2014
5	August 2013	October 2014	16	October 2014	November 2014
6	September 2014	October 2014	17	November 2014	November 2014
7	September 2014	October 2014	18	November 2014	Not reported as not a SIRI
8	October 2014	October 2014	19	November 2014	December 2014
9	June 2014	October 2014	20	December 2014	December 2014
10	November 2014	November 2014	21	December 2014	December 2014
11	November 2014	November 2014	22	October 2014	December 2014

Figure 26: Dates that incidents were reported to StEIS compared with actual month of death for Q3 2014/15

National guidance expects Serious Incidents to be reported to StEIS as soon as possible and preferably within 48 hours. Deaths are not being reported to StEIS promptly. The Trust have stated that 30% of deaths were not reported on to StEIS within the policy guidelines.

The reports on SIRIs to the Board do not provide an accurate picture of deaths in any given month. Reports do provide an accurate picture of what is reported to StEIS each month. As can be seen there can be long periods between the date of death and the reporting of a death SIRI.

We reviewed other Board papers and committee papers at sub-Board level where they were relevant to reporting on service user outcomes. These included:

- Medical Director reports to the Board from February 2015 to June 2015
- Additional Quality and Safety Committee agenda items as provided by the Trust from May 2014 to March 2015
- Quality and Improvement Development Forum agenda items from August 2014 to May 2015.

Deaths reported through Medical director reports, Quality and Safety committee direct to the Board

We reviewed Medical director reports for 2015. Information in the Medical Directors reports during February 2015 to June 2015 showed more detail than in other Board papers. The SIRI team prepare this report based on detailed information. These full reports do not form part of the Board papers but inform the Directors report in which specific information is shared. The figures reported were seen to reflect the number of suicide SIRIs relating to deaths in both February and March 2015. Inquest outcomes were reported but not shared with the Board.

Reporting deaths as a percentage of all incidents has the effect of framing consideration of deaths such that this results in a reported figure of 0.01% of all incidents. The figure whilst accurate does not give appropriate weight to the seriousness of death in comparison to all other incidents.

The reports also state there are no unexpected death SIRIs in some months - whilst this is the case when looking purely at SIRIs this is not the case when looking at the number of reports to Ulysses of unexpected deaths of service users and subsequent initial management assessments or CIRs.

Additional Quality and Safety Committee agenda items May 2014 to March 2015

There was limited documented discussion relating to death from May 2014 to February 2015. The committee started tracking a SIRI and a complaint at each meeting during 2014 as a way to assure itself of learning. March 2015 was the first time a death SIRI was used for this exercise - it was a suicide to track through learning in Mental Health. The example highlighted that the SIRI team still had to chase the division for the IMA and this resulted in the incident not being reported to StEIS for one month post date of incident.

The SIRIs tracked are chosen at random. Because there were only two SIRIs for Learning Disability in the four year period there is no realistic chance a Learning Disability death or serious case will be chosen through this process. The two deaths that were randomly chosen were suicides. One was

subject to significant challenge and returned to the Trust by the CCG for further review and subsequently an external investigation.

Annual report and Quality Account - 2011/12, 2012/13, 2013/14, 2014/15

- In the annual reports, the total number of unexpected deaths including suicides reported in all services in each of these years were 55, 40, 54 and 49 respectively. Total 198.
- There were for Mental Health and Learning Disability alone in these years the following numbers of SIRIs for unexpected deaths - 50, 43, 52 and 44. Total 189
- However, the annual reports and quality accounts do not refer to any other unexpected deaths that either are investigated as CIRs, or go to inquest but for which no SIRI is reported. So these figures are only for deaths that are reported as SIRIs and not all unexpected deaths and do not include the 76 CIRs into unexpected deaths that were not reported as SIRIs or any of the unexpected deaths subject to an IMA.

Quality, Improvement and Development Forum (QID) August 2014 - May 2015

We reviewed deaths as reported through QID forum. This is an executive forum that reports to the Quality and Safety Committee.

The QID received quarterly reports on the number of SIRIs including those relating to suicides, homicides and unexpected deaths. The same inconsistency in numbers reported arose in these reports (as it is the same report) throughout the year i.e. incidents being backdated onto StEIS.

In May 2014 the NRLS data was discussed in QID forum and the Trust noted that it was 16 of 55 Trusts on reporting incidents and overall incident reporting was up. Reporting on deaths stated the Trust had only 0.2% of reported incidents as deaths compared with a peer average of 0.7% and a national average of 0.9%. We have reported in earlier chapters the unreliable nature of the Trust figures to the NRLS.

In August 2014 there was a discussion about improving the SIRI management process that is consistent with the production of the new policy and procedures.

The Trust has a target (as stated August 2014) to keep the number of SIRIs to less than 58 per year. This is understandable from a patient perspective but given the number of IMAs and CIRs that have not been reported as SIRIs, it is unclear whether this target is creating the wrong incentive. The Trust also has a target to reduce breaches (i.e. the number of times a SIRI is not completed with the agreed timescales of 45 or 60 working days) to zero. Our analysis (as outlined in later chapters) shows that 90% of SIRIs were not signed off within 45 working days and the average time to produce a report ready for review from the date of incident was 84 elapsed days (60 working days). This is far in excess of the 25 days outlined in the 2011 policy and 30 days outlined in the 2014 Trust policy for reports to be written ready for review at panel. This type of analysis was not apparent and the Trust should have picked up the extent of delays through its KPIs if a focus on death SIRIs had been apparent.

Conclusions:

The Trust Board has not provided leadership regarding the investigation of deaths of its service users and has not been able to assure itself that its policies and procedures relating to investigations are being adhered to or that lessons learned may prevent future deaths.

The Trust's strategic objectives do not set the organisations strategy in the context of reducing harm and preventing unexpected deaths. As a result the Trust has limited focus on deaths, its reporting lacks relevant information and learning from deaths is not consistently implemented. In our view, this drives the poor performance across the rest of the Trust in relation to the attention paid to reporting, investigating and learning from deaths.

The Board and sub-committees had sufficient information, however, to demonstrate that the SIRI reporting process was inadequate, that implementing action plans was inadequate and it should have taken more radical and effective action to improve the investigation of serious incidents at a much earlier point.

There were a number of opportunities for the Board to provide far greater challenge but it has relied on executive director reassurance without the back up of objective measures of performance.

There was reporting only on SIRI deaths - which are a small proportion of deaths amongst service users. The Quality and Safety Committee as a Board sub-committee has not reviewed mortality or non-SIRI deaths and QID as an executive forum has not done so either.

The overall level of unexpected deaths has not been reported anywhere so there has not been an accurate reflection of the levels of deaths occurring amongst patients. This means it has not been possible for the Board to secure assurance that all deaths were being investigated and reviewed appropriately. It also means that decisions were made without receiving all the relevant and important information.

The Board has not set a proactive agenda around deaths in the Trust e.g. it could have commissioned a thematic review of Learning Disability deaths but did not.

The delays in reporting data to the Board compromises its ability to have early warning of potential service problems.

A review of 345 non-SIRI reports

We reviewed 345 IMAs and CIRs for Adult Mental Health and Learning Disability services. Amongst the non-SIRI reports there were clear issues from which thematic reviews could have been undertaken.

IMAs and CIRs in Mental Health

People with Paranoid Schizophrenia - A quarter (73) of the IMA/CIR cases related to people with Paranoid Schizophrenia. 12 of these cases were investigated as a CIR but not reported as a SIRI.

A thematic review of all these would highlight the complexities of maintaining people in the community and whether the services provided to them could be improved. There were notable cases where staff have gone above and beyond what is required of them in very challenging circumstances. Understanding all circumstances in which people with paranoid schizophrenia die would provide insight into what further support staff need to continue to help people in the community and what services need to do to improve their input – usually as there can be a number of different organisations and professionals involved.

Alcohol related deaths – at least 67 cases related to people who had died of alcohol related liver disease, a number of these people had a severe mental illness and were complex to manage and provide care for. However, there are themes arising from a review of a number of similar deaths from which services might be improved, for example, care co-ordination; self-referral; and multi-agency management in particular.

Drug related deaths – 40 cases related to drug related issues. A number of these cases highlight vulnerable people and sometimes the inability of services to respond to their needs. Often these services are not provided by the Trust but users are dependent on referrals being made for or by them to other agencies. Without a thematic review about the circumstances of these deaths, limited learning is possible. Drug related deaths rarely constitute a CIR or SIRI.

Self-neglect and safeguarding – unexpected deaths documentation often highlighted issues of isolation and self-neglect. The safeguarding criteria from the Hampshire Multi-agency Safeguarding Policy identifies the issue of self-neglect and the need to report this as a safeguarding concern. We identified five IMAs, which concluded that there was a failure to refer safeguarding situations and highlight that this may have been able to make a difference. A thematic review of these issues would have highlighted whether service users were being referred appropriately so that any actions could be taken by all the relevant agencies. The Trust's safeguarding tracker provided to us showed that there were about 16 relevant cases being reviewed or a review completed by a safeguarding board as at July 2015. However, 11 were already subject to a SIRI. A wider review of the information arising from IMAs should be used to inform safeguarding alerts processes within the Trust.

Multi-agency implications – a large number of service users who die unexpectedly have required multi-agency input. There are often care and service delivery issues highlighted because of difficulties in partners working together. The lack of multi-agency review means that there is a lack of multi-agency learning including cases involving Eating Disorders.

Drug toxicity and side effects – service users often express concerns about side effects from medication and there are clearly complexities in managing dosages of medication to help maintain individuals functioning. However, there is limited input evidenced in IMAs or CIRs from pharmaceutical staff. Where there was input from pharmaceutical staff it was of good quality.

Suicides – there were ten suicides that were not reported on StEIS by the Trust – four had CIRs. It was unclear to the review team in some of these cases why these were not reported to StEIS on notification. As part of the factual accuracy process the Trust agreed that one of these should have been reported to StEIS and was not. The remaining nine cases raise issues that need to be clarified locally or nationally so that the risk of a case not being investigated is minimised:

- Cases of suicide where the individual has been referred or assessed but not yet seen - where does the responsibility lie in investigating whether a delay in seeing a patient or potentially poor referral information being provided may have been a contributing factor? This accounted for nine of the ten cases we highlighted. In four cases, the Trust considered the responsibility to lie with the referring NHS Trust but there is no evidence from the Trust that a SIRI had been completed by anyone else in three of these cases. In five cases, the individual committed suicide before getting to seeing anyone.
- Cases where it is considered that there has been a probable suicide but the Trust waits for a coroner conclusion before either reporting or investigating. It is clear that the delay in reporting to StEIS in these cases delays investigations starting and therefore the learning process. This will also affect families seeking answers and the opportunity for learning is delayed.
- Cases where it is considered that there has been a probable suicide but the Trust waits for a coroner conclusion that is then considered natural causes. The circumstances in these situations may still require investigation as care and service delivery problems may also have been apparent and the Trust Board was informed (as outlined in earlier chapter) that all probable suicides are investigated as SIRIs.

Physical health management including diabetes – in 51 cases service users were suffering from cancer and/or diabetes with others also suffering from other co-morbidities relating to their physical health. Ten further cases were noted as being obese to the extent this affected their health and some were dealing with the post-surgical effects of bariatric surgery. A thematic review undertaken by the Trust looking at 17 IMAs of deaths relating to physical health that did not proceed to CIR, did not evidence any change in practice or care. Whilst these deaths may not be attributed to failings of the Trust there would again be learning from the regular review of these cases to help service users manage long term conditions including diabetic management.

IMAs in Learning Disability

Themes arising from the review of the reports into Learning Disability deaths.

All the IMAs documented care and delivery issues that needed further enquiry. There was a very clear theme that there was a failure to take action through investigation including by other organisations.

The initial management assessments of the deaths of people with a Learning Disability showed a number of concerns that led to the review team taking a sample of cases to a clinical review group that included the Medical Director of the Trust, the Medical Director from the External Reference Group and an independent GP.

The cases were selected to highlight our concerns relating to clinical issues and apparent care delivery concerns documented in them.

These included a range of concerns relating to helping people eat and drink safely, waiting times for therapy services, delayed decision-making across care providers and in some cases patients not being fit enough for surgery due to either deterioration in their condition or delayed decision-making.

Specific issues that were of concern are:

- Hydration and nourishment
- Delays in decisions to provide alternative nutrition arrangements
- Some cases where delays in decision-making resulted in people not being fit for surgery
- Waiting times for therapy services
- Concerns about early warning signs with changing behaviour
- The role of hospital liaison services and mental capacity decisions.

An assessment of the investigation process

There was poor leadership of the investigation of deaths at corporate, director and area level.

There was a lack of adherence to Trust policy relating to the standard of SIRI reports and the agreed sign off process through divisional and corporate panels.

The review and quality assurance of SIRI investigations is poor. There was limited evidence of proper sign off and review.

There was a tendency to interpret SIRI criteria narrowly that reduces the number of SIRIs and investigations required.

There were too many stages in the decision-making process which lack rigour and oversight in decision-making and a rationale for deciding what level of review or investigation is appropriate.

The Trust could not demonstrate a comprehensive, systematic approach to learning from deaths as evidenced by drawing on themes from death SIRIs, CIRs and IMAs, subsequent action plans, board review and follow up, thematic reviews and resultant service change.

There was particularly poor application of investigative decision-making concerning Learning Disability.

Involvement of families was at a low level. Improvements in this need to be monitored closely.

There is evidence that the Trust is beginning to recognise the need to implement a more robust corporate panel system. This is evidenced by the corporate panel beginning to impact by returning poor quality reports to divisions before they leave the Trust and by the CCG stating that some very recent SIRI reports had shown an improvement.

The reasons for the NHS to investigate an unexpected death are:

- to establish if there is any learning for the Trust, the wider NHS and its partners around the circumstances of the death and the care provided leading up to the death;
- to learn from any care and delivery problems or system failures that need to be addressed to prevent future deaths and improve services;
- to identify if there is any untoward issue in the circumstances leading up to death;
- to be in a position to provide information to the Coroner if requested;
- to be able to work with families to understand the full circumstances and if necessary to respond to any complaint; and
- to have the full detail of the events available for any subsequent complaint or legal investigation.

The process to decide on the level of investigation that should be followed once a death is reported as an incident is clearly outlined in both Trust and national frameworks. However, the frameworks are focussed on identifying Serious Incidents relating to service user safety. The interpretation of what constitutes a SIRI remains open to interpretation. There are many unexpected deaths that can be interpreted as not meeting the SIRI criteria. There have been attempts to revise and clarify what is expected between the 2011, 2013 and latterly the 2015 national frameworks.

The decisions that are taken by the Trust at each stage are critical to getting the processes right, demonstrating transparency, capacity to learn and good governance. At all stages, a robust investigation is the right thing to do for a service user's family and carers, for staff and for the organisation and its commissioners.

The way the Trust's investigations process is set out means decisions to investigate, or not, can be made at a number of points. The clarity with which this process is managed is crucial to good governance and public expectations of transparency. Challenge at each stage is vital.

Key points when decisions regarding further investigation are made are:

- in the immediate period of notification of death
- following discussion with the coroner by a medical professional (GP or Consultant)
- in the first 48 hours through the IMA process
- through the CIR process (which may or may not be a SIRI)
- up to and following an inquest conclusion
- working with other partners through the safeguarding process
- working with other partners through Serious Case Review
- following a complaint.

The flow chart on the following page shows the process we have mapped out that is in place for deciding whether to investigate a death within the Trust.

We have rated the Trust at various stages according to a RAG scale:

Red	Inadequate
Amber	Requires improvement
Green	Adequate

The flow chart below maps the main process of decision-making in deciding to investigate:

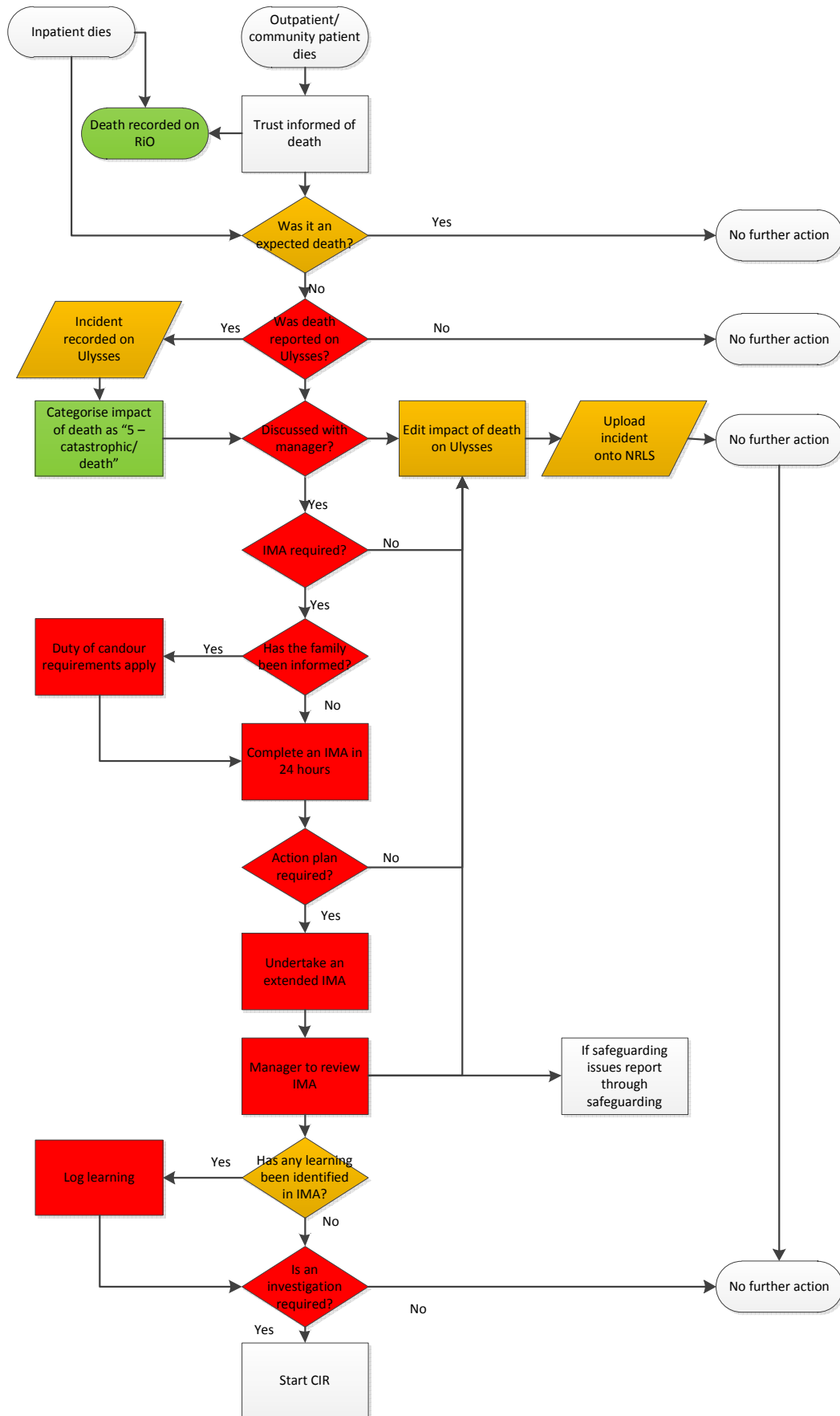


Figure 27: Flowchart of decision-making for investigation

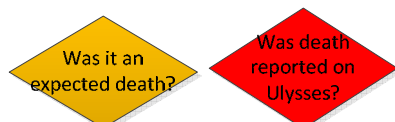
We have assessed the Trust at each point in the process and our findings are set out below:

Identifying all deaths

Death recorded on RiO

Deaths of all NHS service users are recorded in the RiO system in a reliable manner. There are minor errors in dates. The Trust does not interrogate this information sufficiently to identify deaths or to inform the level of mortality across its service users. It has been difficult to readily identify inpatient deaths, deaths of people in detention and Learning Disability service users. The RiO system does not include TQ21 service users - the social care arm of the Trust's services and so does not include deaths of these service users. The Trust needs to interrogate and use this information better. The Trust cannot and does not readily identify all deaths of Mental Health and Learning Disability service users in the various divisions of its provision.

Identifying all unexpected deaths



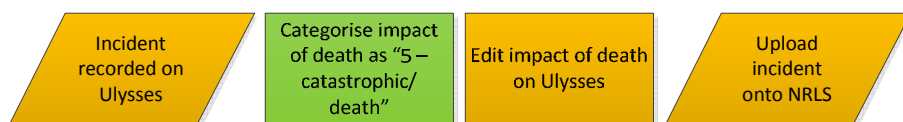
The Trust has not been able to demonstrate that all unexpected deaths are identified. For the Trust, deaths are notified at different times post death. Sometimes staff discover the death; are notified the same day; or relatively quickly post death: at other times, it can be over a year before the Trust is informed of the death.

The Trust relies on the synchronisation of the national spine to update its records when someone has died and then for a staff member to identify the death through an update on RiO. Once a member of staff becomes aware, of an unexpected death, they should report it to their line manager and if the death is considered to be an incident, it is recorded onto Ulysses. This starts the decision-making process.

It is clear that the decision-making process at this point is not corporately overseen. It means that some unexpected deaths may not be reported as an incident. If a member of staff does report a death as unexpected, the death can still be considered as 'expected' in discussion with the line manager and no further action will be taken by the Trust to investigate.

Grading the incident and reporting to NRLS

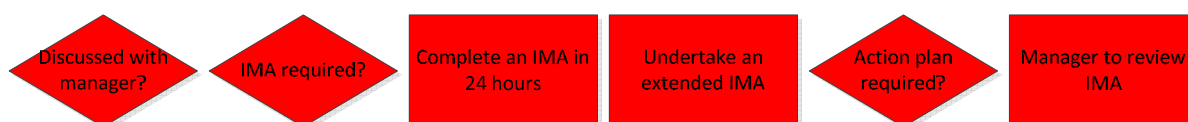
Once reported a brief summary of the circumstances of the incident is entered on to the Ulysses system.



The recording of incidents onto Ulysses worked adequately internally. There were inconsistent levels of information of the circumstances of each death with variable detail. All deaths reported were categorised as actual impact grading 5 until further information became known. The incident was then re-graded at a variety of different points up to corporate panel. The incident was uploaded to NRLS when the final actual impact grading is signed off by managers. This process broadly worked well but the grading of incidents needs senior oversight of deaths to ensure that the impact grading is correctly identified. We have subsequently established that the figures on the Trust systems do not appear consistent with those on the NRLS under the 'degree of harm death' category and this needs further investigation.

Producing an IMA

A decision may be made by managers to produce an IMA for all those incidents reported to Ulysses. An IMA is usually undertaken by the manager of the related team and should be produced within 24 hours of the incident. It is critical that this report is properly considered and the rationale for further investigation, or not, documented. We are not confident that this process is robust.



An IMA sets out the immediate circumstances of the death or incident and provides important information for further investigation. This report is not done for all unexpected deaths at the Trust. Very few IMAs had a clear rationale for limiting further investigation. IMAs are not shared with families and do not involve families or relatives.

There was limited information regarding how decisions to produce an IMA were made. The Trust's area teams heavily determine this part of the process. The timeliness of IMAs were poor taking an average of 14 days to produce and the quality of the reports varied considerably. From about June 2013, the Trust began to introduce an 'extended IMA' process in Mental Health which was an IMA with an action plan. There appears to be no clear understanding of what the purpose of this is and the circumstances in which it is needed. There were 21 IMAs in this time period with an action plan. We cannot see however how actions arising from these plans are logged. 88% of IMAs did not have an action plan. In 2014 there was a clear directive to sign off IMAs at Area panel level – this decision has now been reversed.

In Mental Health, only 35 IMAs were signed and dated by a senior divisional manager or director, although the Trust states that there is evidence of email sign off. The poor quality of the IMAs, however, suggests that any process in place has not been effective and sign off cannot be readily audited or monitored by the Board through this method.

No IMAs for Learning Disability service users had an action plan. Only ten IMAs showed evidence of sign off.

The majority of IMAs do not state the rationale for there being no further investigation. In Learning Disability, no IMAs provided had an action plan. In Learning Disability this is where an opportunity to learn from deaths effectively stop, There is limited evidence of sign off or actions arising or lessons learned from the majority of the reports.

Deciding to investigate



Sometimes the IMA recommends proceeding to a CIR without it being a SIRI. Not all recommendations for a CIR progressed. In 20 cases, the IMAs provided to the review team recommended a CIR or in one case, a multi-agency review but there was no evidence that this had been enacted. The Trust provided further information as part of the factual accuracy process to indicate that six had further investigation and two were the subject of a thematic review into deaths related to Clozapine use. The Trust states that in 12 cases, the recommendation was reviewed and it was decided a CIR would not be undertaken. The Trust recognises the system of evidencing these decisions was weak, as the original IMA was not amended to reflect the decision, so they did not have an accurate 'final' IMA on record. However, they state there is clear evidence of senior review and sign off for each IMA outside of the IMA document itself.

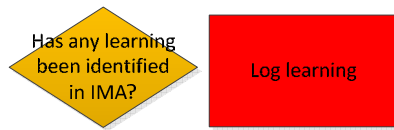
We are concerned that the Trust has been unable to provide accurate reports properly updated in the circumstances of some deaths and the decisions relating to deciding to investigate these deaths or not are not properly evidenced.

There were 76 CIRs in Adult Mental Health services that did not meet SIRI criteria according to the Trust and one CIR for Learning Disability in the four years of the review. Some CIRs should have been reported as SIRIs.

All IMAs and decisions arising from them, until very recently, have been expected to be approved and managed within individual areas and divisions. The most senior oversight of these has been within the areas and divisions themselves. There is little evidence of this level of review being robust as evidenced by the poor quality of the IMAs. We reviewed the area panel notes from August to October 2014 and there was limited documentation of the quality assurance and sign off process.

Sometimes the Trust decides to wait for the coroner's decision or the result of the post-mortem. This means that there is a delay in deciding whether to undertake a CIR or to report the incident as a SIRI. It is unclear given that the process is about learning why a CIR process is not started immediately, as there can be quite a delay at this stage. Some cases have taken a year from incident to deciding to do a CIR or SIRI. A SIRI can always be downgraded if the death is ultimately 'expected'. In a number of IMA reports, there is no update as to the cause of death or the outcome of a post-mortem where these are held.

Learning from IMAs



No actions and limited learning was identified from IMAs relating to Learning Disability deaths.

Actions were identified in 12% of IMAs for deaths relating to Adult Mental Health deaths. The actions arising were expected to be tracked and monitored at divisional level. We saw no evidence that this is done other than one individual team monitoring action numbers and many of these actions were not closed from 2013 and 2014 action plans.

The flow chart below maps the process once a decision has been taken to investigate further:

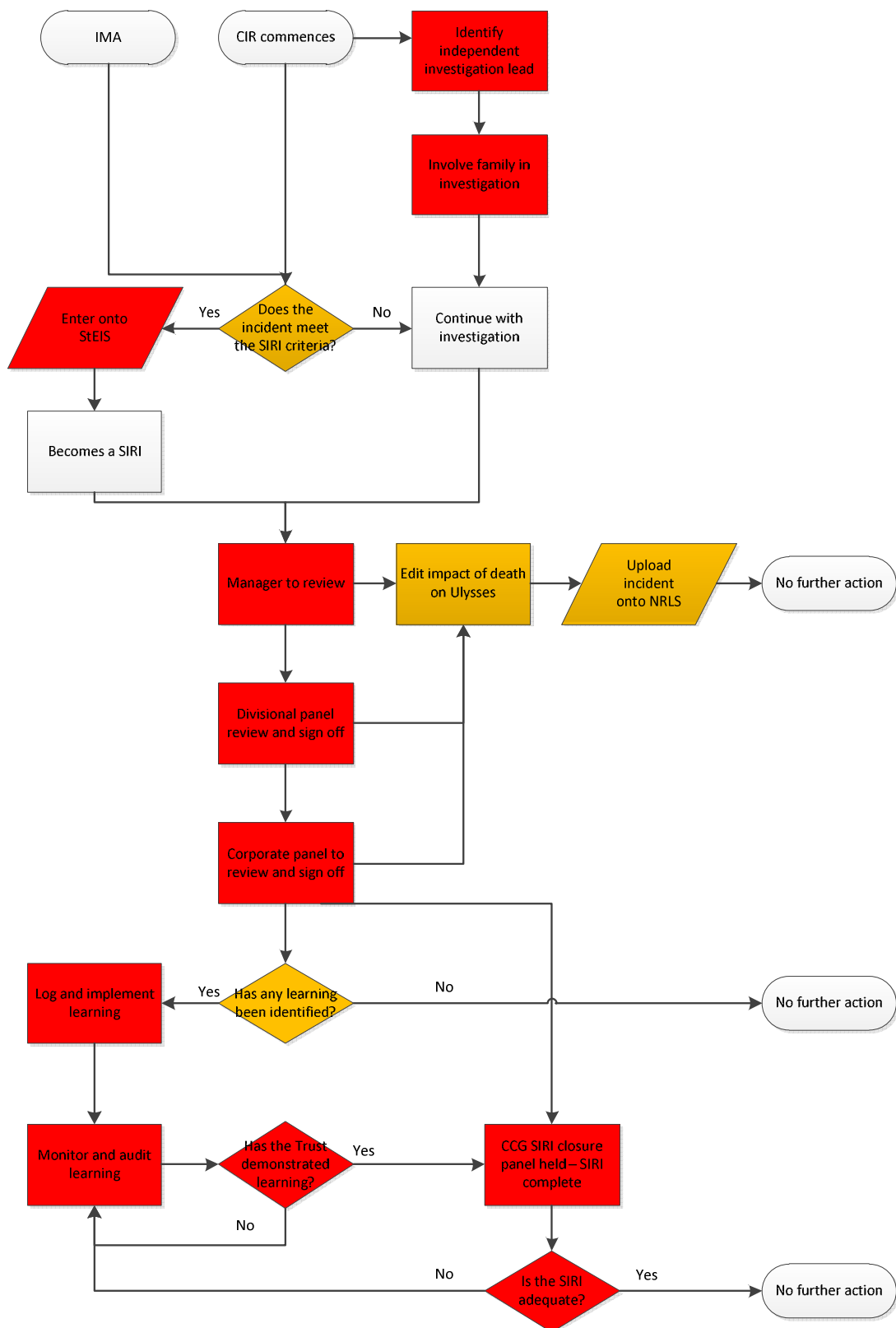


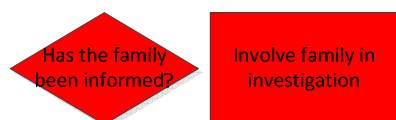
Figure 28: Flowchart of investigation process

CIRs and SIRIs

A Critical Incident Review (CIR) is the next 'stage' of the investigation process from the IMA. This is a more detailed review of the incident building on the IMA and it should include the family, relatives or carers.

The CIR process is expected to follow good practice guidelines set out by the National Patient Safety Agency (NPSA) including having independent investigators. A Root Cause Analysis (RCA) is undertaken which is considered the standard that should be used and requires training and regular use to be undertaken well. For CIRs, the timescale for the investigation is not prescribed as there is no external scrutiny of this process unless it becomes a SIRI.

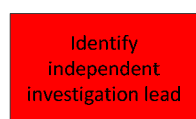
The investigation process - family involvement



Family involvement is discussed elsewhere in the report. However, in total only 36% of families had any involvement in the investigation process. For CIRs that were not SIRIs only 17 families out of 77 investigations were involved. 12 had face-to-face meetings. For SIRIs 80 of 195 cases involved the family.

A number of reasons are given for not involving families. However, based on the information contained in the contemporaneous reports provided, in nearly 20% of cases this was as a result of not being able to contact the family - largely due to not having any contact details or details of next of kin.

Identifying investigation leads



Independence is important in all investigations.

Investigators are drawn from within the areas of the Mental Health Division (although not from the relevant team usually). The Learning Disability division was a small division and a small number of managers were involved in the IMA process without external scrutiny. In our view, these arrangements have meant investigators have not been sufficiently distant from local teams to ensure that the process is and can be seen to be independent. The decisions to investigate and the quality assurance of the investigation reports are all retained within the same area and until recently have not been subject to the necessary scrutiny at divisional or corporate level.

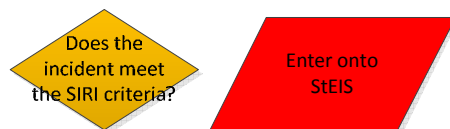
There were cases where clinical teams involved in the care of the service user were also involved in the investigations - this risks compromising independence.

There were at least 110 different investigators leading the 195 SIRIs drawn from the area teams in the mental health division. The 110 reviewers included at least 24 investigations where Consultant medical staff led the work. 87 staff had led only one or two investigations into deaths.

We found that where staff had led more than four investigations in to deaths that the quality was not of a higher standard as might be expected. Of the cases written by Consultants 50% of the reports were of a poor standard and amongst the most experienced staff 44% were assessed as poor. This devolved model of investigation is not producing high quality investigations.

The CIR and SIRI investigation

Deciding on a SIRI



A CIR that is also a SIRI is the full investigation stage through which external scrutiny can be undertaken and the Trust held to account for the implementation of action plans and learning.

From our review, we identified 31 Mental Health CIRs where there was no clear evidence as to why these were not reported as SIRIs.

When we requested IMAs for all the reported Learning Disability deaths to Ulysses we were informed that a large number of deaths did not meet SIRI criteria and so there were only 65 IMAs provided. The Trust did not state why the criteria was not met in those cases without an IMA. Given the descriptions of some of these cases on Ulysses at the time and the information in the IMAs, we considered that some did meet SIRI criteria.

Guidance requires SIRIs to be reported to StEIS within 2 working days and if in doubt to err on the side of caution. We initially identified that SIRIs were not be reported promptly as we could not reconcile board reported numbers of SIRIs to those we had identified in our database.

SIRIs were required to meet set timescales – until April 2015 there were two grades of SIRI – 1 and 2 – with different timescales to close the report. This is very tight for death investigations. It is imperative then that the process commences promptly and to instigate an investigation immediately and not delay depending on others processes. (The main legitimate reason to delay is if there is a clear request because of possible criminal investigation from the Police or Health & Safety Executive).

Some cases may have legitimate reasons for this – e.g. the death is not identified immediately. However, there is a practice that in some cases of probable suicide the Trust will wait for a conclusion before reporting the SIRI. This can result in delay in commencing an investigation.

The consequence of not making this clear in board papers is that the number of deaths reported does not reflect the month the incident happened, rather the date the Trust reported it on StEIS.

We are concerned about this process for two reasons – the need for investigations to occur before an inquest and therefore have all available information to hand for a coroner and the impact that any delay may have on families involved.

The Trust has delayed reporting onto StEIS - our analysis of the last quarter of 2014 showed that these delays can take months and sometimes years before an incident is reported as a SIRI. The Trust states as part of the factual accuracy process that 30% of SIRIs were not reported to StEIS within timescales but this analysis been undertaken on an inaccurate data set.

Quality of investigations

The review team along with an independent Senior Clinical Mental Health Practitioner with experience of investigations and previously a SHA Mental Health lead undertook an initial review of a random selection of 24 SIRIs provided to us from the first cohort provided by the Trust. We selected SIRIs from each of the four years covered by this review and individually identified common themes and issues arising from these SIRIs. We developed the template at Appendix 3 from this pilot stage.

All further SIRIs were read and reviewed by two members of the team to ensure consistency.

Our review of the 195 SIRIs is discussed in a later chapter. However, we outline here the descriptors we used for assessing the reports and the process by which the methodology was developed.

Descriptors used in rating reports:

- **Excellent/good** – *no typographical; grammar; date; naming errors – report was easy to read, followed a logical flow and the evidence gathered clearly linked to recommendations and to action plans. The report could be shared with families as a robust piece of independent writing and with professionalism.*
- **Adequate** – *showed most of the information needed was available but was presented in a manner that made understanding the issues difficult; often these had grammar; date; naming and typing errors. Could have caused distress to families if shared by showing a lack of respect and attention to detail. Probably had not been quality reviewed at any level or detail.*
- **Poor/inadequate** – *these varied between having typographical errors to an unacceptable standard; naming the service user incorrectly; wrong dates; no flow and were either cursory or provided insufficient information to form good recommendations or action plans. These reports lacked challenge or effort in securing learning. Likely to cause distress to a family due to its cursory nature or lack of professionalism; and had most likely not been read properly during any phase of quality review.*

Our review showed that 30% of the SIRI reports were of a poor or inadequate standard. 50% met a basic standard but many still had grammar and date errors. Only 20% were assessed as good or excellent. External investigations were included in the good to excellent category. If shared many of these reports would cause additional distress to families.

More detail about our review of all SIRIs is provided in later chapters. Reports took an average of 84 days (60 working days) to write (i.e. produce a draft for internal review) from the date of incident and this timescale has not improved over the last four years.

The Trust revised its incident reporting policy and procedures in July 2014 and these were ratified and in place during the review period with a new toolkit with templates for quality review, IMA and CIR reports. On the whole the new templates and toolkit were not being used. We have seen no quality review templates and very limited use of the revised reporting templates.

As well as our assessment of SIRI report quality, our review process also included an independent clinical review of 35 Mental Health IMA cases and 65 Learning Disability IMAs and one CIR. This review by a previous PCT Medical Director and GP confirmed the review teams view of the quality of the information contained and the ability to make decisions based upon them.

After the review team identified a number of themes and a range of concerns arising from the review of the Learning Disability IMAs, 12 cases were selected for a further clinical review. The cases were selected to identify a range of ages, themes and out of acute care concerns that we had identified. The group included the Medical Director of the Trust and the Medical Director from the External Reference Group at the time and the overall quality of these was clearly agreed to be poor.

Timescales for reporting Learning Disability and Adult Mental Health SIRIs

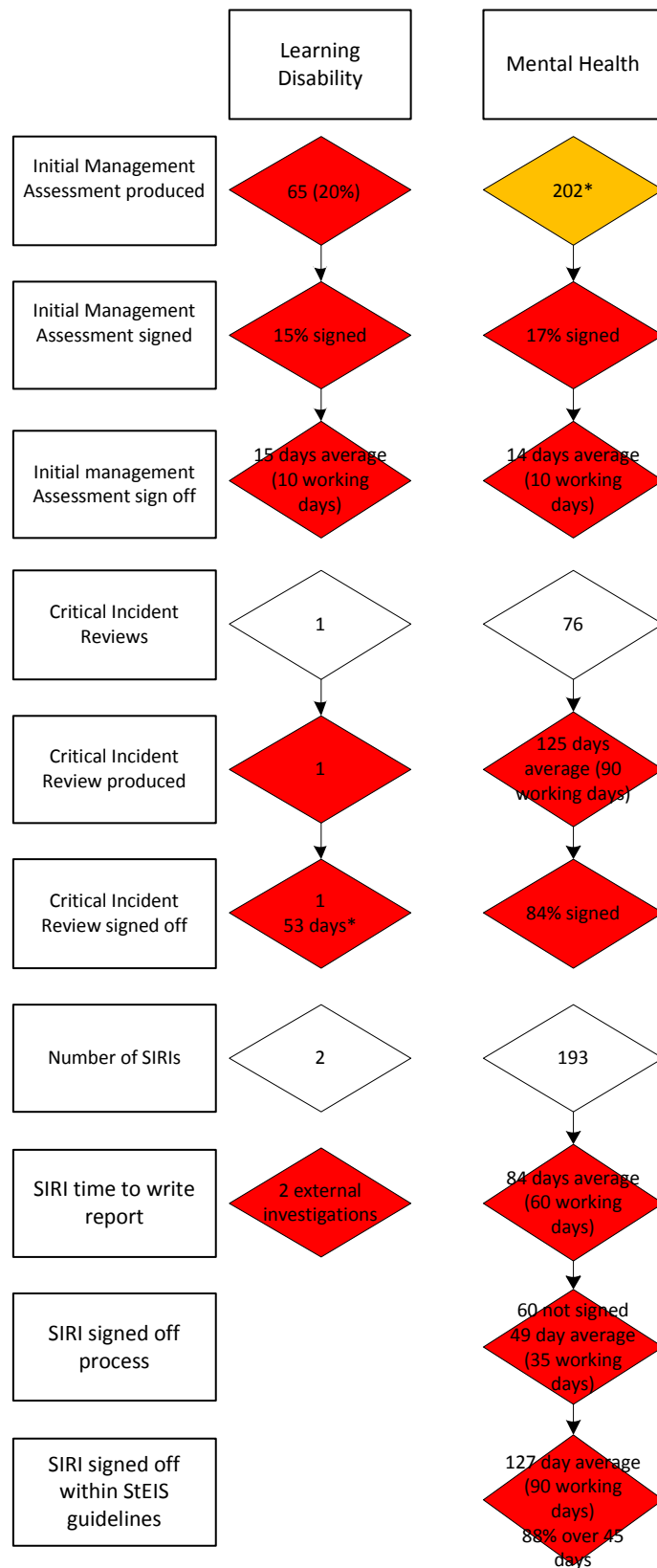


Figure 29: Delays and timescales for reporting Adult Mental Health SIRIs

The Quality review process

Figure 29 above shows the delays at different stages to completing an investigation in Learning Disability and Adult Mental Health. These far exceed the timescales expected of a SIRI process. There were delays in deciding whether to report a SIRI in the first place but once decided it took an average of 84 days (60 working days) to write the report and a further 49 (35 working days) days to sign it off ready for corporate panel. In total it took at least four months instead of six weeks for the Trust to produce a SIRI report for a closure panel in the Adult Mental Health division.

The reports are expected to go through divisional and corporate sign off before leaving the Trust. The diagram below shows the current process. If these stages don't run smoothly this adds to the delay in the overall timescales.

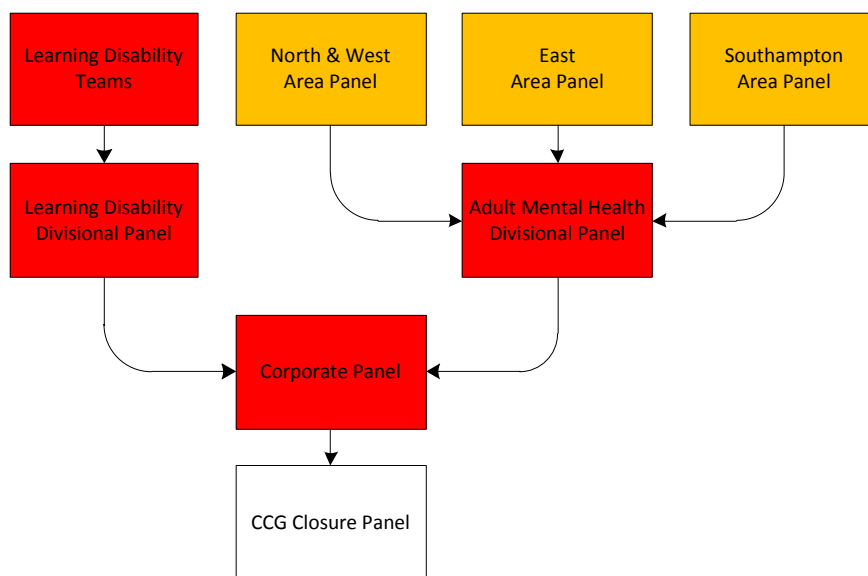
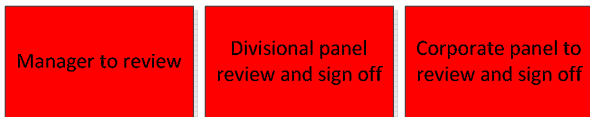


Figure 30: Flowchart of review panels within the Trust before going to the Commissioner closure panel

There have been three serious incident management policies and associated procedures written and approved relevant to the period of the review. The implementation of the policies in the different divisions have been applied differently. However, both the overall delays in producing SIRI reports, closing them and the quality issues raised in the report clearly demonstrate that the process did not produce the required quality and rigour needed.

The divisional arrangements for reviewing the quality of the investigation and the report were not adequate. In Learning Disability, as so few CIRs and SIRIs were undertaken the panels did not occur frequently. The area panels in the Mental Health division had the overall responsibility for deciding what to investigate, who would investigate and for the quality review and approval of the reports. This arrangement resulted in reports of an inadequate standard being signed off. Area leads were quality reviewing reports where senior individuals own standard for reporting was poor - this added to the cycle that was resulting in overall poor quality reporting and investigation.



The Trust state that divisional panels have been held for all SIRs and CIRs since September 2013.

We determined that we would focus on the new 2014 policy to assess the application of the expectations laid down in it. The policy was approved in September 2014 and the associated toolkit available from July 2014.

The Trust 2014 policy sets out that SIRs are expected to be approved through a divisional panel and then a corporate panel before leaving the Trust to go to the relevant commissioner for 'closure'. Reports should be written within 25 working days, approved at 35 working days and ready for the CCG closure panel at 45 working days. Grade 2 SIRs have slightly longer timescales but should be ready within 60 working days.

We requested documentation for divisional panels in relation to the new policy for the period August to October 2014. Following repeated requests for information about divisional panels from Mental Health, it became clear that sub-divisional area panels formed the basis of the divisional process and that divisional sign off has largely been a virtual process.

We received no divisional panel meeting notes. We received notes for each of the three area panels.

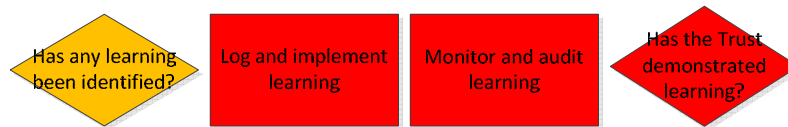
The quality of review at area panels has been inadequate. Reports were being signed off at this level that were not of an acceptable standard. Divisional oversight has been inadequate. Delays were building into the overall process with delays at each stage of sign off. There has been no effective internal enforcement to improve this position as this has been the level of performance for four years.

In the Learning Disability division, we had evidence of one divisional panel meeting in June 2014 being held. The only death considered was a March 2014 death relating to one IMA in which it states the case was referred to Hampshire County Council for a joint investigation. This is not on the Safeguarding Tracker. We have not seen a copy of this joint investigation. It is inconsistent with the information in the IMA that refers to a reflective practice session being held in April 2014. We have had no evidence of the process in place for decision-making. One IMA that we reviewed had clearly been challenged and questions raised by the service managers and divisional director but further action did not follow.

We also requested evidence of corporate panel review in relation to the new policy – for the months October to December 2014 to give the new policy time to bed in. We were informed that none of the panels were relevant as no deaths had been reviewed in those three months. We requested January – March 2015 panel notes; these had not been typed up. We requested April to June 2015 panel notes and we were provided with Corporate panel notes from three panels in February, March and April 2015. It appears that the new Corporate Panel process had then begun to take place with a level of scrutiny and challenge that should have been taking place previously. These panel notes record each SIRI report being reviewed; and demonstrate that some of these reports are now being given the challenge they need. We have no evidence that until the last three months of our work

that either the divisional or corporate panel review process was either taking place or, if it was, was documented. The virtual process that was taking place did not result in high quality reports.

Learning from CIRs and SIRIs



The Trust could not demonstrate a comprehensive, systematic approach to learning from deaths as evidenced by the systematic analysis and monitoring of action plans, board reporting on themes and follow up, a regular programme of thematic reviews including evaluation and resultant service change. Whilst there is evidence of learning in a range of areas across the Trust, few of the thematic reviews provided can clearly show a link related directly to deaths or themes from deaths and overall were of a poor quality with little evidence of change in practice or evaluation.

The Trust analyses suicides numbers annually through a suicide report. These have highlighted the similar issues each year.

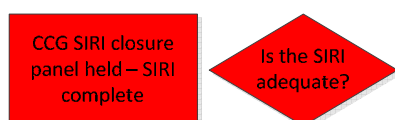
In the Learning Disability division, there were two CIRs and two SIRIs. With so few investigations taking place themes cannot be drawn from them. There is evidence that since 2014 an Epilepsy toolkit has been produced and circulated with evidence that the Trust can demonstrate learning in this specific area. However, as the majority of deaths are not investigated any learning could only come from IMAs.

As there are no action plans from the IMAs and any identified key learning is not systematically provided in the assessments and there is no evidence that learning is systematically logged or monitored by the division or corporately we conclude the processes in place to learn from deaths are weak. The Trust analyses suicides numbers annually. These have highlighted similar issues each year.

The December 2013 board minutes note that auditors reported in August 2013 in a Serious Incident Management audit that on selecting five Mental Health and Learning Disability incidents to review there was no evidence of action plans being monitored or implemented by area matrons. The report also highlighted that of the 10 SIRI incidents they reviewed in the audit no evidence could be provided of lessons learned.

Action plans are still expected to be monitored at area level within divisions. These are still inadequately monitored. We were provided with an action tracker for one area of the Mental Health division. This tracker had no actions logged on it. Action numbers were logged from July 2013 to April 2014 for SIRIs. The actions themselves are not logged, there is no ability to draw themes as a result of identify recurring actions, many actions remain outstanding.

SIRI closure



SIRIs were not delivered and completed within the expected timeframe. Whilst it might be expected that some will not meet the expected timescales (due to police investigations mainly), the level of non-compliance was significant.

88% of all SIRIs exceeded the 45 working day timescale; 67% exceeded 60 working days and 21% exceeded 100 elapsed days. This is before the SIRIs are sent to commissioners for review. The Trust's 2011 policy requires reports to be written within 25 (35) working days, signed off in 35 (45) working days and ready to go to commissioners in 45 (60) working days. Figures in brackets are Grade 2 timings. It is important to consider, however, that deaths are often the most complex SIRIs to investigate and therefore may take longer.

SIRIs have had to be sent back to the Trust due to quality issues, including letters to Directors stating this. SIRIs have had to be chased and postponed from one panel meeting to another and evidencing actions being implemented has resulted in SIRIs not being closed until they can be evidenced as actioned. Some SIRIs are closed before all actions are proven to be implemented due to the backlog that occurred. The process around death SIRI closure has been inadequate as a result.

Conclusions - The SIRI reporting process

The SIRI reporting process over the last four years has been poorly managed.

The quality review process within the Trust over the period of the review has not been a strong or director-led process. There is limited documentation of decision-making and challenge, and the standard of the final reports are so variable as to provide little confidence that any review process has been effective. There have been very specific instances where external organisations have raised concerns but unfortunately the quality of IMAs and CIRs and SIRIs have not improved to the extent expected.

We have seen some change in the last three months of our review (April 2015-June 2015) as a result of Executive Director focus – in particular, the Medical Director who is now holding Corporate Panels. This has latterly resulted in the sort of challenge and scrutiny that should be expected of a Trust. SIRI reports are being sent back to divisions with requests for a number of changes. This suggests that there is still considerable improvement required in the local and divisional quality review processes leading upto corporate panels. This has resulted in a backlog of SIRIs being completed but the Trust and CCG recognise that this is going to occur in an attempt to improve the quality of investigations in a sustainable fashion. The impact of delays for families will continue until this process improves. The CCG reported in August that three SIRI reports at the closure panel could be signed off.

Until this point, however, the Trust had:

- Little corporate oversight of SIRIs involving deaths resulting in continued poor quality reporting
- Poor quality and limited information to the Board and its sub-committees detailing the extent of delay and quality issues
- Very poor SIRI quality review processes resulting in reports that took too long to be finalised; being returned from the CCG closure panels; or signed off to clear the backlog.
- SIRI reports that lacked challenge and robust action plans; IMAs that varied from clear to cursory
- Very limited evidence that all but a small number of SIRI reports were shared with families; those that were, sometimes resulted in further conversations with families wishing to add to the review subsequently. Many reports had significant grammatical, date and typographical errors such that, if shared with families, would have added to their distress
- Lack of control of decision-making in whether and at what level a death was considered unexpected and therefore required further review or investigation
- IMAs not showing the rationale for no further investigation and some recommendations for CIRs not being followed up
- CIRs conducted which showed limited rationale for not being considered a SIRI; as a result system learning is lost as the report remains internal to the Trust (or family if shared)
- Lost opportunity for learning from non-SIRI deaths
- Lost opportunity for informing the need for a thematic review
- Very minimal investigation into deaths of people with a Learning Disability

Deciding which deaths are investigated - an emerging framework

We identified inconsistencies in which deaths were investigated. Expected deaths considered to be natural causes are unlikely to be investigated and this may be appropriate. Unexpected unnatural deaths are more likely to be investigated. But inconsistency arises for specific service groups. In particular, Learning Disability deaths which were unlikely to be investigated. Each death needs to be considered with a degree of consistency and deaths classed as expected should be properly assessed to ensure there is no chance that they need further review or further investigation.

The diagram below suggests a framework for classifying deaths based on our review.

Emerging Framework for ensuring the appropriate identification of deaths for further investigation

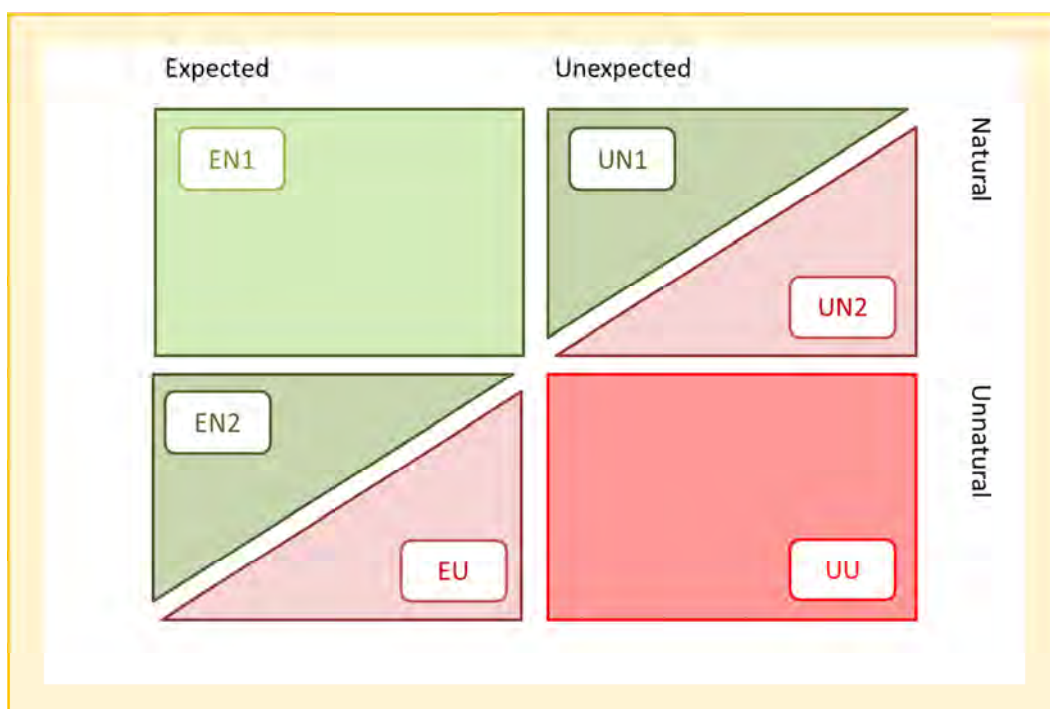


Figure 31: An emerging grid for categorising deaths for the purposes of review and investigation (Mazars).

The table below provides a broad description of what these look like but a framework should be developed for each group of service users - Learning Disability, Adult Mental Health and Older People Mental Health as the characteristics and circumstances are markedly different.

Type	Description
Expected Natural (EN1)	A group of deaths that were expected to occur in an expected time frame. E.g. people with terminal illness or in palliative care services. These deaths would not be investigated but could be included in a mortality review of early deaths amongst service users.
Expected Natural (EN2)	A group of deaths that were expected but were not expected to happen in that timeframe. E.g. someone with cancer but who dies much earlier than anticipated These deaths should be reviewed and in some cases would benefit from further investigation
Expected Unnatural (EU)	A group of deaths that are expected but not from the cause expected or timescale E.g. some people on drugs or dependent on alcohol or with an eating disorder These deaths should be investigated.
Unexpected Natural (UN1)	Unexpected deaths which are from a natural cause e.g. a sudden cardiac condition or stroke These deaths should be reviewed and some may need an investigation.
Unexpected Natural (UN2)	Unexpected deaths which are from a natural cause but which didn't need to be e.g. some alcohol dependency and where there may have been care concerns These deaths should all be reviewed and a proportion will need to be investigated
Unexpected Unnatural (UU)	Unexpected deaths which are from unnatural causes e.g. suicide, homicide, abuse or neglect These deaths are likely to need investigating

The descriptions are not definitive but serve to demonstrate that there are natural cause deaths that would benefit from a review or investigation.

An outline assurance framework - a suggested approach

Securing assurance that deaths are quickly identified, properly categorised and then investigated and reported improves patient safety. It provides the Trust Board with the information it needs to be confident that systems and processes are working well and that learning can lead to improved patient safety, outcome and experience.

If Parity of Esteem is to become real all parts of the NHS along with other stakeholders (i.e. public health) have a role to play. The reports of unexpected deaths in this review only serve to highlight the realities of people with a mental health problem and those with a learning disability dying early. If NHS Trusts and commissioners do not review mental health and learning disability deaths in a systematic way then it is hard to see how systemic change can be identified and then implemented.

NHS time, effort and resources go into completing reports at all levels and much of the learning that can come from them is lost. This is apart from the time spent by families seeking answers and the time required to help them.

From the findings in this review we outline below a suggested approach to assurance on all aspects of mental health and learning disability deaths which uses the information from this review in a productive way. This approach is applicable to both the Trust and its commissioners.

What controls should the Board put in place to monitor the identification of unexpected deaths and assure itself of the quality of investigation and the learning from them.

Our review highlighted deficiencies in five areas:

- Identification and reporting of unexpected deaths
- Investigation of unexpected deaths
- The governance of investigating unexpected deaths
- A lack of learning from unexpected deaths
- A lack of transparency and openness including with families related to unexpected deaths.

We therefore suggest that the Board puts in place a framework to ensure that these areas form part of the Board assurance framework. The Quality and Safety Committee and the Audit and Assurance Committee will have the predominant role in seeking assurance from directors on these points. The Medical and Nursing directors have a specific role now in relation to oversight of clinical aspects of learning and the quality of investigations and these roles should ensure that learning from deaths is robustly identified and implemented.

We have recommended above that the CCG and the Trust develop a mortality dashboard / dataset which should form the basis of answering these questions. The CCG will need to work jointly with the Trust to provide some information e.g. public health related information as well as providing a feedback loop on performance improvement to both the Trust and the CCG governing body.

Outline questions for a framework for the board to use as assurance relating to systems relating to unexpected deaths of its services users.

In order for the Board to gain assurance in this areas the table below outlines a range of questions arising form this review which would form the basis of a future framework.

<u>Questions for a Board Assurance Framework focussing on reducing unexpected deaths and improving investigation</u>	
<u>Do we identify and report deaths correctly?</u>	<u>Do we investigate unexpected deaths properly and without delay?</u>
<p>How many deaths are there amongst our service users? How many of our inpatients die? Where and how do our service users die? How do we identify unexpected deaths correctly? How do we report unexpected deaths as incidents?</p>	<p>How so we know we are making the right decisions at IMA stage? How do we know we are investigating the right cases? What is the quality of our investigations? How do we know our quality review processes adequate? How do we know if we have any delays in completing investigations? How do we know if we working with other agencies well? How do we know we are informing other agencies when we are concerned about a case in their care?</p>
<u>Do we meet our obligations to others?</u>	<u>Do we learn from deaths?</u>
<p>How do we know how many of our service users in detention die? Have we reported and investigated all deaths in detention and how do we know this is accurate? Have we reported appropriate deaths to NRLS in line with Trust policy and best practice and how do we know this is accurate? How many deaths require our involvement with the coroner and are we meeting accepted standards? How many deaths require an inquest? How do we know we are providing the right information to the inquest? How many SIRIs are being signed off? How many are outstanding? How do we know? Have we met our obligations to inquests and are we reporting our deaths in accordance with guidance? Are we meeting our safeguarding obligations? How do we know?</p>	<p>What are the causes of deaths? What do our investigations tell us about our services? What themes are arising and are we refining our services as a result? What learning is there? How is it monitored?</p>
<u>Are we being transparent and open in our reporting and investigating?</u>	
<p>Are we involving families in the right way? How do we know? Why are families not involved in our investigations? How can we improve involvement? What is best practice for family involvement and do we meet it? Has the coroner commented on our services or our investigations? How do we know we've responded properly? Is it clear when we report unexpected deaths in our Annual Report what we mean?</p>	

Figure 32: A proposed framework for Board assurance on mortality and unexpected deaths

Linking information to Service improvement

Investigating deaths can identify learning. There needs to be a clear framework from which the Trust and commissioners can secure assurance that learning and improvements are achieved. Learning can be derived from all levels of review and investigation. The diagram below provides a suggested way forward for the Trust and its commissioners to better understand mortality in the local population.

The pyramid represents the various levels of review and report that should be undertaken to identify service change. The rest of the diagram indicates at what level learning can have an impact based on the reports we received.

Linking information to Service improvement

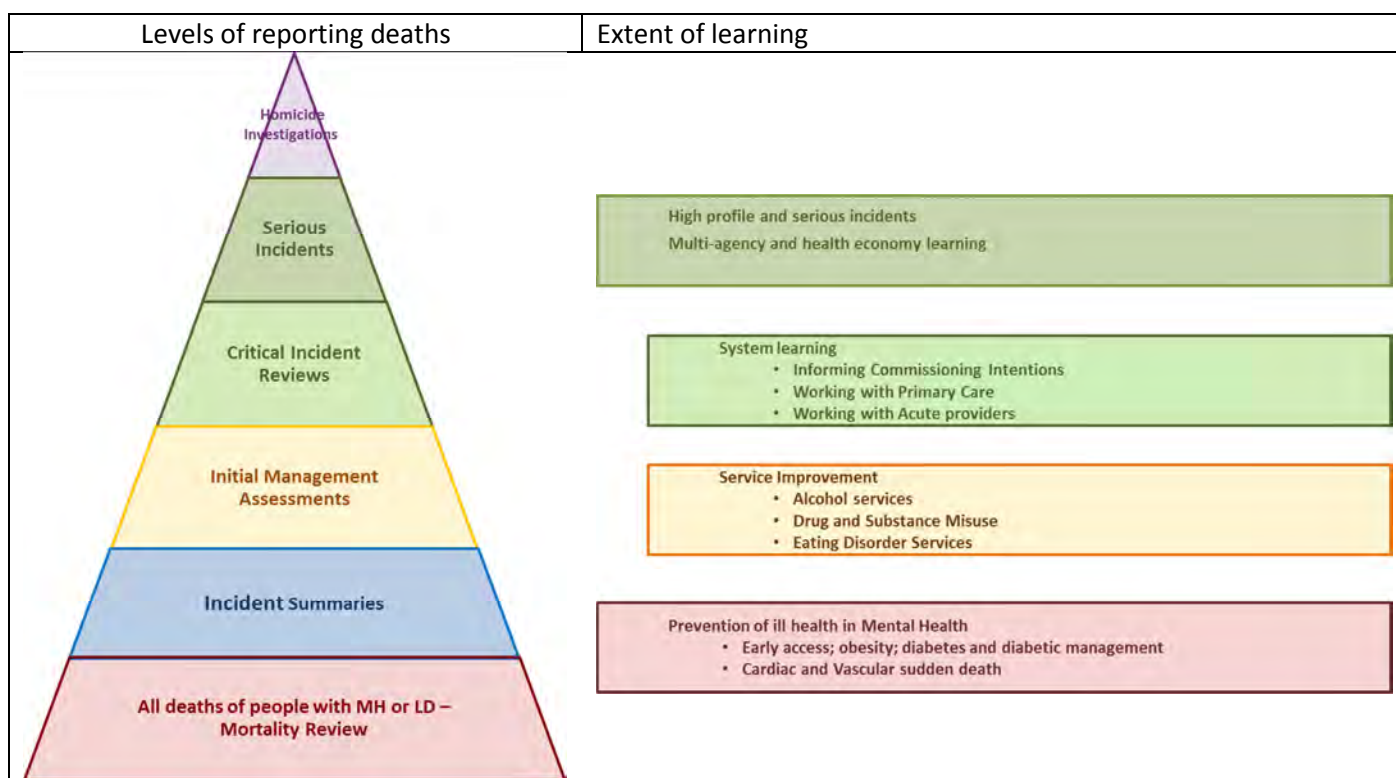


Figure 33: Using information on deaths to provide system learning for improvement.

Our findings from this review inform each section of the approach below.



An overview of all deaths of people with a mental health need or a learning disability provides local insight into the major killers and would enable evidence based commissioning decisions. Public health profiles should aim to ensure that causes of death for these groups of patients become more visible.

The comparative information at the end of this report highlights how ONS information can be used based on ICD10 chapters to begin to highlight differences in causes of death. This experimental linkage between ONS and MHMDS uses for the first time deaths linked to providers and the underlying cause of death. The Trust stands out in some chapters and more detailed work was not in the scope of this review but such a linkage provides valuable information for comparison and focus.

The Trust's RiO system also provides detailed information about ages, genders and geography of all deaths.

A priority could be to develop a data set around Mental Health and Learning Disability deaths that enables ready replication and assessment.



Incident summaries provide an overall picture of incidents relating to unexpected deaths. Analysed over a period of time a picture emerges of where unexpected deaths are occurring. The incident numbers of all unexpected deaths should be reported separately from all other incidents as otherwise the numbers become small when compared with all incident reports. This should be presented as a dashboard with how many incidents have been reported and the themes arising from them are suitable for trend analysis and sharing with commissioners. This should form the basis of an early warning system.



There is often an absence of detail underlying the high level information in incident summaries which can be a barrier to further investigation which is why an IMA is often required.

These provide more detailed and local insight into the circumstances of unexpected deaths. In this review we highlight:

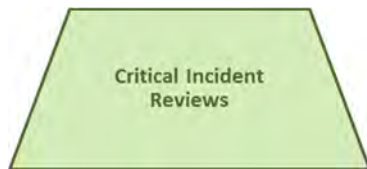
- service users who need help with alcohol dependency and substance misuse;
- people dying with complex co-morbidities, while
- obesity, cardiac conditions and diabetes in particular feature regularly;
- the side effects of anti-psychotic drugs, the impact on physical health and the importance of good monitoring

We found that IMAs raised questions about the role of primary care in managing complex mental health service users and in providing care to people in residential and nursing home care.

In the Trust this is where review effectively stops for people with a Learning Disability. If there is no use made of this information source there can't be any systematic learning for this group of people.

IMAs are also the point at which it is possible to identify concerns in other parts of the local system - including in acute and social care. Monitoring information from these reports has the potential to identify, for example, safeguarding concerns, training requirements and referral delays.

These assessments if carefully analysed and properly logged provide a clear insight into what services need to improve and potentially how.



Critical incident reviews that are not considered SIRIs provide insight into some of the more systemic issues when an unexpected death occurs. These too should be used to inform learning. At the moment only the Trust sees these reports as they do not get reported externally. Learning from these should also be carefully logged and analysed for trends. Some CIRs highlight multi-agency issues and should be shared with commissioners. We highlight some unexpected deaths of people with Eating disorders, for example, where there is a need to bring physical care and psychological care together.



Serious Incidents and homicide investigations attract the most attention. Homicide investigations are often more detailed multi-agency reviews but are uncommon. Logging local learning from serious incidents highlights some of the most urgent actions needed and in our review also demonstrate repeat issues which require concerted effort to change. For example, risk assessment, care planning and capacity concerns including referral difficulties, and lack of timely service response. Logging and implementing change from these incidents is important for the insight it brings into local care and delivery problems. They tend to focus largely on the Trust care and delivery problems as distinct from the wider difficulties picked up in IMAs and CIRs and therefore looking only at SIRIs can potentially limit insight into what needs to change over the longer term more widely.

In order to secure a detailed picture of family involvement in investigations - a key area for improvement each template at IMA, CIR and SIRI provides a section for documenting family involvement. This structure should be used to gather and use this information for monitoring improvement.

Detailed Findings

RiO analysis of all deaths

The total deaths in the Trust reported to us by the Trust are broadly consistent with those provided through the ONS for the latest available information and can be relied upon as a list of all Mental Health and Learning Disability NHS service user deaths but does not include TQ21 information.

However, the Trust did find difficulty in providing a consistently accurate extract of all Mental Health and Learning Disability deaths including when the two RiO systems merged in July 2015.

Identifying Learning Disability deaths as a subset presented greater difficulties. TQ21 social care deaths are not included in RiO unless being seen by a health care professional.

90% of the deaths are of people over 65 years. 51% of the deaths were of the very elderly - over 85 years.

61 deaths were of people aged 24 or under : 46 in Adult Mental Health services and 15 of people with a Learning Disability. 23 deaths were investigated as Serious incidents in this age group.

The average age of deaths of people with a Learning Disability receiving health care or from TQ21 services was 56 years. The median age of deaths was 59. The reasons for this need to be fully understood.

ONS-MHMDS and RiO comparison - triangulating the dataset.

10,296 people were reported by RiO as having died (and had been in contact with the Trust's Mental Health or Learning Disability services in the preceding 12 months) during the period. The numbers of deaths per year are shown below with the available information from ONS for the same year.

We triangulated the information from the Office of National Statistics (ONS) data with the RiO data. We requested information from a new experimental data linkage between ONS and the Mental Health Minimum Data Set (MHMDS). ONS data is only available for 2011/12 and 2012/13 at present. We were able to reconcile sufficiently closely for the year 2012/13 with the deaths reported to us from RiO to be confident that the RiO extract from the Trust was reasonably accurate. (There were national changes to the data collection instructions in 2012 which meant the 2011/12 data was not as comprehensive and therefore not as readily reconcilable). This provided us with reassurance that the RiO data provided below was largely accurate.

Year	No of deaths recorded on RiO	Office for National Statistics (ONS)
2011/12	2347	1860
2012/13	2703	2800
2013/14	2648	-*
2014/15	2598	-*
Total	10,296**	

Figure 34: deaths reported to RiO compared to those recorded as deaths by provider from the Office of National Statistics *not yet available ** these figures do not include social care only TQ21 deaths

Creating the RiO dataset

We requested an extract of all deaths from 1st April 2011 to September 2014 where the service user had been in contact with services in the 12 months prior to their death. Subsequently, we then requested a further dataset from 1st October to 16th March 2015. We amalgamated these extracts to create a full dataset.

This resulted in the identification of 9653 deaths. However, in August 2015 the Trust provided slides from a workshop held for Commissioners which stated significantly more 2014/15 deaths than had been provided to us to date. We requested an updated extract for 2014/15. Further enquiry and data matching identified several issues:

- The new dataset was overstated due to double counting post a merger of two RiO systems
- We identified patients on the previous dataset that were not on the new extract - this was as a result in part of Learning Disability service users being seen by physical health care services as the last contact and therefore not being picked up in the query
- Some patients were not on the previous extract for unknown reasons
- Some patients were not on the previous extract due to them being at the end of the year and probable delays in the deaths on the national spine being synchronised

We ultimately agreed the differences between the various extracts with the Trust to create the final dataset from RiO - 10296.

We were also informed that TQ21 patients would not be on RiO. We therefore requested a further extract from local spreadsheets to identify deaths of 24/7 TQ21 service users. We data matched these to be certain of no duplication - 28 were duplications and 10 were not on RiO. We therefore included a further 10 service users in our final total deaths figures.

We recognised that these figures do not include TQ21 service users with 'part-time' provision as the Trust's systems could not provide this information at the time. Therefore the figures stated for Learning Disability service users will be the minimum number that occurred.

Our analysis is, therefore, on the deaths that are on the RiO extract and the additional TQ21 deaths are identified separately where appropriate.

We have therefore made recommendations so that a protocol is developed to ensure future extracts on Learning Disability deaths and Mental Health deaths are accurate for further mortality review purposes.

RiO deaths analysis

The age of all health care Mental Health and Learning Disability service users at death is shown below. The average age was 81 years with a median of 85 years.

All deaths		
Age	Number	%
15-24	61	0.6%
25-34	93	0.9%
35-44	180	1.7%
45-54	262	2.5%
55-64	430	4.2%
65-74	893	8.7%
75-84	3094	30.1%
85+	5283	51.3%
	10296	

Figure 35: Age bands of all deaths recorded on RiO

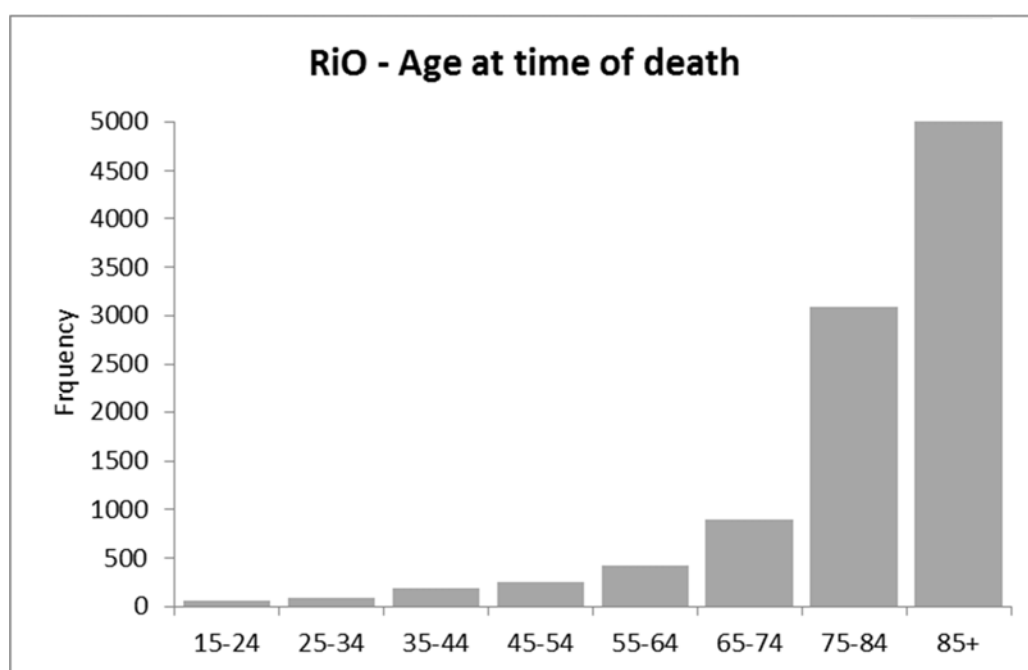


Figure 36: Age of all Mental Health and Learning Disability service users at time of death April 2011-March 2015

Active Caseload

65% of the service users were on an active caseload (seen in last 3 months) based on last appointment recorded on RiO. In Learning Disability this rose to 70%.

Deaths of the very elderly - 85 years and older

The number of deaths of the very elderly is a significant proportion of the caseload. Of the 5283 deaths of the very elderly, 60% were actively being seen (defined as a last appointment in the 3 months pre death or between appointments) and 79% had been seen in the previous 6 months in total. Only 21% appear to have been not actively in touch with services as they were not recorded as being seen for at least 6 months pre-death.

Deaths of young people

61 people under the age of 24 died during this period.

There were 46 young people being seen by Mental Health services and 15 had a Learning Disability.

Age analysis of deaths of service users in Learning Disability services

	RIO	TQ21	All	%
15-24	15	0	15	4%
25-34	18	1	19	6%
35-44	44	1	45	13%
45-54	45	0	45	13%
55-64	109	1	110	33%
65-74	71	3	74	22%
75-84	24	2	26	8%
85+	1	2	3	1%
	327	10	337	100%

Figure 37: The age bands of all deaths of service users with a Learning Disability

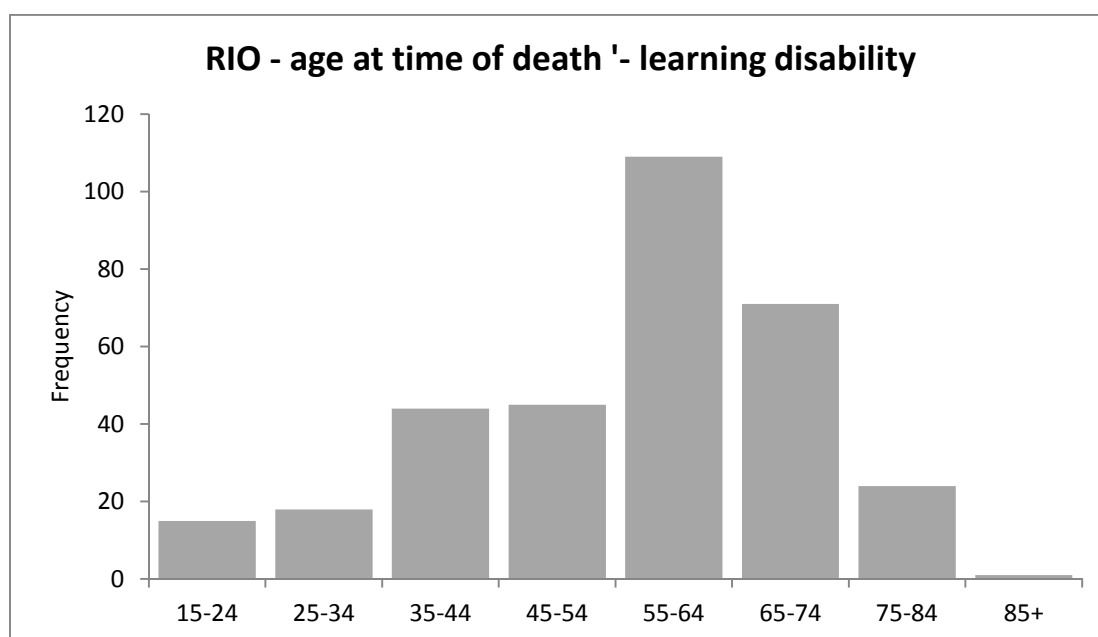


Figure 38: Age band at time of death of RiO health service users with a Learning Disability

People with a Learning Disability are dying much younger compared with the average age of total deaths in RiO. This is consistent with findings in the CIPOLD review.

The average age of death of the total Learning Disability group was 56 years; the median age was 59 years old. It is not possible without individual case review to know the extent to which this group of service users were of a higher level of dependency than that of the CIPOLD cohort. It is possible that they were more dependent given the need for therapy and nursing care - 70% of the caseload had been seen in the previous 3 months and 30% in the preceding week. More analysis and investigation needs to be undertaken and the data shared with the CIPOLD team.

Mean and median ages at death of service users with a Learning Disability at the Trust.

	Number of deaths	Mean age (average)	Median age
Mazars review	337	56	59

Mean and median ages at death of Learning Disability service users over 18 in the Trust

	Number of deaths	Mean age (average)	Median age
CIPOLD (over 18 deaths)	233	63.18	65

Mean and median ages at death Learning Disability service users over 18 in the CIPOLD study.

Analysis of deaths by area

The geographical analysis has been undertaken on best available information.

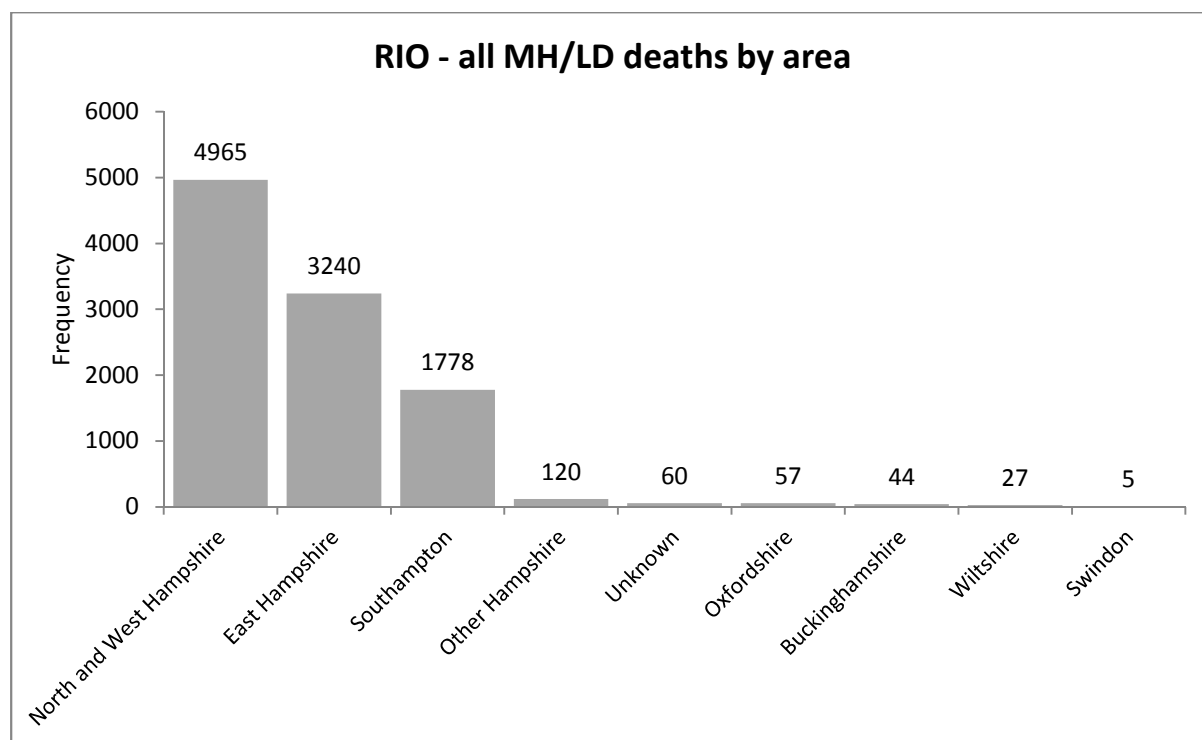


Figure 39: All Mental Health and Learning Disability deaths by area April 2011-March 2015

The graph below shows that the majority of Older People Mental Health deaths occur in the North & West area of the Trust’s Mental Health services.

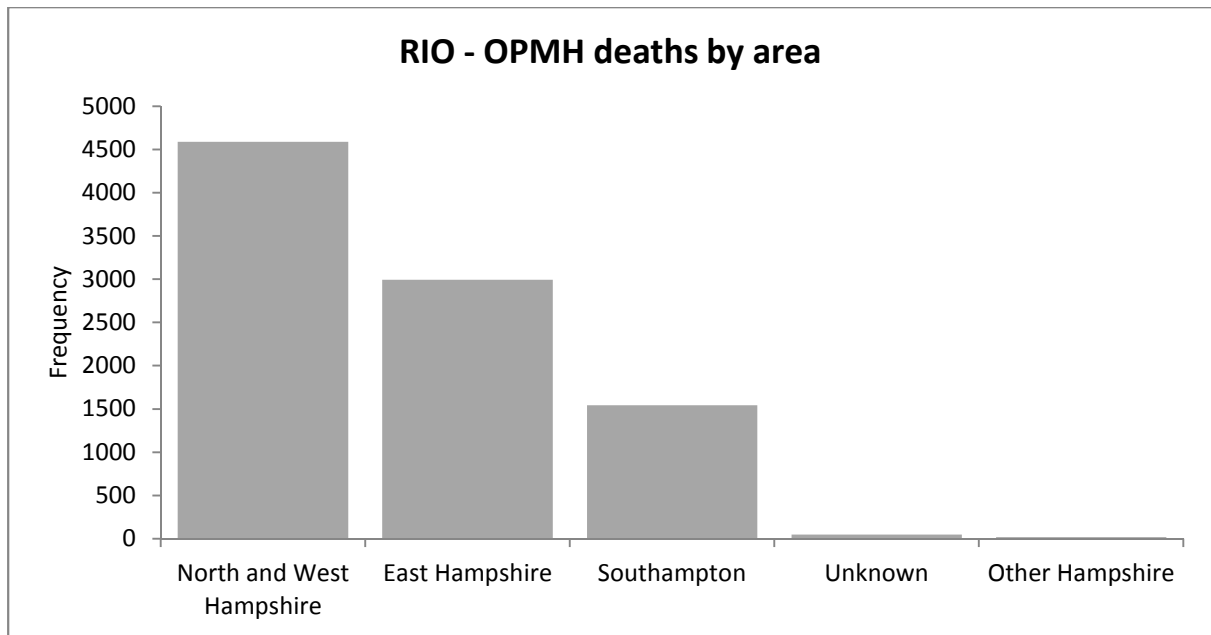


Figure 40: All Older People Mental Health deaths by area

Adult Mental Health deaths present slightly differently with more deaths in the Southampton area in the age group. We have been unable to determine the precise geography for 98 other Hampshire cases.

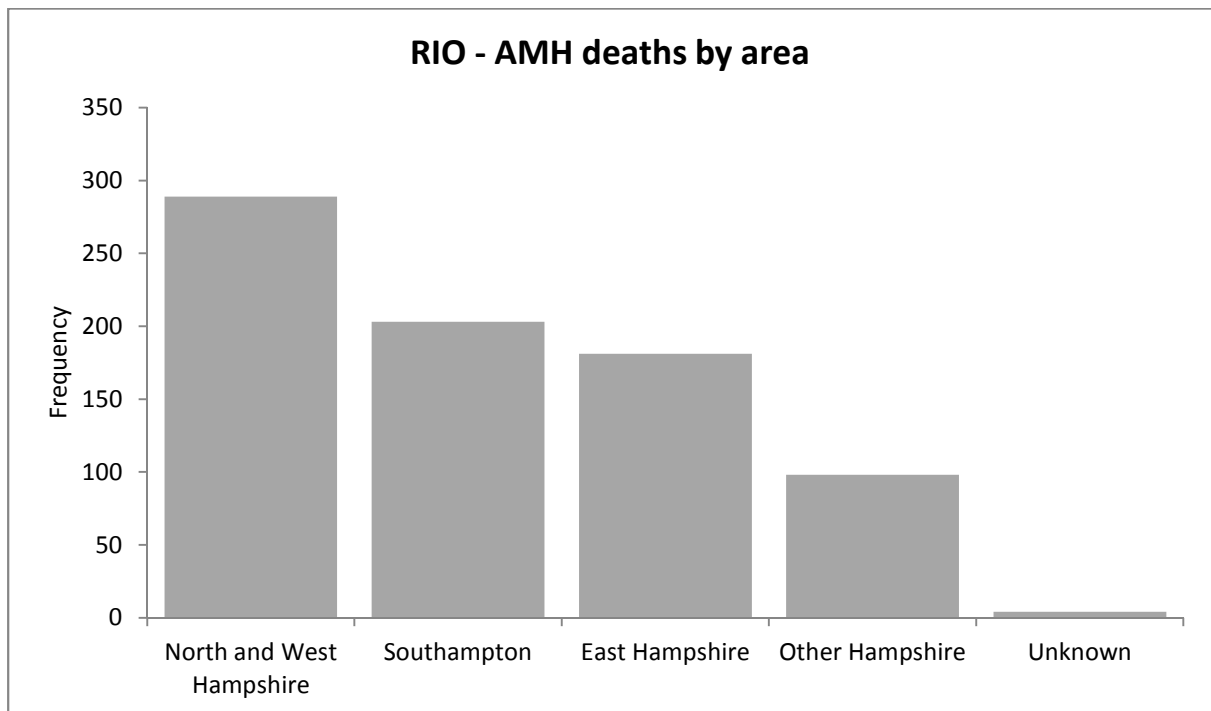


Figure 41: All Adult Mental Health deaths by area April 2011-March 2015

Learning Disability deaths are spread more evenly over the area reflecting the wider coverage of services for these service users. This does not include ten deaths in social care services in TQ21 where there is no health provision.

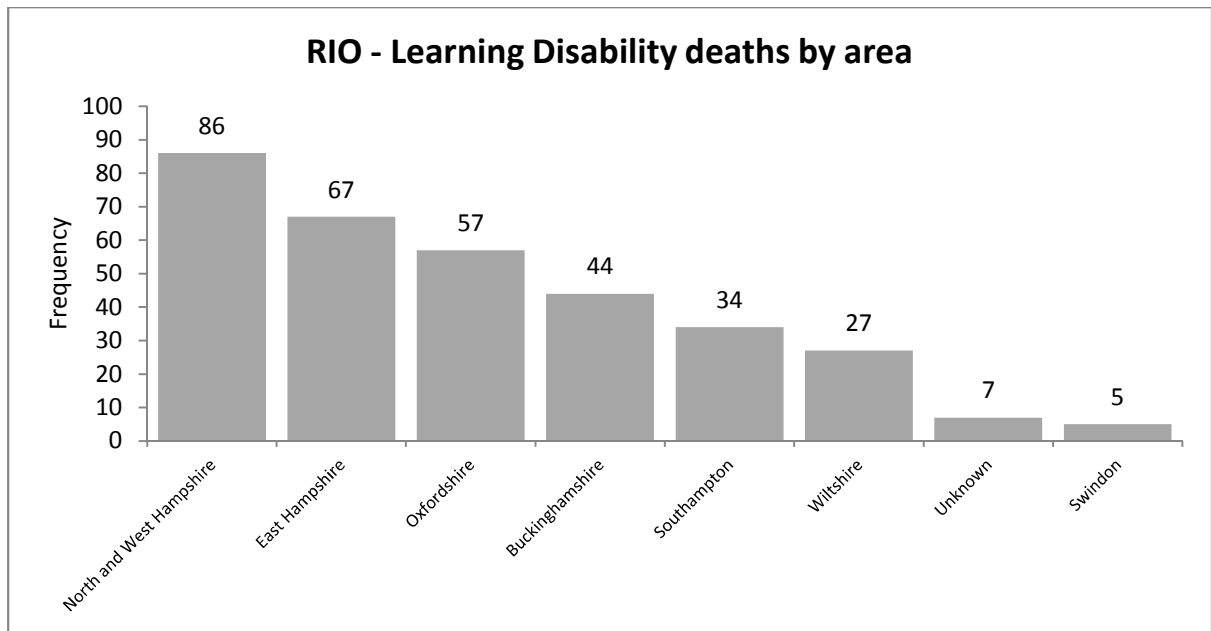


Figure 42: All Learning Disability deaths by area April 2011-March 2015.

Changing practice in reporting deaths to Ulysses over the period of the review

There was a steadily reducing number of deaths reported to Ulysses and then subsequently investigated over the period. The total number of deaths remained largely constant.

There was a change in reporting practice for Older People Mental Health deaths which has led to a marked reduction in reported deaths. At the end of 11/12 fewer deaths began to be reported probably as a result of over reporting expected deaths previously. There has been a continued steady decline since then. This is repeated for reported deaths in Adult Mental Health and Learning Disability.

There was wide variation in reporting practice between divisions.

We analysed the data to see if there had been any change in reporting practice over the last four years.

Total incident reporting

Incident reporting across the Trust has increased slightly. There is clear guidance on reporting to Ulysses in the Trust policy.

The graph below shows the total number of incidents reported over the period. These are increasing. Reported Mental Health and Learning Disability incidents reduced over the period.

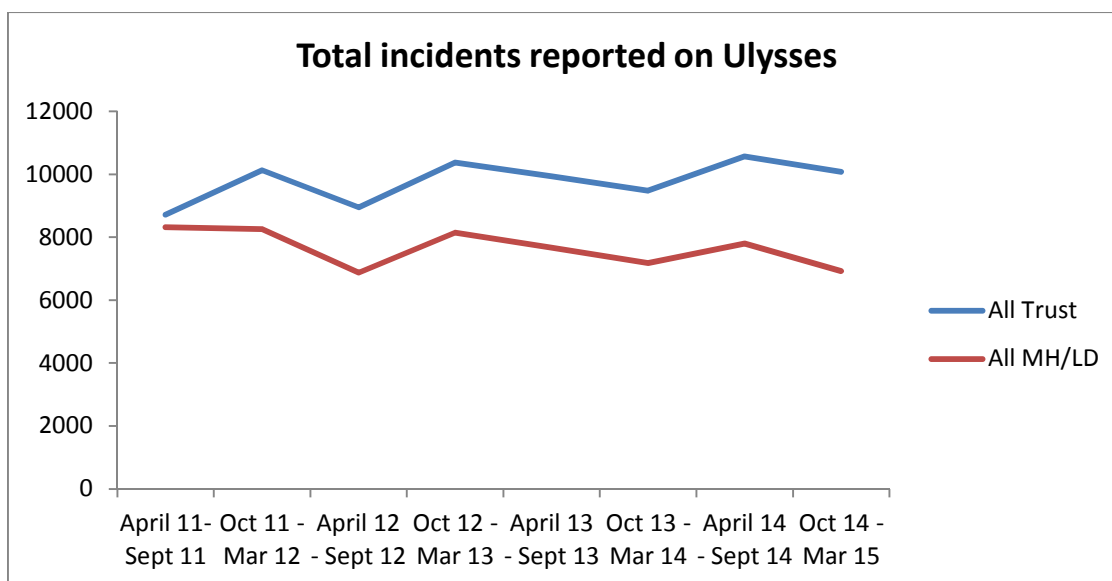


Figure 43: Total incidents for all Trust incidents and Mental Health and Learning Disability incidents April 2011 to March 2015

Nearly 20,000 incidents are reported to the Ulysses system every year across the Trust. Of these upto 70% are patient safety related. In 2014/15 9,973 incidents out of 14,720 incidents were considered patient safety incidents (PSI). They are categorised into actual harm categories. The majority of incidents are categorised as no or low harm categories. The Trust determines the level of categorisation on Ulysses having undertaken various levels of review, assessment or investigation.

The graph below splits the incidents into patient safety incidents (PSI) and non-patient safety incidents (non-PSI) cases. The Trust states the increase in PSI cases is most likely to be as a result of more accurate categorisation of incidents over time. This is because the Trust has undertaken a development programme aimed at categorising incidents more reliably. This programme has resulted in incidents being updated across the whole period of the review so that the graphs below reflect updated information following changes made by this programme.

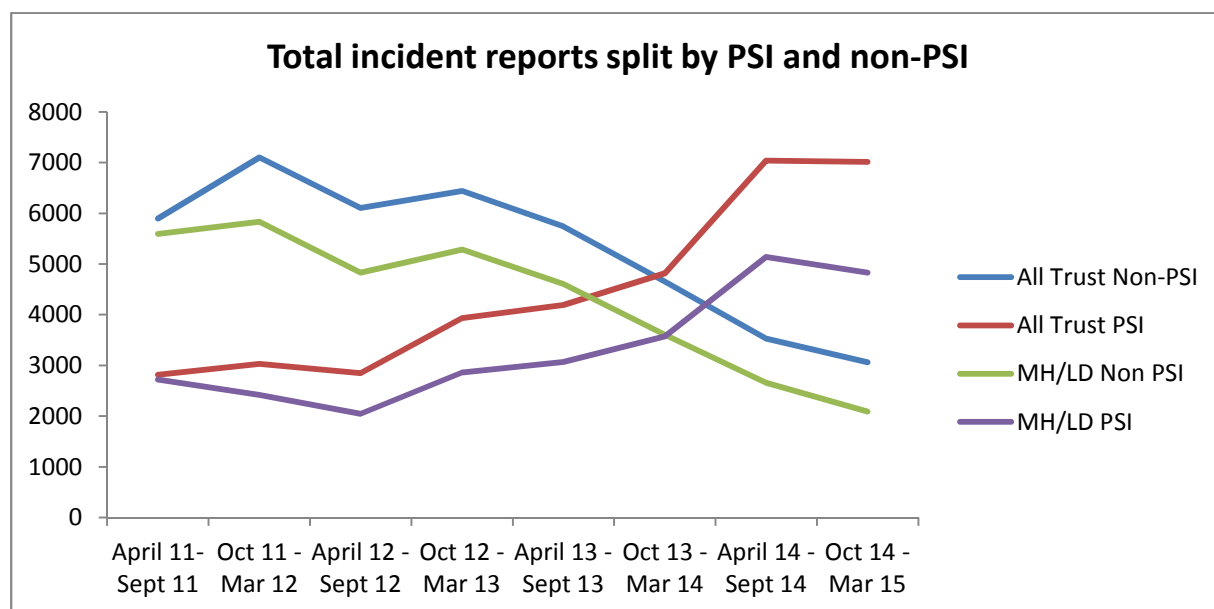


Figure 44: The total number of incidents reported across the Trust for all categories and all services compared with all incidents for Mental Health and Learning Disability April 2011-March 2015.

As can be seen in Figure 44, partly due to changing management and classification of the data and staff reporting practice, the number of incidents classified as patient safety incidents as opposed to non-patient safety incidents has increased. The incidents in Mental Health and Learning Disability show a similar trend as for the whole Trust as it makes up a large proportion of all the incidents reported.

As can be seen in Figure 43 below the number of Mental Health and Learning Disability deaths reported are very small compared with total incidents. It would be expected that there would be a small number of deaths reported as a proportion of all incidents. For the Trust death reports are a little over 1% of all Mental Health and Learning Disability incidents.

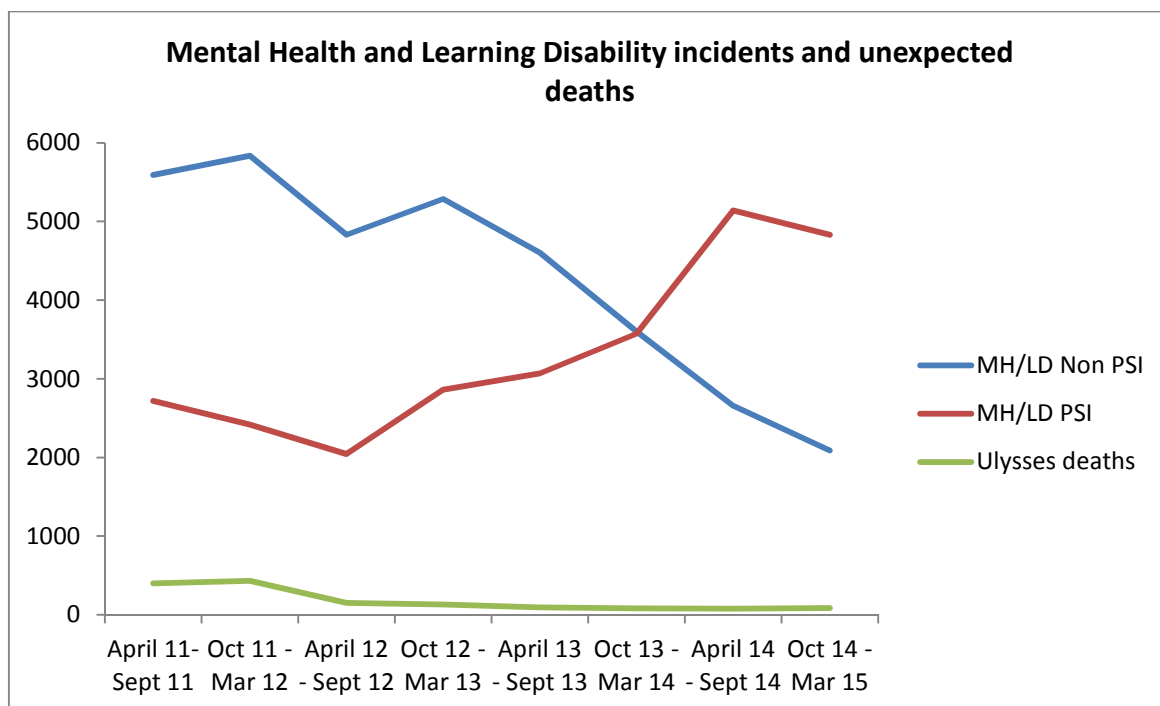


Figure 45: Mental Health and Learning Disability patient safety incidents compared with reports of deaths April 2011-March 2015.

Deaths reported on Ulysses

Year	OPMH	AMH	LD
2011/12	657	122	51
2012/13	112	118	53
2013/14	29	116	31
2014/15	33	108	22
	831	464	157

Figure 46: Number of deaths reported to Ulysses by group by year.

It is apparent that there is a reduction in the number of deaths reported to Ulysses in all groups across the last four years which is marked in Older People Mental Health services and Learning Disability.

There is a particularly marked change in practice at the end of 2011/12 in reporting of Older Peoples deaths with a steady decline since. There is limited documentary evidence to explain why such a marked change has occurred in February 2012. The Trust state this is due to no longer reporting palliative care cases.

The 2011 Trust policy states that all expected deaths in AMH, Specialised Services, Learning Disability and TQ21 as well as OPMH inpatients should be reported and have an IMA. Had this occurred in line with Trust policy at the time we might have seen a larger number of expected deaths reported to Ulysses and a higher number of IMAs in line with the policy.

The 2012 Trust policy changed these guidelines so that only unexpected deaths were reported and this meant that expected deaths should not be reported to Ulysses as an incident. The policy came

into effect in August 2012. Although as can be seen in the figure below this change appears to have taken effect from February 2012 - 6 months before the policy was issued.

This had a marked effect on the number of Older People deaths reported to Ulysses and now only a very small minority of deaths of people over the age of 65 are reported as incidents. See Figure 47 below.

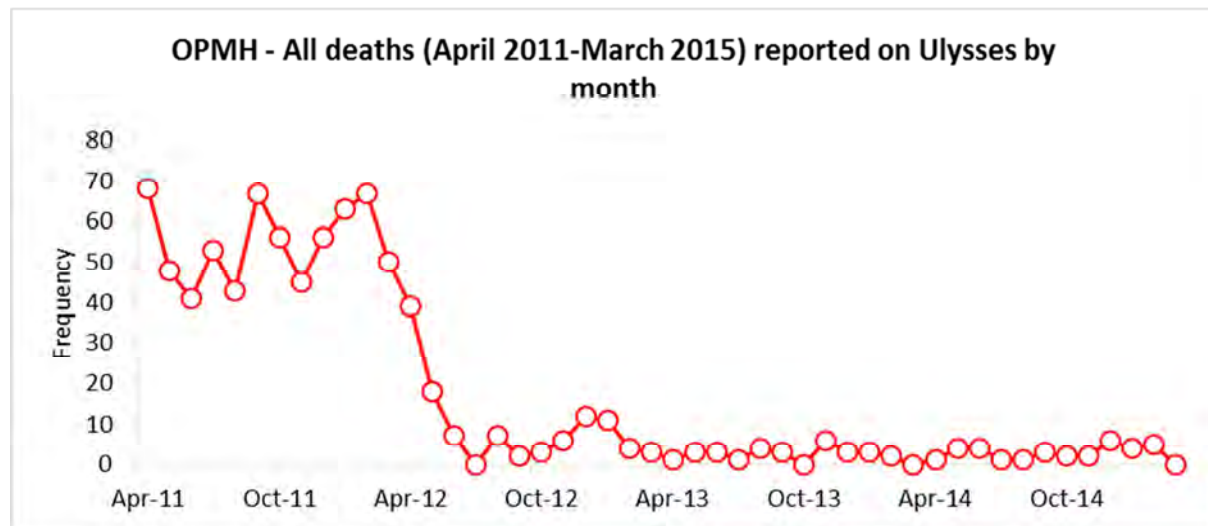


Figure 47: All OPMH deaths reported to Ulysses by month (April 2011-March 2015)

In Adult Mental Health there has been a slight but steady (11%) reduction in all deaths being reported.

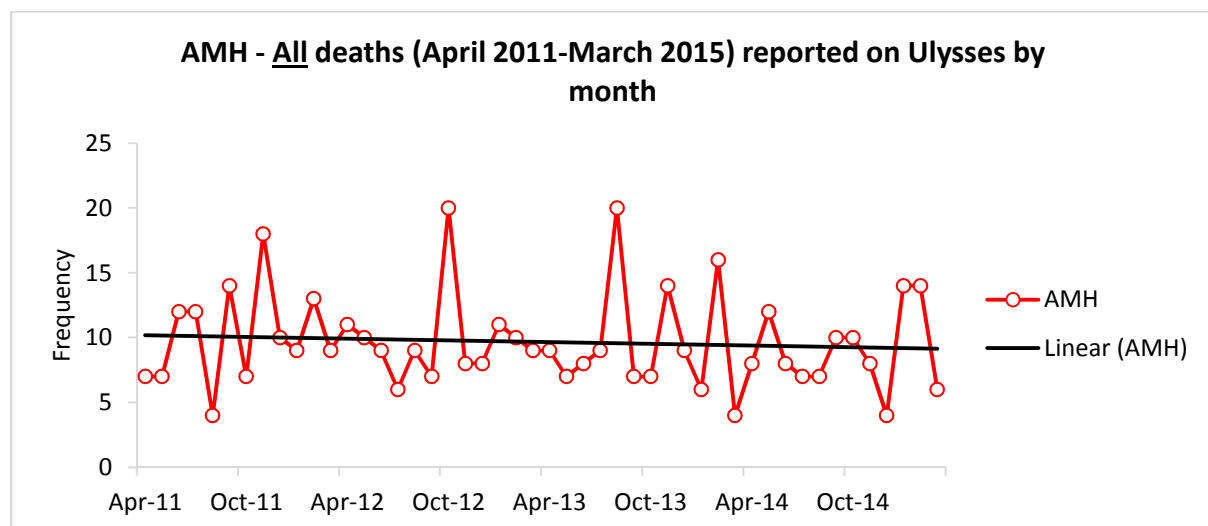


Figure 48: All AMH deaths reported to Ulysses by month (April 2011-March 2015)

However, in Figure 49 based on the Trust’s categorisation of all the Ulysses reports of expected and unexpected deaths the number of Adult Mental Health deaths categorised as unexpected has increased slightly. This would appear to be consistent with the overall practice of categorising incidents as outlined earlier. i.e. that expected deaths are no longer being reported for Adult Mental Health. This may be an indication of better categorisation.

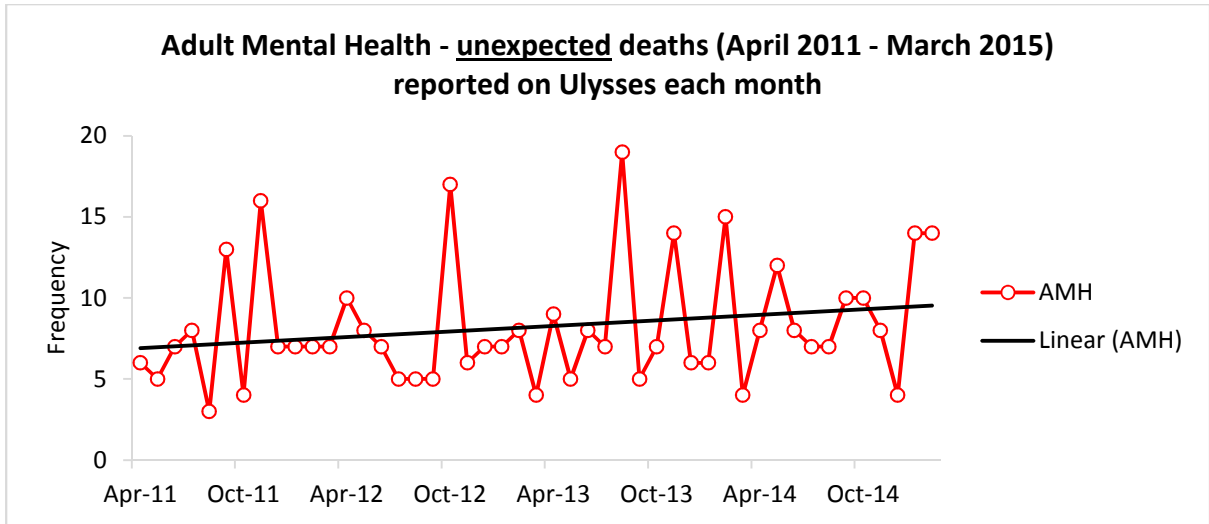


Figure 49: All Adult Mental Health deaths categorised as unexpected on Ulysses by month (April 2011-March 2015)

In Learning Disability, there has also been a reduction in the number of deaths being reported to Ulysses of 57%. Less than half the number of Learning Disability deaths were reported to Ulysses in 2014/15 as there were in 2011/12 despite the Trust acquiring Ridgeway services. See Figure 50 below.

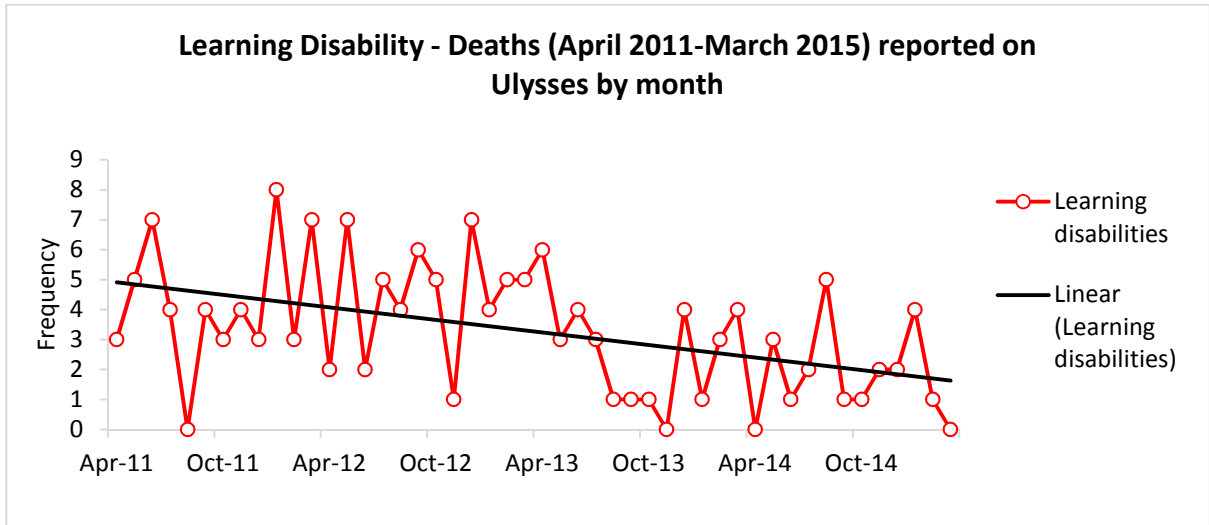


Figure 50: All Learning Disability deaths reported to Ulysses by month (April 2011-March 2015)

Over the four years however, SIRI numbers have remained largely constant. It appears that the Trust is nearing the situation where only unexpected deaths that are likely to be investigated are reported onto Ulysses in the first place.

Getting this part of the reporting process right is important in ensuring that deaths incidents are identified and that the deaths are ultimately reported to CQC or NRLS where appropriate, as well as providing information for board assurance.

Ulysses analysis of all deaths reported as incidents

1454 deaths were reported to Ulysses over the period. After the Trust categorised these through incident reporting processes about half (722) were categorised as 'unexpected'.

70% of Older People Mental Health deaths were expected and the majority were reported in 2011/12. It is not possible to say if these deaths were categorised correctly.

The Trust has undergone a development programme relating to the local risk management system (Ulysses) which has resulted in significant changes to the identification of patient safety related incidents, increased reporting and changes to the actual impact grading given to each case.

As a result the nationally reported data has been updated and the number of deaths reported as Category 5 (under the 'degree of harm death' category) has reduced. Alongside this we understand the changes have not been discussed with the NRLS team and there are therefore considerable differences arising between the number of deaths categorised as Category 5 in the Ulysses system and those currently reflected in the NRLS database. This needs further investigation as the reporting of deaths to CQC is fulfilled through uploading incidents to the NRLS. We describe the concerns below.

Deaths are often classed as being no harm incidents in line with NRLS guidance, as no safety incident, act or omission was considered to have occurred by the Trust. However, given the poor quality of investigations noted in this report over this period and the weak governance processes in the categorisation of deaths retrospectively this cannot be relied upon as accurate. This needs to be reviewed and a full audit trail kept of the decisions to make amendments in order that a more accurate picture of harm relating to deaths emerges. Some deaths were categorised as too low an impact.

The table below shows the actual number of Mental Health or Learning Disability deaths reported to Ulysses. Reported incidents of deaths have reduced over the period:

		Ulysses
2011/12	1/4/2011 - 30/9/2011	399
	1/10/2011 - 31/3/2012	432
2012/13	1/4/2012 - 30/9/2012	151
	1/10/2012 - 31/3/2013	132
2013/14	1/4/2013 - 30/9/2013	93
	1/10/2013 - 31/3/2014	83
2014/15	1/4/2014 - 30/9/2014	79
	1/10/2014 - 15/3/2015	85
Total		1454

Figure 51: The number of deaths reported to Ulysses April 2011-March 2015

There were 1454 deaths reported onto Ulysses over the period as at March 2015. We have discussed the change in reporting practice over the years in the previous chapter. The number of deaths reported by each division are shown in Figure 52 below.

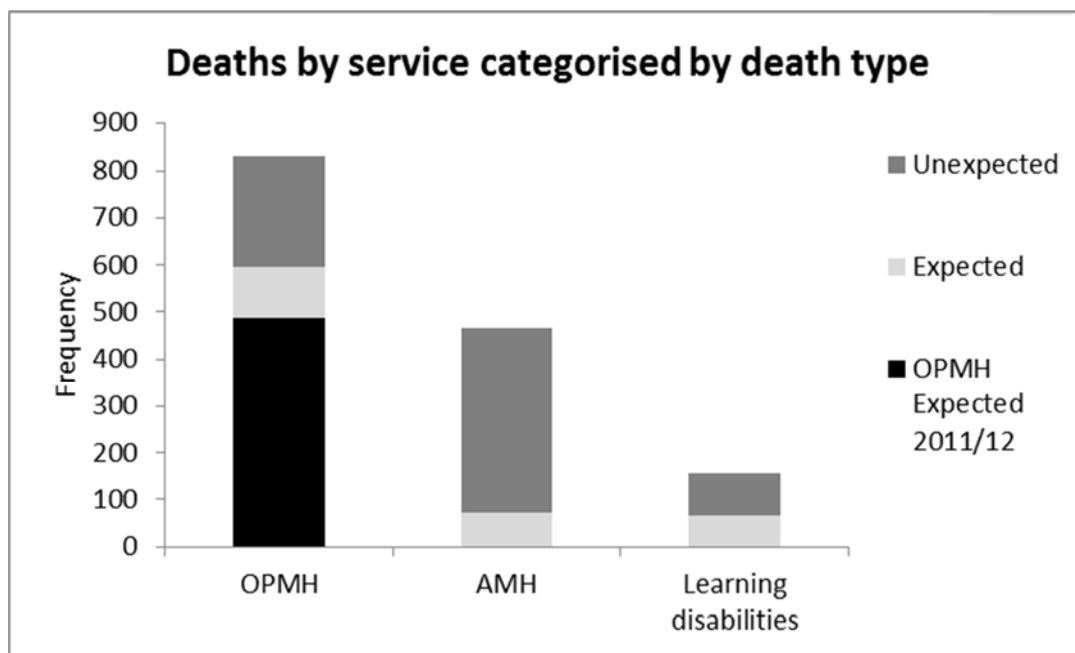


Figure 52: Number of deaths by division split by expected or unexpected category

Older People Mental Health services reported most deaths with 70% expected:30% unexpected. The reported deaths since 2011/12 reduced significantly - these are indicated in the figure above. Adult Mental Health deaths were more likely to be reported and more likely to be reported as unexpected. Amongst Learning Disability deaths, 87 of the 157 reports were classed as unexpected in the extract we received.

A further breakdown by incident type shows that of the 722 deaths ultimately classed as being 'unexpected', 346 deaths were classed as unexpected natural causes; 123 as confirmed suicides and 19 as possible suicide (116 suicides were investigated as SIRIs).

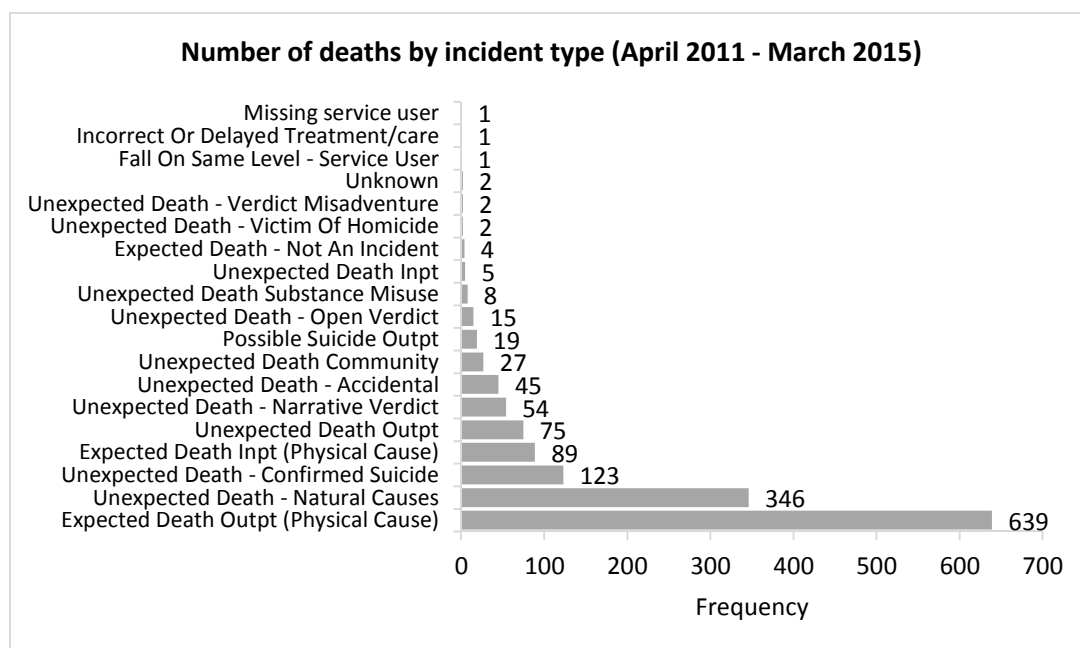


Figure 53: Deaths between April 2011 and March 2015 as categorised by type of incident.

Deaths are graded as red severity (and occasionally amber) and graded as actual impact 'Category 5' and 'unexpected - under investigation' initially based on the actual harm to the service user. This is ultimately then re-graded once more information becomes available.

Death incidents are finally graded as one of five categories:

Actual Impact
1 No Harm / Damage / Loss
2 Low / Minimal Harm, On-Site First Aid
3 Moderate, Medical Treatment/Short Term Harm
4 Major, Permanent/long Term Harm
5 Catastrophic / Death
Grand Total

Figure 54: Actual impact grades on Ulysses (Full definitions in Appendix 14)

The graph below shows the resulting actual impact grading as at April 2015 from the extracts provided to us. Few Ulysses incidents relating to unexpected deaths were classified as a Major (4) or Catastrophic (5) incident.

The categorisation is important for external reporting.

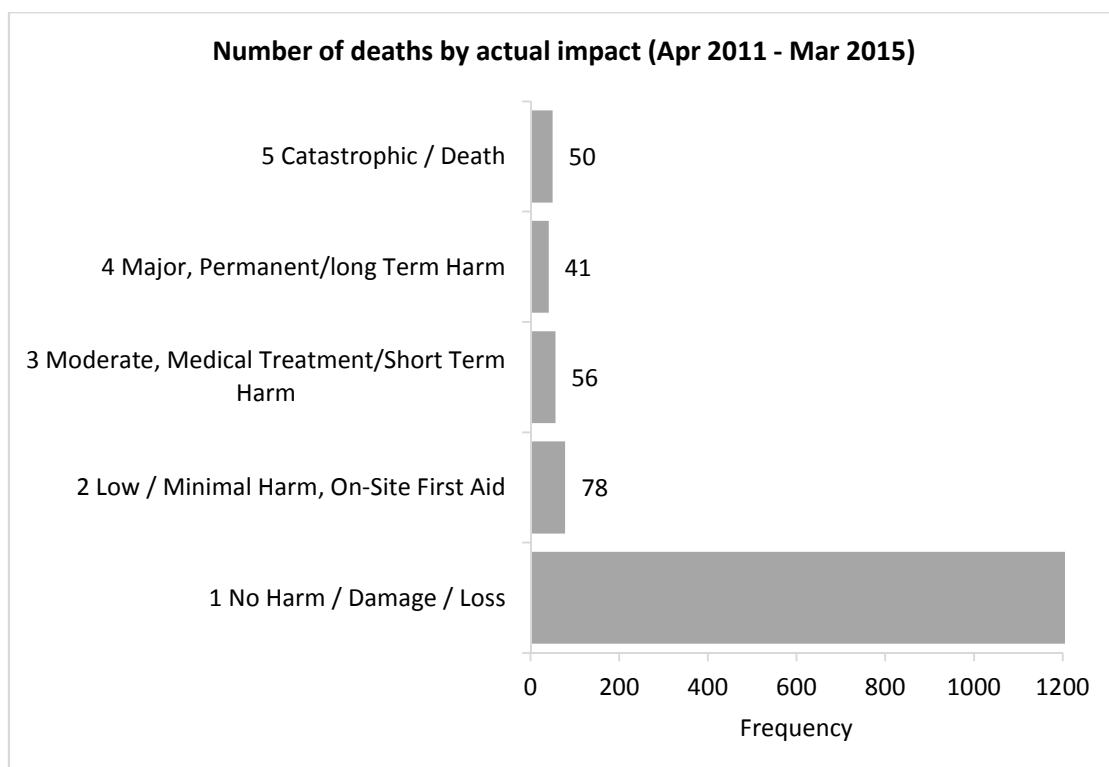


Figure 55: All deaths reported to Ulysses by impact grading as at April 2015.

The process for ultimate grading is important as it informs a number of incident reports internally and externally.

Reporting on local risk management systems (Ulysses) must be accurate as the data is uploaded to the National Reporting and Learning System. This system feeds three things:

- The local reporting of deaths and is the basis for the decision-making for CIR and SIRI investigation as well as board reporting on unexpected patient deaths
- The reporting of patient safety incidents (the original use for NRLS); and
- The reporting of deaths under Regulation 16 of the Care Quality Commission (Registration) Regulations 2009.

There was extensive change to these local gradings; as evidenced by the 111 degree of harm death NRLS reports that were originally submitted to NRLS being changed to only 11. The Trust stated that there were now not as many and provided an updated list as at August 2015 for all incidents categorised as Category 5. There were a total of 11 deaths in Category 5 of which 8 are Mental Health or Learning Disability deaths.

Death categories on local risk management systems are mapped to degree of harm categories on the NRLS and therefore may not be exactly the same but the NRLS team have confirmed that this was the case in 2010 but no confirmation work has taken place with the Trust since then. The Trust states the mapping remains the same.

Degrees of harm in NRLS:

NRLS Degree of harm*:
B : Low (Minimal harm - patient(s) required extra observation or minor treatment)
C : Moderate (Short term harm - patient(s) required further treatment, or procedure)
D : Severe (Permanent or long term harm)
E : Death (Caused by the Patient Safety Incident) (Any unexpected death or unintended incident that directly resulted in the death of one or more persons. The death must relate to the incident rather than to the natural course of the patient's illness or underlying condition).

Figure 56: Degree of harm categories on NRLS

* Appendix 14 for full definitions of all degrees of harm in place from 2004 - Seven Steps to Patient Safety: full reference guidance (NPSA 2004. P.100)

Trusts upload information to the NRLS on a regular basis and every 6 months a report is produced which compares similar organisations (e.g. Mental Health Trusts) and reports back to individual Trusts on their reporting rates. We are informed that the information is not suitable for time based benchmarking and so will not be providing comparisons in this report. This is also discussed elsewhere.

However, we are concerned that there is a significant difference in the data reported publically, that held currently by NRLS and the number of Category 5 cases currently categorised in the Trust's system.

The Trust clearly state that the mapping of Category 5 deaths on Ulysses should be what is reported on NRLS under the 'degree of harm death' category and that major harm incidents map to 'severe degree of harm'.

The Trust states it has reported the following subset of death to the NRLS (and therefore the CQC) for all deaths:

Actual Impact	Count of Incident Number
1 No Harm / Damage / Loss	149
2 Low / Minimal Harm, On-Site First Aid	51
3 Moderate, Medical Treatment/Short Term Harm	52
4 Major, Permanent/long Term Harm	44
5 Catastrophic / Death	11
Total	307

All deaths by Category from Trust at 2.11.15

Actual Impact	Count of Incident Number
1 No Harm / Damage / Loss	132
2 Low / Minimal Harm, On-Site First Aid	47
3 Moderate, Medical Treatment/Short Term Harm	47
4 Major, Permanent/long Term Harm	41
5 Catastrophic / Death	8
Total	275

MH/LD deaths by Category from Trust at 2.11.15

Figure 57: Classification of all deaths and Mental Health deaths by actual impact grade on Ulysses that the Trust states were reported to CQC via NRLS

As can be seen 307 deaths were reported with 275 (90%) being Mental Health or Learning Disability deaths.

The number of deaths reported publically (across each 6 month period reported in the period) stated that there were 111 incidents reported as 'degree of harm death'. We expected this number to reduce a little due to finalising investigations and we requested the current data on the NRLS system for all death categories for the same period from the NRLS. The table below is therefore the most upto date information available to NRLS to match the most upto date information on the Trust's Ulysses system.

Financial Year	Number reported as 'Death'
2011/12	25
2012/13	12
2013/14	4
2014/15	7
Total	48

Figure 58: Number of deaths on NRLS under 'degree of harm death' category on November 2015 by financial year

There are a number of observations:

- The number of cases categorised as ‘degree of harm death’ has reduced over the period.
- The Trust state only 11 deaths should be ‘degree of harm death’ but the NRLS system is showing 48.
- If the Trust Board requested the numbers of deaths on Ulysses in Category 5 there would be only 8 Mental Health and Learning Disability deaths reported.
- The Trust has used the benchmarking from the NRLS in the Quality Improvement and Development Forum (May 2014) to state that it has a lower proportion of ‘degree of harm death’ incidents than its peers and nationally - this may not be an accurate reflection.
- A definitive number of deaths under ‘degree of harm death’/Category 5 can not be provided without further work between the NRLS team and the Trust.

The vast majority of deaths are graded as having no harm. These do not get reported to the NRLS as patient safety incidents but they do reflect in the CQC figures.

We have concerns that during the period of the review categorisation has not been robust, that re-categorisation through the development programme has had an impact or that the interpretation of degrees of harm may also be limited. We reviewed a number of deaths that were classed as less than Category 5 and it is clear that the categorisation should have been higher in some cases. There has been a significant change in the last four published reporting periods as indicated below. The latest published reporting period saw a sudden spike in ‘severe harm’ reports and no ‘degree of harm deaths’.

Period	Deaths	Severe harm	Rate all incidents per 1,000 bed days	Rate all incidents per 1,000 bed days (median) all other Mental Health Trusts
April 13 - September 13	16	36	21.45	26.37
October 13 - March 14	1	11	25.03	26.71
April 14 - September 14	7	41	48.38	32.82
October 14 - March 15	0	122	65.84	31.1

Figure 59: Incidents reported by Southern Health and the rate of all incident reporting alongside the national median as reported by NRLS

Increased incident reporting is often a sign of a good reporting culture and is considered to be preferable to under reporting. However, we are of the view that the Trust categorises and reports very few deaths in the death categories and less than we would consider appropriate having read 540 death reports.

Geography and location of deaths

We analysed Ulysses and broke down the deaths by area. The categorisation is based on the best available information. It is important to note that these are absolute numbers and do not denote higher or lower rates of deaths in each area.

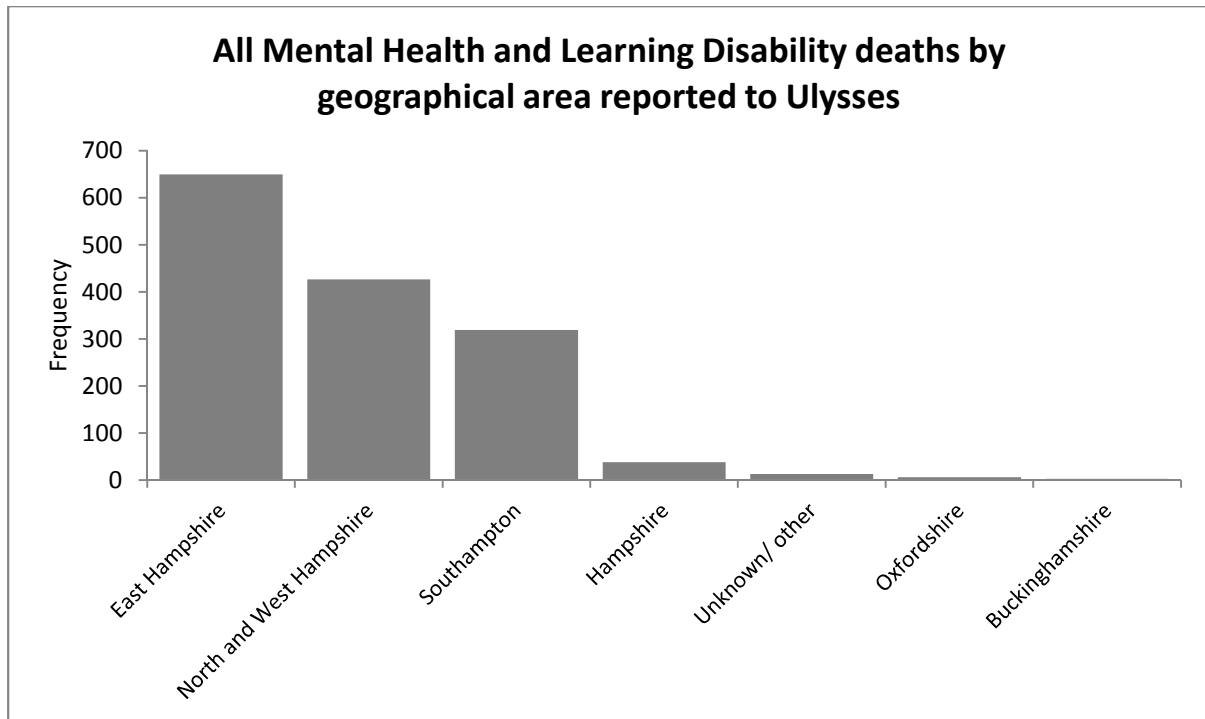


Figure 59: All deaths reported to Ulysses by area

The East Older People Mental Health services reports 70% of the reported deaths to Ulysses which is consistent with the number of total deaths. 50% of deaths in the North and West are Older People. Only 22% of reported deaths in Southampton are Older People. See figures 55 and 56 below.

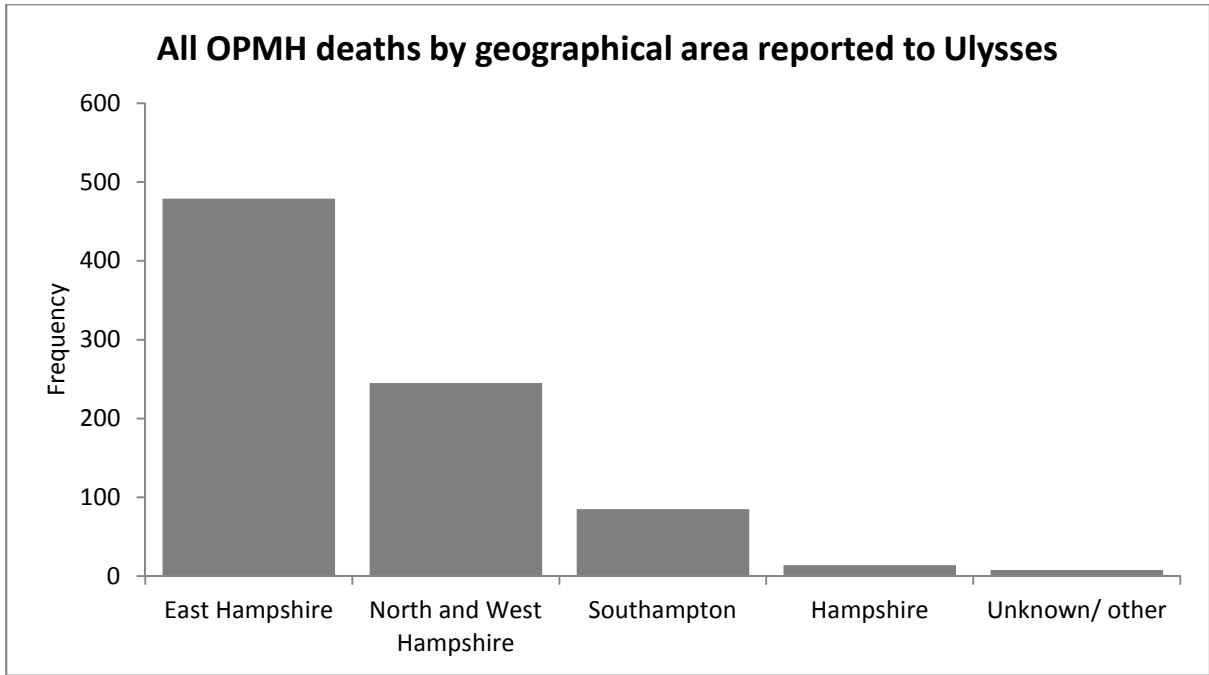


Figure 60: The number of Older People Mental Health deaths reported by area.

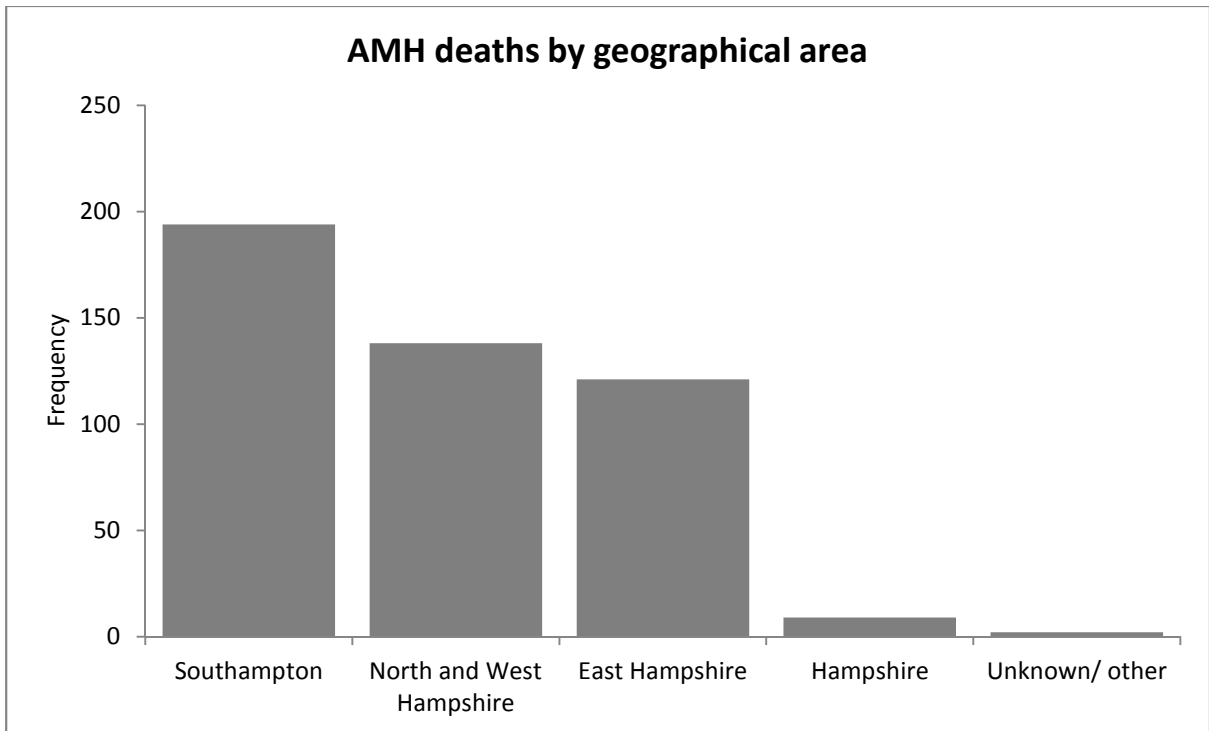


Figure 61: The number of Adult Mental Health deaths by area

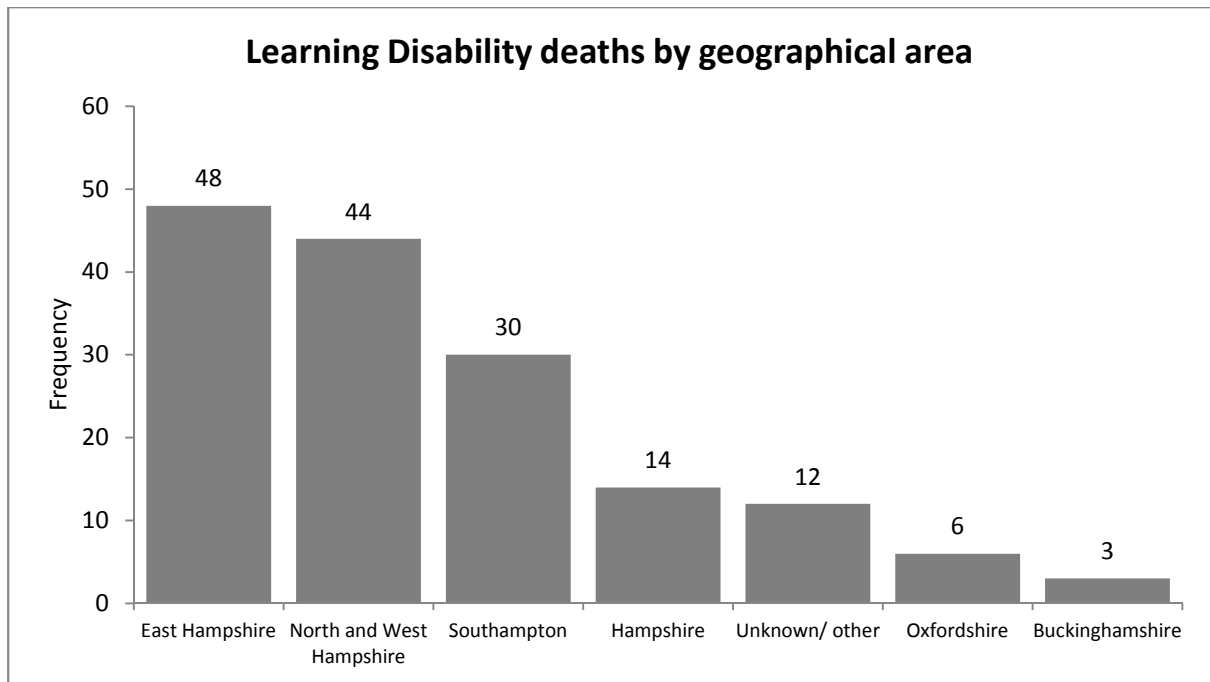


Figure 62: The number of Learning Disability deaths reported to Ulysses by area including TQ21.

Reporting practice appears to vary across divisions and geographical areas. The number of deaths reported to Ulysses in the Oxford and Buckinghamshire areas compared with the number of deaths on RiO is very low. Only six deaths from the Oxford area were reported with five being unexpected compared with 57 deaths on RiO; three in Buckinghamshire compared with 44 deaths on RiO. This compares, for example, with the East where 67 were on RiO, 48 reported to Ulysses and 33(half) were reported as unexpected.

Deaths by location

We analysed deaths by location. There were many locations logged on the Ulysses system; the graph below shows the locations where more than 30 deaths were reported over the period. These are typically service users of Older People Community Mental Health teams.. There were 61 deaths of service users of the Southampton Community Treatment Team (more than in the adult mental health teams elsewhere in the Trust though this might just be a consequence of the size of the service”

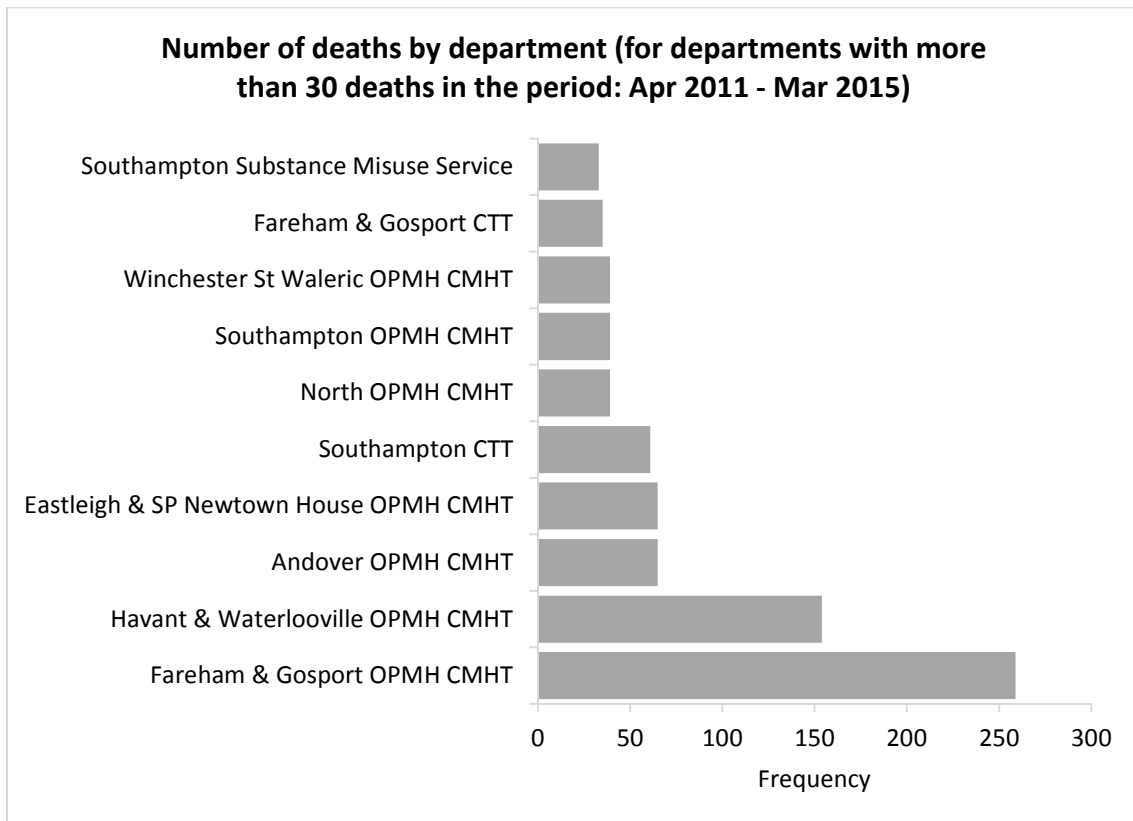


Figure 63: Departments reporting more than 30 deaths to Ulysses April 2011-March 2015.

The free text information within the Ulysses reports as a whole provides an insight into themes that the various categorisations do not. We reviewed the information in all 1454 cases. There were cases that on the face of the information provided should have had at least an IMA. The information is limited but sometimes staff provide a detailed account of their concern relating to the incident that is reported to them.

We reviewed the Ulysses reports relating to people with a Learning Disability. There were cases that raised cause for concern based on the information provided or for which there was no IMA or further investigation. We asked for all relevant IMAs. The issues we raise however highlight the range of questions that should be asked at this stage and the need for better management of the process for further review or investigation.

Scenario	Mazars observations and wider questions that arise
A service user found deceased despite reporting they were unwell. No GP called or physical health check done.	<p>Whilst this appears to be a social care case health care services were involved.</p> <p>What role had the Trust played in engaging with this service user? Did their staff know there was a problem at any point? What diabetic management services were being provided?</p>
A decision was made that service user would not survive surgery. Person died next day.	<p>What is the Trust role once an incident is reported by staff to them?</p> <p>What is the process for referring to an acute trust or social care for a review of decision-making and care in this case?</p>
Service user received general anaesthetic. Service user was discharged home but became unwell. Person died. Cause of death not yet known or formally identified.	What review is needed regarding the care in the lead up to the need for the anaesthetic in the first place?
Service user was so malnourished that despite attempts at refeeding service user died. The Trust only involved for 1 day.	What is the Trusts role? Who should investigate this? Was the person malnourished in a care home setting?
Service user was found dead by the support team. Service user was found lying on the floor dead with a head wound.	<p>What input did the Trust have to help manage epilepsy?</p> <p>If none was there anything the Trust could have done? Is there a need to ask any further questions?</p>
Service user had complex health needs, severe Learning Disability and dysphagia. Died following complications from a surgical procedure.	What is the role of the Trust in reviewing a case like this? There are several agencies involved.
Service user had difficulty to manage Epilepsy. No inquest held, death natural causes, IMA only, no care/service delivery problems identified. There was no planned post mortem.	Given this sudden death is there a need to review this case to learn and improve good epilepsy care? We were not provided with an IMA.

A further incident which did go to external investigation as a SIRI but which raises concern about the quality of statements on Ulysses:

Service user deceased. "Death did not occur as a result of an incident in our care"	Why was this classed as a case 'not in our care' when this appears to be overnight support by Trust staff ?
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Conclusions:

Most deaths occurred within Older People Mental Health services and half of all reports were 'expected'.

The categorisation of incidents provides the opportunity to analyse deaths to understand if there are trends or themes that should be explored further. However, there is no mechanism for doing this other than reporting the numbers within divisions.

Due to there being so many locations and only a few deaths reported for each location it may be difficult for the Trust to identify themes especially over a short time period unless reviewed on wider geography.

There are a larger number of deaths amongst the service users of the adult mental health teams in Southampton compared to elsewhere in the Trust, though this might be a consequence of the respective size of local services. The free text information within a number of incident reports suggests that there is sufficient cause to justify at least an IMA to be undertaken to ask further questions in some cases. There are cases which are examples of a range of issues relating to aspiration pneumonia, malnourishment and feeding difficulties, epilepsy, diabetic management, decisions not to operate, possible delays in decision-making. Many of these cases are service users from residential and nursing home care who die in acute hospitals. However, the incidents have been reported to the Trust by its staff and there appears to be no mechanism for being sure that someone is investigating or asking questions even if it is not the primary responsibility of the Trust.

Incident reports are a valuable source of information available to the Trust and Divisions. The information is also a valuable source of information for Commissioners but this information is not being used to monitor deaths or mortality across the Trust.

Ulysses reports also provide insight into issues that could be brought to the attention of other organisations e.g. acute providers and social care commissioners. The safeguarding procedure provides the mechanism to do this but requires incidents to be reported appropriately in the first place (not necessarily onto Ulysses). The information in Ulysses does not provide sufficient detail to be assured that all incidents are logged and reported through this procedure.

The mapping of Ulysses to NRLS for public and regulatory purposes needs further investigation to ensure accurate reporting of the most serious incidents of service user deaths in the right categories.

IMA and CIR analysis - Mental Health

There were 278 deaths that were investigated or reviewed but not reported as a SIRI. 202 IMAs and 76 Critical Incident reviews.

There were clear themes arising from these reports that highlighted a range of issues that could form the basis of Board action, further research, audit or multi-agency review.

Deaths relating to alcohol or drug issues rarely get thoroughly reviewed as arrangements for multi-agency investigation are unclear. Often the cause of death is given as a conclusion of natural causes (by the Coroner) and the circumstances do not then constitute a serious incident.

There were cases that should have been reported as Serious incidents or at the very least reported on more widely to inform commissioning intentions or to facilitate improvement of care.

The quality of the IMAs and CIRs was of a generally poor standard. IMAs are not signed off, CIRs tend to be signed off but often remain of a poor standard. Sign off and quality review is not effective.

On the whole multi-agency investigation or review does not occur.

The previous section looked at the total number of deaths reported to Ulysses. A proportion of these incidents were subject to an IMA. We requested all IMAs available for the Adult Mental Health division where these had not been assessed as SIRIs.

Summary of findings:

- Across the Adult Mental Health division there were 202 IMAs and 76 CIRs undertaken. These CIRs were not considered to be SIRIs but required an investigation.
- The quality of many of the IMAs was poor; only 17% showed evidence of sign off.
- There were very few IMAs that showed a clearly documented rationale as to why no further investigation was undertaken.
- 84% of CIRs were signed off by a senior member of staff at Director level.
- The CIRs were also of variable quality.
- There were a number of CIRs that would have merited SIRI status.
- IMA and CIR action plans are not collated formally across the division or corporately and not routinely shared with commissioners.
- The extended IMA was limited in its use; only 24 (12%) Adult Mental Health IMAs had an action plan.
- 12% of CIRs did not have any action plan.
- Many of the IMAs involved multiple agencies caring for an individual and no one organisation took the lead in reviewing the wider circumstances or the possibility of premature death.
- Unexpected deaths that were investigated only at IMA stage showed some very distinct themes.

- Families were involved in only 22% of CIR investigations. Some CIRs appear to have been shared with families though it was not possible to determine with any certainty exactly how many CIRs were shared.

There were 76 CIRs which didn't get reported as SIRIs which meant that there was limited oversight of the lessons learnt and care and delivery problems to commissioners. By CIRs remaining internal to the Trust this limits transparency.

We tracked unexpected deaths through area panels for a 3 month period from August 2014 to October 2014 to establish whether the decision-making process from notification to CIR decision-making was documented.

- There was poor documentation of the rationale for decisions
- There were different processes in place in all three sub-areas of the Adult Mental Health division
- There was a great deal of operational responsibility to manage the SIRI process which has resulted in limited independence and transparency of decision-making.
- Area panels have effectively been responsible for the oversight of the whole process including decisions whether to investigate or not.
- Investigating officers are usually selected from the same area and are not sufficiently independent from the 'Area' team for the review team to be confident that there is sufficient ability to challenge practice. Whilst the argument may be that the areas are the size of many Trusts it has not been sufficiently demonstrated that there is sufficient independence for investigations relating to deaths.

IMA/CIR analysis

Family involvement

IMAs do not include involvement of the family and are not expected to as they are completed in the first 24-48 hours after an incident.

Critical Incident review reports do log the involvement of families and relatives in the investigations as it is the same template as SIRIs.

Assessing all CIR reports provided and collating the evidence within the relevant report we analysed family involvement .

The following analysis shows the limited involvement of families in CIRs. 78% of CIRs did not evidence involvement of families. 22% of CIRs involved families - 17 cases. Of the remaining 59 only two declined; 57 were either not contacted or not involved.

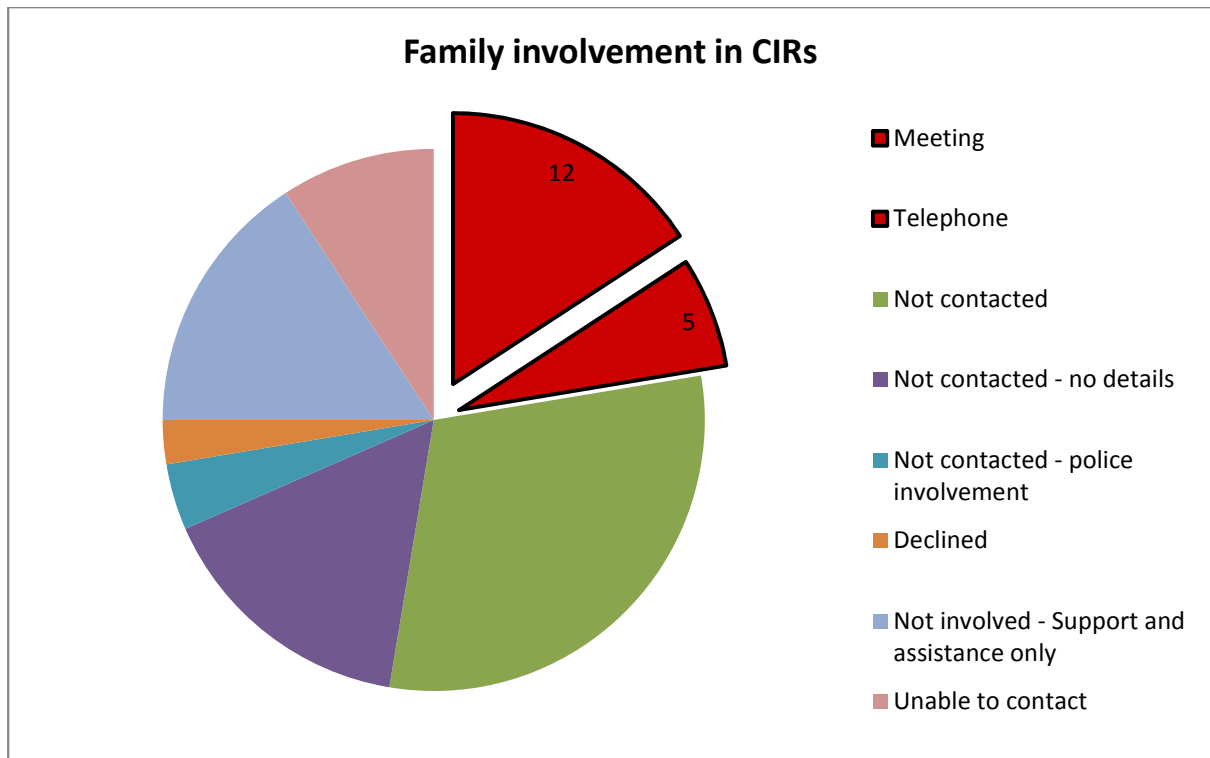


Figure 64: Family involvement in non-SIRI Critical Incident Reviews

There is little evidence that families are engaged to any significant degree in the investigations into the circumstances of unexpected deaths that are subject to CIRs or become SIRIs. This is not in accordance with the Trust’s own policy/national guidance as recommended by Being Open and latterly Duty of Candour.

Themes:

- The age range in the IMAs and CiRs was 18-89

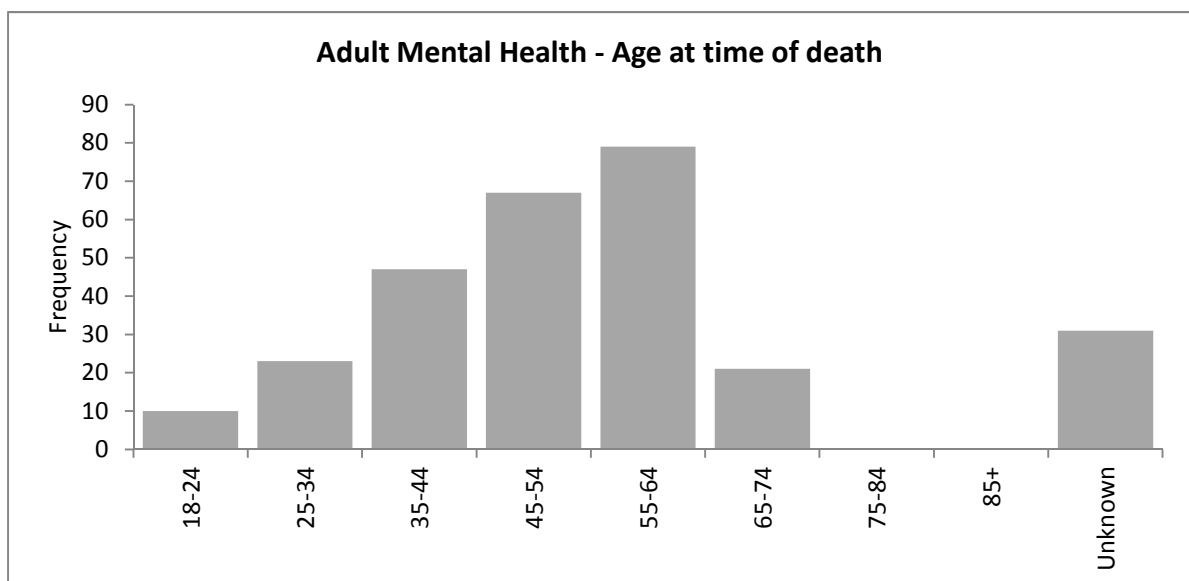


Figure 65: The age band of service users in Adult Mental Health at time of death for IMAs and CIRs

The average age of people for whom an IMA or CIR was undertaken was 50 years old.

We mapped all IMAs and CIRs where possible to one of the three areas within the Adult Mental Health Division. The geography highlighted that Southampton area team undertook most IMAs and CIRs. This is consistent with the area reporting most unexpected deaths to Ulysses.

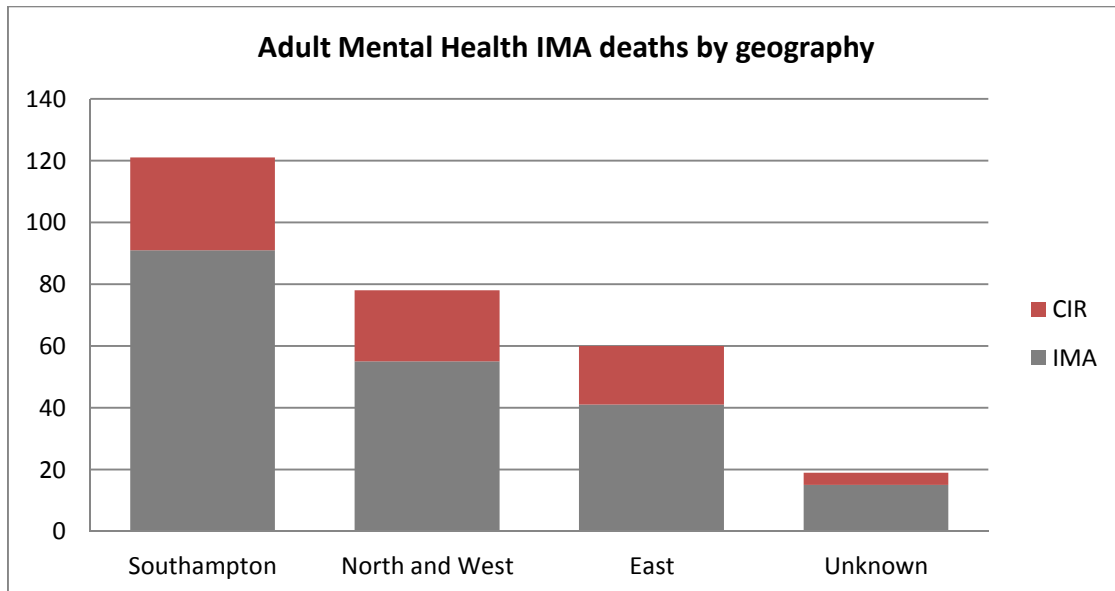


Figure 66: IMAs and CIRs by area team in Adult Mental Health services

We identified a number of repeat themes throughout the review of IMAs and CIRs. We have grouped these in order of frequency in the graph below.

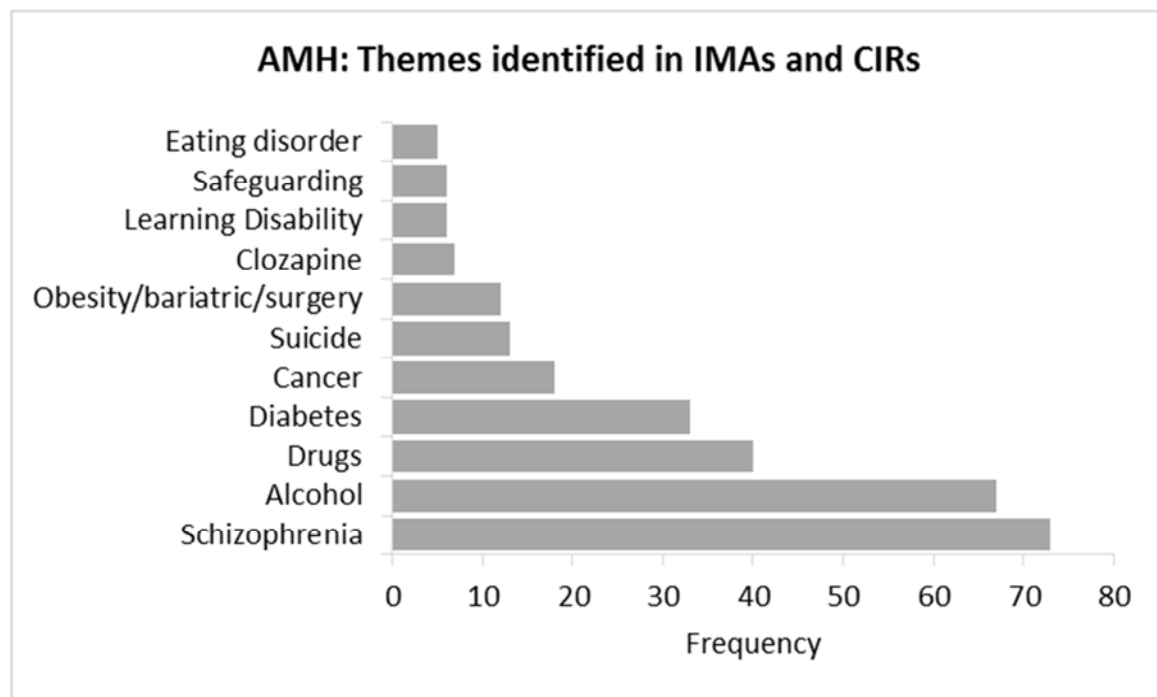


Figure 67: Issues identified within IMAs in Adult Mental Health

There are clear themes from which thematic reviews could have been undertaken:

- **People with Paranoid Schizophrenia** - A quarter (73) of the cases related to people with Paranoid Schizophrenia. The average age at death was 51 and the range was from 22-73 years old. People with paranoid schizophrenia can often be alcohol dependent and are usually on anti-psychotic medication. 12 of these cases were investigated as a CIR but not reported as a SIRI. A thematic review of all these would highlight the complexities of maintaining people in the community and whether the services provided to them could be improved. The typical makeup of these service users are male (55) and often living in isolation or self-neglect. There were notable cases where staff have gone above and beyond what is required of them in very challenging circumstances. Understanding all circumstances in which people with paranoid schizophrenia die would provide insight into any further support staff need to continue to help people in the community and what services need to do to improve their input – usually as there can be a number of different organisations and professionals involved.
- **Alcohol related deaths** – at least 67 cases related to people who had died of alcohol related liver disease, a number of these people had a severe mental illness and were complex to manage and provide care for. However, liver failure is considered a natural cause death and is expected where alcohol consumption continues unabated. However, there are themes arising from a review of a number of similar deaths from which services might be improved for example, care co-ordination; self-referral; and multi-agency management in particular.
- **Drug related deaths** – 40 cases related to drug related issues. Where an individual takes drugs there is an implicit assumption that the cause may be of their own making and therefore no further investigation is merited. However, a number of these cases clearly highlight very vulnerable people and sometimes the inability of services to respond to their needs. Often these services are not provided by the Trust but users are dependent on referrals being made for or by them to other agencies. These service users often have chaotic lifestyles and managing referrals between agencies is a crucial part of their overall care. Without a thematic review about the circumstances of these deaths limited learning is possible. Drug related deaths rarely constituted a CIR or SIRI.
- **Clozapine** is an effective anti-psychotic medication to help treat paranoid schizophrenia that is resistant to other anti-psychotic medication. It requires monitoring through blood tests on a regular basis. There was a thematic review of Clozapine following a spate of deaths in 2013. This was as a result of a diligent reviewer highlighting this in an action plan from a SIRI. Seven people with paranoid schizophrenia died in this group of service users for whom an IMA or CIR was undertaken. However, this has not been re-visited since then.
- **Self-neglect and safeguarding** – unexpected deaths documentation often highlighted issues of isolation and self-neglect. We identified five IMAs which concluded that there was a failure to refer safeguarding situations and highlight that this may have been able to make a difference. A thematic review of these issues would have highlighted whether service users were being referred appropriately so that any actions could be taken by all the relevant agencies. The Trust's safeguarding tracker provided to us showed that there were about 16 relevant cases being reviewed or a review completed by a safeguarding board (there are six such boards covering this area) as at July 2015. However, 11 were already subject to a SIRI. A wider review of the information arising from IMAs should be used to inform safeguarding alerts processes within the Trust.

- **Anorexia and eating disorders** – there were four cases where Eating Disorder Services were involved with three where a CIR was undertaken into the death of young women with severe eating disorders. The circumstances clearly show system problems in two of these very difficult cases but without a thorough investigation the learning is limited. These cases should have become SIRIs but the actual deaths happened in an acute environment and it is not clear whether further investigation took place by other organisations. These cases highlighted the need for multi-agency review.
- **Multi-agency implications** – a large number of service users who die unexpectedly have required multi-agency input. There are often care and service delivery issues highlighted as a result of difficulties in partners working together. The lack of multi-agency review means that there is a lack of multi-agency learning, e.g. Bridge Centre, St James Society, New Road Centre, Shared Care arrangements and the involvement of primary care services.
- **Drug toxicity and side effects** – service users often express concerns about side effects from medication and there are clearly complexities in managing dosages of medication to help maintain an individual's functioning. A number of cases have highlighted drugs being at toxic levels in the blood on post mortem. However, there is limited input evidenced in IMAs or CIRs from pharmaceutical staff.
- **Suicides** – there were ten suicides that were not reported on StEIS by the Trust – four had CIRs. It was unclear to the review team in some of these cases why these were not reported to StEIS on notification. As part of the factual accuracy process the Trust agreed that one of these should have been reported to StEIS and was not. The remaining nine cases raise issues that need to be clarified locally or nationally so that the risk of a case not being investigated is minimised:
 - Cases of suicide where the individual had been referred or assessed but not yet seen - where does the responsibility lie in investigating whether a delay in seeing a patient or potentially with poor referral information being provided may have been a contributing factor? This accounted for nine of the ten cases we highlighted. In four cases the Trust considered the responsibility to lie with the referring NHS Trust but there is no evidence from the Trust that a SIRI had been completed by anyone else in three of these cases. In five cases the individual committed suicide before getting to seeing anyone.
 - Cases where it is considered that there has been a probable suicide but the Trust waits for a coroner conclusion before either reporting or investigating. It is clear that the delay in reporting to StEIS in these cases delays investigations starting and therefore the learning process. This will also impact families seeking answers.
 - Cases where it is considered that there has been a possible suicide but the Trust waits for a coroner conclusion that is then considered natural causes. The circumstances in these situations may still require investigation as care and service delivery problems may also have been apparent.
- **Physical health management including diabetes** – Nationally people with a Mental Health need suffer from worse physical health and often die prematurely. In 51 cases we reviewed, service users were suffering from cancer and/or diabetes with others also suffering from other co-morbidities relating to their physical health. Ten further cases were noted as being obese to the extent this affected their health and some were dealing with the post-surgical effects of bariatric surgery. A thematic review undertaken by the Trust looking at 17 IMAs

of deaths relating to physical health that did not proceed to CIR did not evidence any change in practice or care. Whilst these deaths may not be attributed to failings of the Trust there would again be learning from the regular review of these cases to help service users manage long term conditions including diabetic management.

- Staff are working in some very challenging situations where without an investigation shared more widely commissioners cannot develop insight into the challenges of complex community care or invest in service improvements.

A number of cases reflected issues that do not meet SIRI criteria or have not been investigated as a SIRI that could have been.

AMH IMA/CIRs - Cases that could have been investigated as a SIRI

We identified the cases below as being cases that in our view could have merited a report as SIRIs. The Trust agrees that five should have been reported to StEIS.

Case studies:

	Description	High level observations
1	Service user with Paranoid Schizophrenia. Died unexpectedly when found collapsed.	The IMA relating to this service user clearly stated the need for a CIR but this was not undertaken.
2	Service user with Paranoid Schizophrenia being taken advantage of and safeguarding concerns	Complex case which failed to raise safeguarding concerns. A long IMA was undertaken but no CIR or SIRI.
3	Service user with Paranoid Schizophrenia under MHA – but MHA responsibilities transferred to acute hospital.	Service user transferred to acute care under the MHA and died. No CIR or SIRI report undertaken. The MHA responsibilities had been transferred to the acute Trust but the IMA is inconsistent with information provided by the Trust.
4	Service user - failure to provide psychological support and 1:1 support on the ward. Funding for specialist need not provided.	A comprehensive CIR was undertaken but not reported as a SIRI. Trust investigated from their perspective and the acute hospital was investigating some aspects it would appear.
5	Service user was a complex case where the inability to provide physical and psychological help was a major issue	Another comprehensive CIR but not reported as a SIRI.
6	Suspected suicide not investigated	CIR undertaken but not reported as a SIRI. CIR inadequate as to circumstances, cause of death and provides no reflective learning
7	Service user in detention and CIR recommended but SIRI only decided on after comments from Coroner a year later. Conclusion given but 5 months to decide to investigate	This service user was under the MHA and under detention. This is immediately SIRI reportable. Yet it took a long time to instigate an investigation.
8	IMA written by the Care co-ordinator who describes own care as good and no need for further investigation	An IMA into an expected death and recommends no CIR but written by the person providing the care. Some suggestion of financial abuse, poor care plan and out of date risk assessment. Would

		be more appropriate for this to be reviewed by someone else. Safeguarding concerns.
9	Service user found unresponsive at home by carers. Care staff told relative to call GP. Returned later to find dead.	A scenario where the care agency should have investigated and circumstances warranted a further review.
10	Service user had death from insulin overdose but not meeting criteria for specialist Mental Health support	Service user referred when 'quota' for referrals had been used up and therefore needed to be re-referred. Lack of clarity about the Dual Diagnosis pathway; service user meeting criteria and gaps in appointments.
11	Service user death under MHA after long term inpatient admission	Only an IMA was completed even though service user was detained under the MHA for a lengthy period.
12	Methadone user found dead	No investigation
13	CIR done because coroner gave open conclusion but not a SIRI	3 months post death CIR commenced due to Open Conclusion. Family concerns but not reported as a SIRI as didn't meet criteria.
14	Service user with Schizophrenia and Learning Disability - safeguarding and concerns about care in nursing home	No investigation
15	Service user died from Sepsis - possibly with a Learning Disability but not clear	IMA recommends further investigation but not done. May have been a case where capacity assessment was needed but not done
16	Service user admitted to acute care from Mental Health ward due to confusion and dehydration.	CIR completed – not reported as SIRI but physical care on ward may have been lacking.

IMA and CIR analysis - Learning Disability

Of 337 deaths of service users with a Learning Disability there were 64 initial management assessments (IMAs) and two Critical Incident Reviews.

The information contained within the IMA reports suggests that the majority would have benefitted from significantly more review or investigation.

The quality of the IMAs was very poor with very limited rationale provided for no further investigation.

There was little evidence of review from directors within the division.

There are clear themes arising from the IMAs along the lines of some of the CIPOLD findings.

Over half the cases subject to an IMA involved an unexpected death in an acute environment.

The care of service users with a Learning Disability was provided by a range of providers. A single organisation investigation process as currently in place in the NHS mitigates against investigating unexpected deaths in these cases. Most of the cases should have been multi-agency reviews. It was interesting to note that the majority of cases we reviewed were cared for in the community and that the quality of this care should be subject to very careful scrutiny given the policy directive to move people increasingly into community provision.

IMA analysis

We reviewed all Learning Disability IMAs available as only two deaths were investigated as SIRIs.

- For Learning Disability there were 64 reports and two CIRs.
- There was an IMA for one inpatient. A CIR was provided as part of the factual accuracy process for this case.
- There were 11 IMAs that showed a documented rationale to some extent for further investigation or not.
- A number of Learning Disability IMAs would have merited further investigation as a CIR or possibly as a SIRI.
- The attrition of Learning Disability unexpected deaths resulting in two CIRs and two SIRIs suggests that the criteria being used for reporting cases as a SIRI mitigates against investigation.
- All of the IMAs in Learning Disability highlighted care from multiple agencies and no one organisation appears to have taken the lead in reviewing the wide circumstances of the possibility of premature death amongst the unexpected deaths.
- 22 cases involved safeguarding issues to some extent or referral to Adult services including five from TQ21
- Unexpected deaths that were investigated only at IMA stage showed some very distinct themes.
- The quality of Learning Disability IMAs was poor with often scant or incomplete information and a lack of challenge.

- IMAs were not formally signed off and there was little evidence of review by directors documented.
- Key learning from the IMAs was documented to some extent in 25 cases but there were no action plans outlined to action or implement the learning identified

Themes:

- The age range of the people involved in Learning Disability IMAs was 19-82 years old
- The majority of cases were for people living in community, residential, nursing home or supported living arrangements
- In 33 (50%) IMAs the location of death was in local acute hospitals
- None of the deaths were jointly reviewed or investigated with the Acute trust
- One death was investigated by the Acute Trust involved but this only examined the immediate acute episode and there were no other investigations into other aspects of care
- PEG feeding, aspiration and dysphagia were common themes
- Delays in waiting times were highlighted in a number of cases – this appeared to be the case in particular for Speech and Language therapy and at times Occupational Therapy
- Little evidence of intent to take a lead role in reviewing or investigating further
- No-one ultimately took the lead in undertaking a multi-agency review
- Some examples of excellent hospital liaison staff attempting to advocate for service users but no further investigation to prevent the same situations happening
- No systematic sharing of circumstances of deaths with commissioners or others due to the lack of critical incident review was apparent for the period of the review
- Some service users dying malnourished
- No family involvement in the reports - whilst this would not be expected in the immediate period the IMAs took an average of 15 days to complete. The concern being that with so few IMAs becoming CIRs that family involvement and engagement is minimal.
- Whilst lessons learned were documented in some cases no action plans were produced to the review team or evidence that any were implemented
- Some safeguarding reviews and reflective practice sessions were held but it is difficult to establish what changed as a result
- Delays in decision-making which may have contributed to the medical fitness of the service user for surgery
- Difficulty in managing challenging behaviour in hospital

Ultimately, a failure to pick up learning from IMAs in a systematic manner means that there is a risk of failure to learn from any unexpected death from this vulnerable group of people.

As part of the review and due to the level of concern raised in the 66 cases that we reviewed, a Clinical Review group was convened. This included a Medical Director from the External Reference Group, the Medical Director from Southern Health and a GP. The purpose of the group was not to undertake a full clinical case review but to highlight a number of cases to establish if there were immediate concerns that the Trust needed to take action on. Some of the clinical notes were reviewed alongside the IMA reports. The group did not highlight any immediate clinical concerns from the notes provided. However, a full review of each of these cases would need to involve

primary care, social care and acute care records and so the review was still limited in its ability to fully establish circumstances around deaths.

The group noted that:

- Governance around IMAs was poor - no IMAs were signed off and one example demonstrated some challenge but without robust follow up and intent
- From the information available and given the lack of clarity in the notes available to the group that it was difficult to attribute clear responsibility to the Trust
- The standard of the IMAs was poor - poorly written, grammatical errors, date errors and spelling errors alongside poor chronology and in some cases cursory levels of information
- System wide issues - there was no information in the IMAs which helped identify lead agencies or determine a multi-agency approach to review or investigation
- Decision-making through to SIRI was poor with no rationale provided as to why there was no further investigation
- The Trust should bring a lens to these cases from a professional stand point
- There was clear evidence of delays in decision-making and a lack of urgency in some cases
- Lack of advocacy for these patients

From our review of all Learning Disability IMAs, there were individual cases relating to acute and social care which raise a number of questions.

Case studies of Learning Disability IMAs relating to Acute care:

	Description	Observations
1	An admission as a result of refusing food	1. What delays in decision-making occurred that may not have occurred for someone without a Learning Disability? 2. Did these delays ultimately mean an inevitable premature death? 3. Was the discharge appropriate given the refusal to eat and had reasonable adjustments been made? 4. Given the Trust was informed of the incident what duty of care is there?
2	The insertion of a PEG system and the over-riding of Best Interests decisions for DNACPR by the Acute Trust. The LD liaison staff acted to address the problem but this made no difference.	Whilst local nurses appear to have made local attempts to resolve the problem what responsibility is there on the Trust's Directors to review the issues of DNACPR decisions and best interest decisions being changed? Was there any escalation of this to the Acute Trust concerned? Or with commissioners?
3	Concerns about care being provided in hospital. Refusing to eat and drink.	The Trust were informed about concerns of care quality - what did they do to advocate? Did the Trust escalate the case on notification? What support did the staff get to ensure relevant Directors in the Acute Trust were made aware of the concerns? Or with commissioners?
4	Long standing problems with eating and	The information in the IMA is insufficient to get

	drinking - IMA stated service user died of starvation and infection.	to a decision about whether this was a serious incident and needed further investigation when on the face of the information it did. Questions to be asked here whether PEG needed earlier, use of Mental Capacity Act early enough; adequacy of support to eat and drink. Did the Trust escalate the concerns raised with the Acute Trust involved? Or with commissioners?
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Further information provided by the Trust indicates that three cases were referred to Adult services or a safeguarding review took place. But these are not on the Safeguarding Tracker provided. Two cases involved problems with the best interest decision-making process. The case studies raise doubts as to the strength of review and whether positive action is taken in cases subject to IMAs. This includes whether these situations are being raised by directors directly with acute providers or through CCG commissioners. Whilst there is evidence that operational staff are acting to advocate at the time the divisional and corporate processes are not robust enough to pick up themes like this and ensure there is an opportunity for systematic learning to occur and ultimately that practice changes.

Cases relating to Local Authority care:

5	Learning Disability with physical disability. Refusal by physical health team to see and work as a team. Intentional self-neglect?	What was the role of the Trust to ensure the right agency investigated?
6	Mix of drug issues and Learning Disability. Inquest held - no SIRI or CIR	How can the potential issues leading up to this death be fully understood without more enquiry?

The two cases above raise a similar issue as the acute care case studies. The Trust state there was resistance to engage in the first case study. Our concern is that weaknesses in raising learning regarding problems of inter-agency working will limit improvements in care provided.

Conclusions:

Learning Disability deaths were not fully investigated though some were subject to an IMA.

The IMAs are of a very poor standard. There was no evidence of sign off in the IMAs as presented. In the factual accuracy checking process the Trust informed us there was email sign off. But we can only conclude that these do not get kept with the IMA record. Furthermore, there has only been one divisional meeting held as evidenced by minutes provided. It is our view that the absence of formal sign off and accountability in line with the policy means the Board are not in a position to be confident that policies have been applied consistently and appropriately.

Half of the IMAs relate to service users cared for in acute hospitals with no information relating to further investigation by another acute provider except one.

Themes raised in the case studies above highlight potential weaknesses in feedback mechanisms both to acute providers and the relevant local authority adult services departments. This is a significant concern where learning is not being systematically identified.

We reviewed 12 cases during the clinical review group and the members concluded that

- The IMAs were poorly completed and of a poor professional standard.
- That the cases required some form of multi-agency or health system review as the cases did not relate solely to any single provider
- That there was a potential role for the Trust to provide a stronger leadership role to advocate for better investigation
- There was no sign off
- That some cases should have been further investigated across organisations

Serious Incident Requiring Investigation report review

195 deaths were reported and investigated as SIRIs. The majority were in the Adult Mental Health service division. 60% of all reports involved suicide. The number of SIRIs remained constant over the four year period.

30 deaths were investigated as SIRIs over the four year period for people over the age of 65 years although there were over 9190 total deaths in the period in this age group.

24 inpatient deaths were reported as Serious Incidents Requiring Investigation.

The North & West area team had most SIRIs; although the Southampton area reported most to Ulysses only 40% were investigated as SIRIs.

Overview - StEIS reporting

The total number of Mental Health and Learning Disability deaths reported to StEIS in the period was 195. The number of SIRIs were broadly constant across each year.

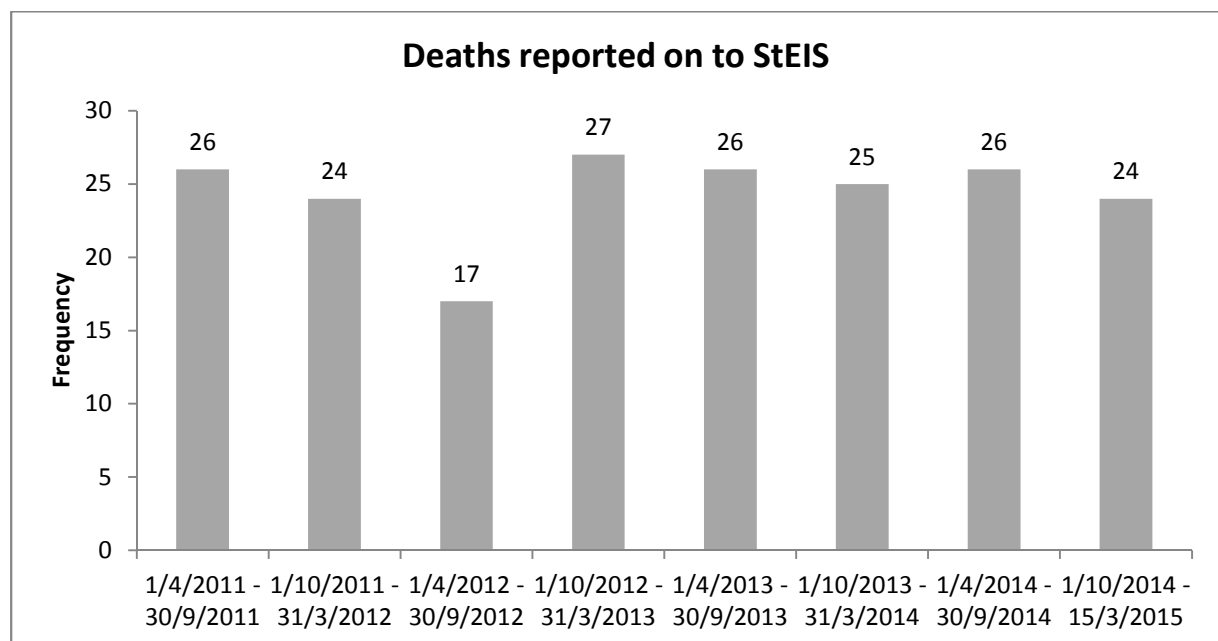


Figure 68: Total deaths reported as SIRIs onto StEIS April 2011-March 2015

The Trust is a low reporter of deaths under the categories relating to death through StEIS compared with nine other Trusts in the region. The graph below shows the reducing rate of deaths reported to StEIS in these categories per 1,000 Mental Health service user and the lower rate overall for the period.

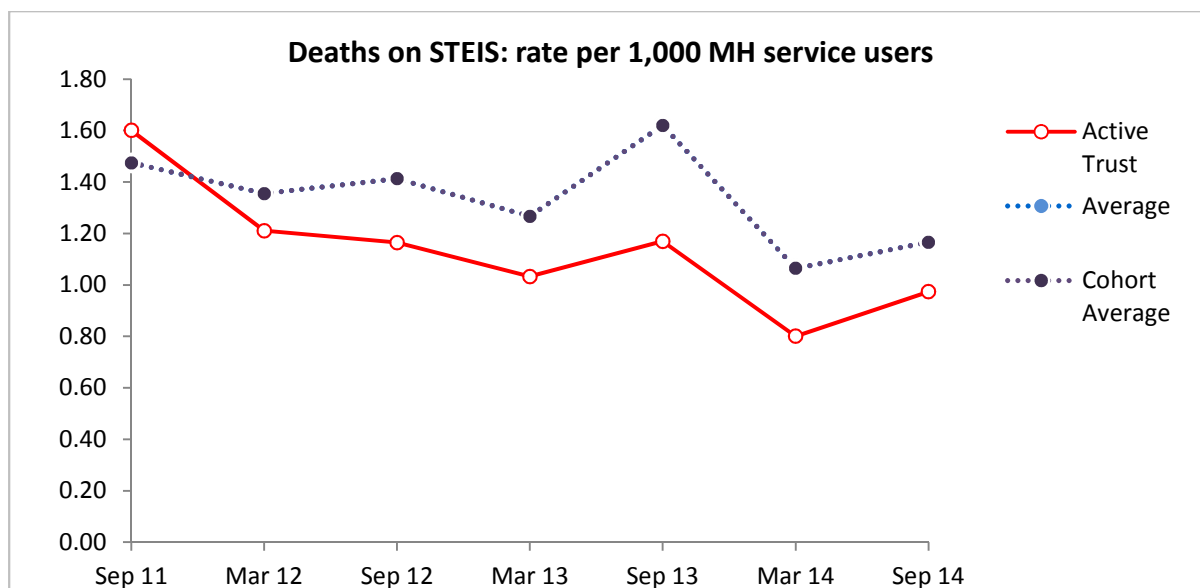


Figure 69: The rate of deaths reported to StEIS in the period April 2011 to September 2014 in each six month period compared with Mental Health Trusts in the Southern Region.

Whilst the national guidance has changed on what to report as SIRIs between 2010, 2013 and 2015 the broad principles remain and Trusts have the freedom to report any death to Commissioners that warrants it and then investigate it. The frameworks are guidance and there was no statutory requirement to report SIRIs throughout the period under review. The frameworks are not prescriptive but when we asked the Trust what criteria were used for determining what to report as a SIRI we were told they use the detailed guidance per the National Patient Safety Agency (NPSA) 2010 in support of the 2010 reporting framework. This national document is a guide developed by the NPSA and intended to be adapted locally. It is referred to in the 2010 national framework in order to identify to which other organisations' incidents should be reported in addition to the NPSA. The full criteria contained in it, as related to death, are shown in Appendix 6. The criteria relate to NHS funded services and care. However, it is important to note as in the bullet point below that there is *"a duty to investigate when a service user is in receipt of care (usually defined as 12 months pre-incident) and importantly, any unexpected death to whom the organisation owes a duty of care"*.

The criteria cover most of the eventualities that we have found in the IMA and CIR review. The criteria contained are specific; later national frameworks have become less specific and provide greater flexibility and judgement. The list below is an extract as it relates to any death related incidents for the period under review in the guidance used by the Trust:

Criteria	Mazars observations
<i>Unexpected or avoidable death of one of more service users</i>	Many deaths are unexpected but do not meet the criteria for a SIRI. Deaths of people at risk of neglect or self-harm are avoidable and whilst they may be expected to be premature as a result of life style issues they were not expected at that time
<i>NHS funded care - partially funded, fully funded regardless of location</i>	The Trust provides care in a variety of settings - as is the nature of community and Mental Health provision. It is surprising therefore that the location

	of death seems to mitigate investigation of NHS quality of care.
<i>Unexpected death where natural causes are not expected</i>	Many people with Mental Health and Learning Disability suffer from long-term conditions or physical health challenges. Natural deaths can be premature and unexpected but a number of service users are dependent on others to provide their care and may not be in control of their environment. These cases may warrant investigation.
<i>Abuse - act of neglect or omission to act</i>	Intentional abuse is clearly defined but can often be invisible. Unintentional neglect and omissions in care happen and can often be related to quality of surroundings and staff including training. The definition of neglect also includes self-neglect where services might have been able to do more to help. The interpretation of this could be very wide.
<i>Relevant categories are:</i>	
<i>Death of a vulnerable adult where abuse or neglect is suspected</i>	This could include: People with psychosis living in isolation and subject to abuse or persecution by others and self-neglect. Service users in care homes subject to safeguarding concerns Service users subject to self-harm or substance misuse
<i>Regulation 28 Care Standards Act for independent provider organisations registered with CQC where a death is reported in an establishment, during treatment or as a consequence of treatment</i>	This has now been replaced by regulations under the Health and Social Care Act 2008. This requires deaths to be reported under Regulation 16, 17 and 18. Regulation 17 deaths are deaths in detention
<i>Media - if police and involved or media</i>	
<i>Sudden unexpected incidents</i>	This covers a range of incidents and could include choking, SUDEP or falls, collapse.
<i>Medical devices - including human error</i>	This could include the use of PEG feeding devices where human error is an issue in the administration of feeds
<i>Homicide by service user in receipt</i>	This means murder committed by any service user having been seen in the last 12 months
<i>Service users detained under MHA AWOL</i>	These are service users that are absent without leave under the MHA 1983
<i>Inpatient in secure unit if informal</i>	People currently in a secure unit voluntarily
<i>All deaths in secure settings</i>	All specialist and secure unit deaths
<i>All service users subject to MHA</i>	This would include a range of sections under the Act including S17 leave. The Trust has not investigated any deaths subject to S117 after care packages. It appears these may not be required to be included.
<i>Clusters of unexpected deaths</i>	
<i>Adverse comments from coroner</i>	Where the coroner has made comment or raised concerns
<i>Suicide in receipt or strong suspicion of self harm</i>	All suicides or suspected suicides or self-harm e.g.

	overdoses
<i>Verdict of suicide or an open verdict</i>	All suicides and all open verdicts
<i>Death with foul play</i>	
<i>Death out of county</i>	Possibly including deaths abroad where the service user is in receipt
<i>Prison deaths - in probation hostels, prisoners</i>	
<i>Unexpected deaths where service user suffering unexpected death in receipt</i>	This covers a wide range of situations which gives the Trust flexibility to investigate
<i>Unexpected death to whom the organisation owes a duty of care</i>	This should cover all service users where the Trust is providing advice, support or care and would be especially applicable to many of the vulnerable people the Trust provides care to.

It appears that this document was not intended to be a nationally prescribed list of serious incidents. It is the guidance provided to us by the Trust that was in use throughout the period. However, based on our analysis there are some inconsistencies in which sections are and are not used in the above criteria by the Trust.

Serious Incidents Requiring Investigation (SIRI)

We reviewed 195 SIRIs on StEIS that were deaths between April 2011 and March 2015. In total 116 reports were suicides (60%).

These were broken down into four groups:

- Adult Mental Health (AMH) (under 65 years) - 161
- Older Peoples Mental Health (OPMH)(over 65 years) - 30
- Learning Disability (LD) – 2
- Secure Services (SS) - 2

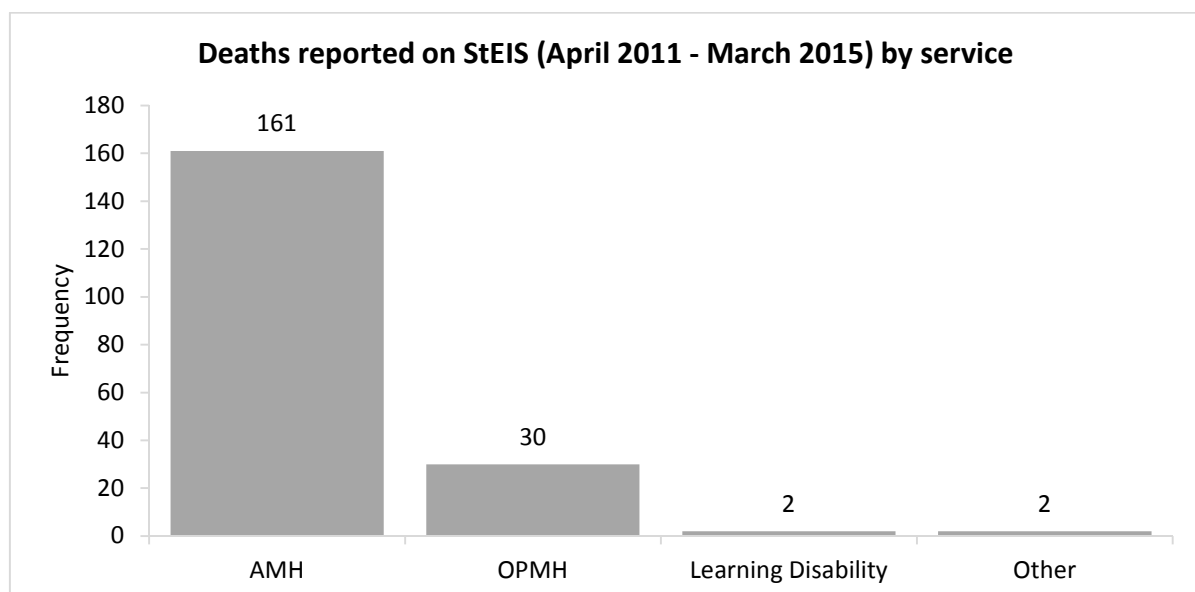


Figure 70: SIRIs by service

As can be seen the vast majority of SIRIs occurred in the Adult Mental Health division (18-65yrs).

This is driven by the clear requirement in Serious Incident Frameworks to investigate all suicides. 100 out of the 161 deaths in Adult Mental Health had a final conclusion of suicide; one was a homicide.

Further Adult Mental Health conclusions were:

- 12 open,
- 4 narrative,
- 11 accidental,
- 2 misadventure;
- 3 natural causes;
- 3 overdose conclusions. Some of these would have been considered probable suicides.

The majority of Adult Mental Health SIRIs relating to death are driven by the suicide criteria. Ten deaths were drug or alcohol related. Of the remaining SIRIs four were waiting for inquests at the time of writing. Conclusions were not clear from the Trust's tracker system for six deaths.

There were 30 deaths of people over the age of 65 with a SIRI. The age range was 65-92 years old. Nine were inpatient deaths. There were five deaths with no inquest; of which four were inpatients.

Conclusions were:

- 16 suicides
- 4 accidental deaths (of which 2 were inpatients)
- 1 open conclusion
- 1 narrative
- 1 natural causes.
- 1 inpatient death is still pending an inquest 30 months post death.

Two deaths were reported as SIRIs for people with a Learning Disability over the four years. One was Connor Sparrowhawk for which an external investigation was held and an inquest was held in October 2015. The other is a young person for whom the SIRI was re-opened and is now being externally investigated a year post incident.

There were 109 male and 86 female deaths.

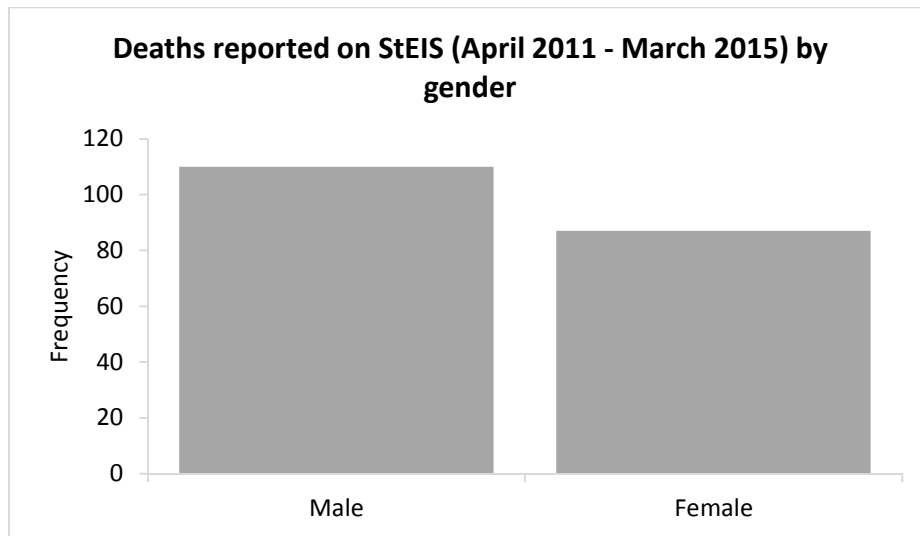


Figure 71: SIRIs by gender

The age breakdown of SIRIs was as follows:

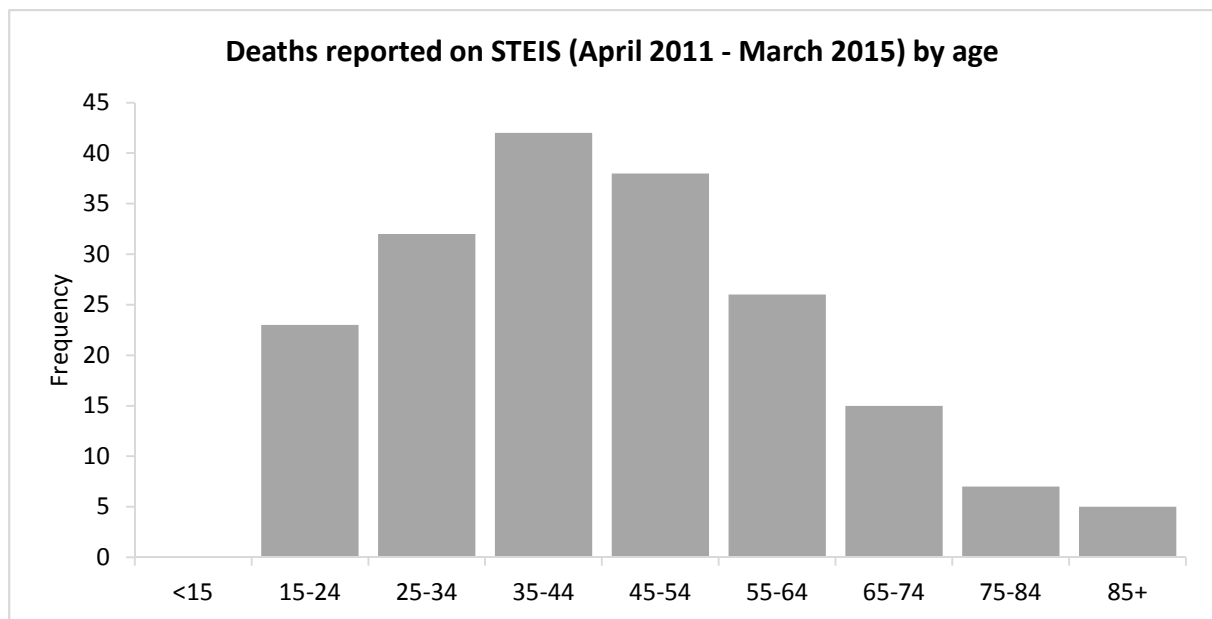


Figure 72: SIRIs by age

The average age for all SIRI reports was 46 years.

SIRIs by 'team geography'

Deaths can be categorised by geographical area. The graph below groups deaths by the three predominant areas of the Trust's services and draws out inpatients separately. It was not possible to allocate some SIRIs to an area in 13 cases.

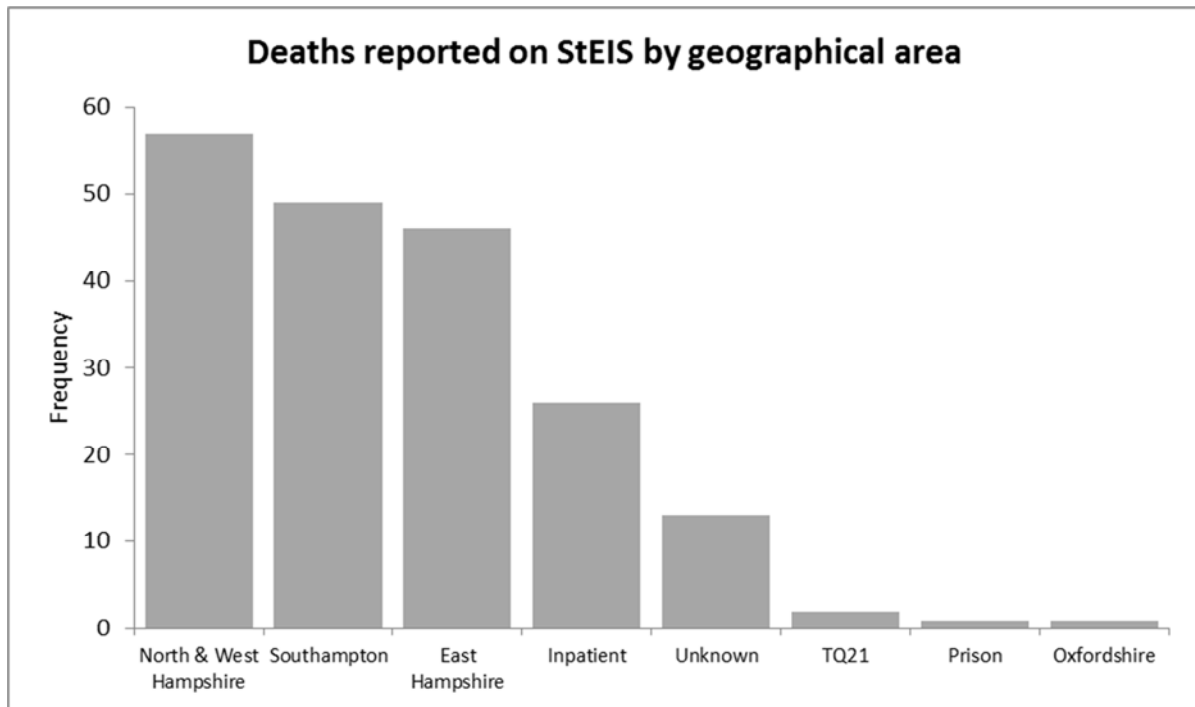


Figure 73: Deaths reported as SIRIs by geographical area

Adult Mental Health SRI reports by area as a proportion of RiO and Ulysses reports

System	Southampton	North and West	East
RiO totals	1778	4965	3240
Ulysses totals	120	78	60
StEIS totals	49 (40%)	57 (73%)	46 (76%)

Figure 74: Proportion of total deaths investigated as SIRIs by area team in Adult Mental Health

The Southampton area appears to report more deaths onto Ulysses but investigate a smaller proportion. North and West area and the East area appear to report more of the deaths onto StEIS once reported as incidents.

Family involvement

Figure 75 shows the involvement of families in SIRI investigations. 80 families were involved - approximately 20 per year.

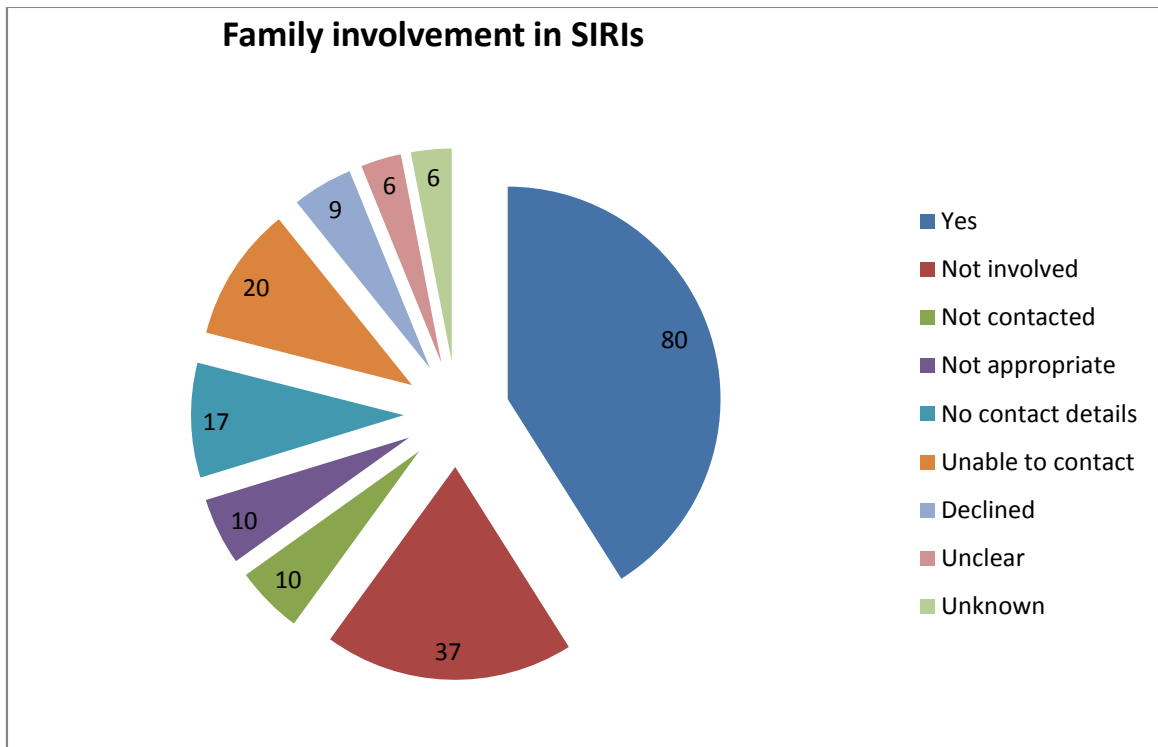


Figure 75: Family involvement in SIRIs

Analysis of SIRI investigations

The quality of SIRI reports was variable regardless of the seniority of the reviewer.

Many staff were involved in undertaking the reviews. There were over 110 reviewers across the 191 SIRI reports made available - most of whom led only one investigation. The quality assurance process was weak. The quality of both written reports and investigations varied considerably. There were five investigations undertaken by people external to the Trust, which were of an excellent standard.

Family involvement in investigations was documented as having taken place to some extent in 41% of SIRIs.

Reports took a long time to complete and there is limited evidence that reports have been properly reviewed or quality assured and signed off.

There were clear themes arising from the reviews with repeat issues recurring throughout the four years.

Our methodology involved:

- A pilot to review a random selection of SIRIs across the four years to develop a template for review. We identified a number of themes against which we then reviewed all remaining SIRIs allowing for an option to highlight other issues that the random sample had not identified.
- A review of all remaining SIRI reports against this template. The template is at Appendix 3.
- We developed a set of descriptors against which to give an overall assessment of the quality of the report.

After analysis of StEIS and mapping to other systems to identify relevant SIRIs not immediately identifiable in StEIS, we identified 195 relevant SIRIs for this review. 216 cases were identified initially but several reports provided or reviewed turned out not to be deaths or were out of scope. We were able to review 191 reports. 183 finalised SIRIs were provided, six were provided that were at Corporate Panel stage, two still with Division and four were not provided - four were still under investigation.

The breakdown of the SIRIs not ready for CCG closure panel is below (no reports were provided for those cases highlighted in red):

Incident date	Comments on the version we reviewed
August 2013	Report still not finalised August 2015
December 2013	Version sent back to Division June 2015 (but notified late)
May 2014	Decision for a SIRI after an open conclusion in January 2015 - no report available at August 2015
October 2014	Corporate panel version August 2015
October 2014	Corporate panel version returned by panel April 2015 no final version provided at

	August 2015
November 2014	Trust missed chasing this one. Corporate panel version returned by panel June 2015 -no final version August 2015
January 2015	Still under investigation no report available August 2015
January 2015	Corporate panel version returned May 2015 no final version August 2015
February 2015	Version prior to submission to Corporate Panel
February 2015	Version prior to submission to Corporate Panel
March 2015	Still under investigation no report available at August 2015
March 2015	Still under investigation no report available at August 2015

Descriptors used in rating reports:

- **Excellent/good** – no typographical; grammar; date; naming errors – report was easy to read, followed a logical flow and the evidence gathered clearly linked to recommendations and to action plans. The report could be shared with families as a robust piece of independent writing and with professionalism.
- **Adequate** – showed most of the information needed was available but was presented in a manner that made understanding the issues difficult; often these had grammar; date; naming and typing errors. Could have caused distress to families if shared by showing a lack of respect and attention to detail. Probably had not been quality reviewed at any level or detail.
- **Poor/inadequate** – these varied between having typographical errors to an unacceptable standard; naming the service user incorrectly; wrong dates; no flow and were either cursory or provided insufficient information to form good recommendations or action plans. These reports lacked challenge or effort in securing learning. Likely to cause distress to a family due to its cursory nature or lack of professionalism; and had most likely not been read properly during any phase of quality review.

Quality of reports

SIRI reports are conducted and written by a range of staff at different levels within areas of the Trust. There were 110 different reviewers involved in the 191 SIRI reports reviewed. The majority of staff (67) prepared one report only; 31 staff wrote two or three reports; 60 reports were written by a group of 12 staff who had written four reports or more during the review period. Of these seven senior staff wrote 40 reports between them – we assessed only six of these as ‘good’. The 12 staff who had written the most SIRI reports (and some of whom were also involved in review and quality assurance of the SIRIs of other people) didn’t produce reports that were significantly better. Of the 40 reports written by those most frequently commissioned to write the reports, 44% were of a poor or inadequate standard.

The quality of reports on a significant number of occasions was poor. There were typing errors; date errors; naming errors; grammatical errors; cut and paste and repetition. In a number the chronology was hard to follow. We assessed 19 reports as being ‘good or excellent’. Consultant doctors were involved in and wrote 24 reports in total. Of these 50% were considered as poor and 33% (8) assessed as good.

Training of reviewers:

The guidance in place at the time for Serious Incident Investigation states:

“Provider organisations will ensure there is an up to date list of competent staff within the organisation familiar with the organisation’s investigation policies and protocols, skilled in good practice root cause analysis methodologies and techniques.

These staff will be kept up to date through the provision of regular investigation officer training (in-house or external) and this training will include the following as a minimum: RCA investigation methodologies and techniques, statement taking and report writing.”

Most reviewers have had some training. There was no training record for divisional training provided. However, the central training department provided a comprehensive list of everyone who had been through the LEAD department for training.

Some of the most senior staff, however, were last listed as having been trained in 2008. Five of the Mental Health/Learning Disability reviewers had training in March 2012. The next training logged on the central records for staff across the Mental Health and Learning Disability divisions was provided in July and September 2014 for staff across all divisions involved.

We understand a large cohort of Consultant staff attended a 2 day training session in early June 2015 to refresh their skills. This was held by the National Clinical Assessment Service and was entitled Case Investigator Training. It is aimed at investigating medical performance and practice.

The independence of reviewers

Whilst it was difficult to be precise based on the information available, a large majority of SIRI reports were written by people from the same ‘area’. The quality assurance was also held within the same area and there was limited external challenge from outside. The extent to which true independence and objectivity exists in the Trust must be reviewed.

Delays in reporting

At least a third of the reports took more than four months to complete from date of incident. However, as a large number were not dated when final and did not have a closure panel date clearly marked it is not possible to be precise for the entire group of 195 SIRIs. Our analysis of 55 cases heard at closure panels in 2014 identified an average timescale of nearly 10 months from date of incident to closure by the CCG. See Figure 4.

There are a variety of reasons for delays which all contribute in adding to what can become very lengthy timescales.

- delays in starting (due to allocation and decision-making as well as allocating an investigating officer occur as well as delays in identifying the SIRI in the first place – on some occasions the Trust is not notified until a long time post incident);
- delays in collating evidence (usually due to annual leave or staff not being available due to leave, sickness, compassionate leave or having left the Trust);

- delays in writing;
- delays in reviewing;
- delays in sign off;
- delays in getting to corporate panels;
- delays in getting to CCG closure panels.

Figure 29 provides further information relating to delays in getting reports written, signed off and finalised.

The Trust does monitor the 'breaches' of 45 working days and 60 working days (as existed in the review period) but this has not improved the timescales. The focus on these timescales however may have had the opposite effect of resulting in poor quality reports with an emphasis on getting the reports signed off and less focus on the quality of the evidence, recommendations and actions arising.

Examples of report delay based on nine cases outstanding at 11th August 2015 are:

- August 2013 case still being completed. An initial report was produced in April 2015 and is with the Safeguarding team for completion 2 years post incident.
- December 2013 case has been returned to the Adult Mental Health division for revision by the corporate panel. Inquest conclusion was delivered in June 2014.
- May 2014 case of a death subject to a Community Treatment Order (CTO) and an inquest conclusion was delivered in January 2015 is now under investigation. This death was reported to CQC but it is unclear why an investigation did not commence immediately post notification.
- October 2014 case returned to division for revision and is expected at Corporate panel in August 2015
- November 2014 case returned to division and awaiting divisional sign off before booking to Corporate panel
- December 2014 case returned to division and expected for virtual review still outstanding.
- A Grade 2 January 2015 case returned to division and not yet completed. Due to go to a CCG Grade 2 panel at the end of October 2015
- A January 2015 case returned from Corporate Panel in May and still outstanding in August 2015
- Three February 2015 reports awaiting divisional sign off as of August 2015.

Some of the delays this year are due to the Trust now not accepting SIRIs of poor quality and repeat returns to divisions to refine and revise. This more robust exercise is reported by the CCG to be producing higher quality reports to closure panels.

Family involvement in reports

Every SIRI report is required to set out the involvement of the family and the majority do. The reports are often not precise in the nature of contact with families where there is contact – i.e. it doesn't state whether the interaction is one of condolence and support as distinct from being part of

an investigation. However, we have given the benefit of the doubt where the information suggested family involvement had been undertaken to some degree.

Even with this benefit only 41% of SIRIs demonstrated family involvement. Very few SIRIs articulated clearly when they have been shared with a family or relative. At times when reports have been shared and families not engaged until that point, the SIRI report has resulted in further input from the family. It is not clear however how the family input at this point has led to enhanced or amended recommendations or actions.

In a number of cases where the family can clearly be seen to be involved the family have raised concerns and questions – in some reports it is clear that these queries have not been addressed. Families are often involved at the end of the process with, on occasion, families being ‘interviewed’ the same day as staff and just before the author writes their report. Families that are engaged are rarely engaged face to face and often phone calls are the medium of choice.

For the remaining reports where family involvement was not apparent a variety of reasons were given. These included most commonly the lack of next of kin details and no knowledge of how to get hold of the family. On occasion some authors detailed efforts to secure information from coroners. Given the majority of SIRIs had Coroner involvement it is surprising that this persisted as a problem. Other reasons given were that involvement would be too distressing for the family and so they were not approached; on occasion there was disagreement in this regard within the investigating team.

Root cause analysis (RCA)

In 40 cases was a root cause identified (20%). 80% of investigations did not establish any sort of root cause. This calls into question the effectiveness and quality of the RCA or of its understanding and application. Ten cases identified root causes in 2014/15.

Lessons learned

Lessons for learning were noted in at least 100 of the SIRI cases. However, these were not necessarily turned into recommendations or highlighted through action plans. In some it was apparent that lessons learned had been repeated in previous investigations.

Evidence, recommendations and action plans

In order to sustain change and improve, evidence from investigations is crucial in order to ensure recommendations are made that are appropriate and which then form clear actions that can be implemented. We assessed whether evidence linked to recommendations clearly and therefore had greater chance of being developed into good action plans.

Only 69 reports could demonstrate complete or partial links between evidence and recommendations.

Whilst there were some very clear action plans which clearly linked, there were many repeat actions which focussed on process and audit of records or supervision.

We have seen very little evidence of a systematic process for monitoring action plans. Each area tracks the actions arising from its own SIRIs. We reviewed a tracker from one area where there were

no actions tracked – rather it tracked the process of the stages of investigation locally, safeguarding alerts and carers issues.

Clinical themes arising from the review

Whilst individual investigations must be thorough; it is also important to identify themes arising from the whole group of SIRIs. Typically, this is done on a quarterly basis and trends in suicides in particular are reported on annually. However, reviewing over a quarterly timescale would fail to identify some themes, though not all.

It was apparent that there are repeated concerns being raised in a large proportion of the investigations :

- Concerns involving the use of RiO; access to, completion of, validation of, completing the right part of the record; reading the records; completing the right part of the risk assessment were all repeated issues over the whole period. In the earlier reports the transfer of information onto the new RiO system had resulted in some crucial history not being available. The use of the secondary record remains important. RiO issues were noted in 91 cases.
- Risk assessment was raised in 82 cases varying from having not been done; being inadequate or not timely.
- Care planning was a concern in 98 cases (50%). This included the use of the CPA approach which involves a co-ordinated approach to care planning. Typical issues raised were: care plans out of date; not completed, updated or reviewed; no care co-ordinator being allocated; not implementing enhanced CPA; not engaging or making use of Multi-Disciplinary Team members; lack of discharge plans or inpatient plans still being used post discharge.
- Staff sickness or absence or staff capacity was a concern in 45 SIRI investigations. This raised a range of issues which demonstrates the dependence many Mental Health service users have on individual staff members or teams. The concerns raised were:
 - Absence of care co-ordinator and lack of cover during leave and sickness
 - Multiple staff in short, crisis periods
 - Staff caseloads high and busy wards
 - Service reconfiguration impacting on service users changing teams
 - Lack of or delay in the allocation of care co-ordinators
 - Support for care co-ordinators
 - Care co-ordinator not engaged or relationship with service user or other agencies breaks down
 - Key members of staff off sick
- Consultant and medical input was raised as an issue in over 40 cases. This included the Consultant not being available and no other medical input sought; service users seeing multiple different psychiatrists; the role of the consultant as care co-ordinator; waiting times; on occasion a lack of senior medical input and high consultant caseloads.
- There was very minimal input from pharmacy into the death investigations. Given the complexity of medication in Psychiatry and the potential side effects we found this needs to be more regular. Where pharmacy input was provided it was of high quality and insightful.

Conclusions:

All the SIRIs were reported to StEIS correctly, although not within the timescales expected. The length of time taken to complete the investigations and write up the reports is excessive at times. Investigations can be complex and completing within a 45-60 day timescale can be challenging.

Some SIRIs are not commenced until a coroner conclusion has been given. However, it is apparent from this review that there were care and delivery problems highlighted in all the reports and this would suggest that there is little reason to delay the commencement of an investigation until a conclusion is provided. It is recognised that it may not be possible to sign off an investigation until a coroner conclusion is complete in some circumstances.

The quality of SIRI reports has been consistently poor throughout the last four years.

SIRIs can take a significant amount of time to complete the closure process – sometimes extending into years. A clear reason is not apparent in some of these cases.

Inpatient deaths

The Trust had no readily available reliable Trust-wide list of all inpatients who had died whilst on a ward.

We identified 128 inpatient deaths (those occurring on a ward belonging to SHFT) upto 3rd March 2015.

There were no investigations of deaths where service users were transferred to an acute ward in another hospital (under S17 leave or S19) from the Trust.

24 inpatients were subject to detention under the Mental Health Act (see next section for detail).

Of the 128 inpatients we identified, 76 were initially reported onto Ulysses and 24 were subsequently investigated as SIRIs. There were four service users who died whilst on or following S17 leave. There were some deaths on inpatient wards that should have been investigated further although not necessarily as a SIRI.

Three service users died whilst in Secure Specialist Units and a further person immediately post discharge from one of these units. Two deaths were considered SIRIs, one a CIR and the service user who was discharged was not subject to an IMA or investigation into the circumstances of their death.

There were three Learning Disability service users who died whilst in an inpatient unit. One was investigated as a SIRI in terms of the death. Two IMAs were completed and a CIR provided to the team as part of the factual accuracy process. Two further service users who died elsewhere but had recently been cared for in an inpatient unit and were subject to other Serious Incident investigations. Both were being cared for by Trust staff.

We requested a list of all inpatient deaths over the period. The Trust identified inpatients for this exercise by matching the last date of appointment with date of death. This has proven unreliable. Our list was drawn from RiO in the first instance and reconciled against other information we had collated. Due to some deaths occurring in other non-SHFT locations (e.g. if transferred in the immediate hours pre-death to acute care), wrong dates in the RiO extract and needing to map deaths in detention, to StEIS and to Ulysses it was difficult to get a prompt or precise list.

We identified 128 deaths as having occurred within the wards of the Trust or which were effectively Trust inpatients by virtue of being detained under the Mental Health Act.

Of the total 128 inpatient deaths we could match 76 that were reported to Ulysses. At the time we completed our analysis 45 remained classified as unexpected. 13 (out of 18 reported) Adult Mental Health deaths were considered as unexpected; 29 (out of 56 reported) Older People Mental Health deaths were considered unexpected. 2 were Specialised services and 1 was Learning Disability. Subsequently, 24 were investigated as SIRIs (12 in AMH; nine in OPMH; one LD and 2 SS). There were an additional six Critical Incident Reviews provided to the team that were not reported as SIRIs. As part of the factual accuracy process a further CIR was provided.

There have been a relatively consistent number of inpatient deaths each year over the period. Fewer deaths are being reported as incidents through Ulysses though. There was a reducing bed base over the period. See table below:

	RiO	All Ulysses	Unexpected Ulysses	SIRI
2011/12	41	31	15	7
2012/13	31	19	8	3
2013/14	27	11	7	6
2014/15	29	15	15*	8
Total	128	76	45	24

Figure 76: Inpatient deaths – numbers of SIRI by year

*This figure has since reduced further following re-categorisation post coroner decisions.

The table below breaks down the attrition by service:

Inpatient deaths	Total	Ulysses	Unexpected	SIRI or CIR
Older People MH	104	56	29	12
Adult Mental Health	18	15	13	15
Learning Disability	3	2	1	2
Secure Services	3	3	2	2
Total	128	76	45	31

Figure 77: Inpatient deaths – number of SIRIs by service

There were fewer deaths reported to Ulysses and subsequently categorised as unexpected over this time as a proportion of total inpatient deaths and few inpatient deaths are investigated as SIRIs.

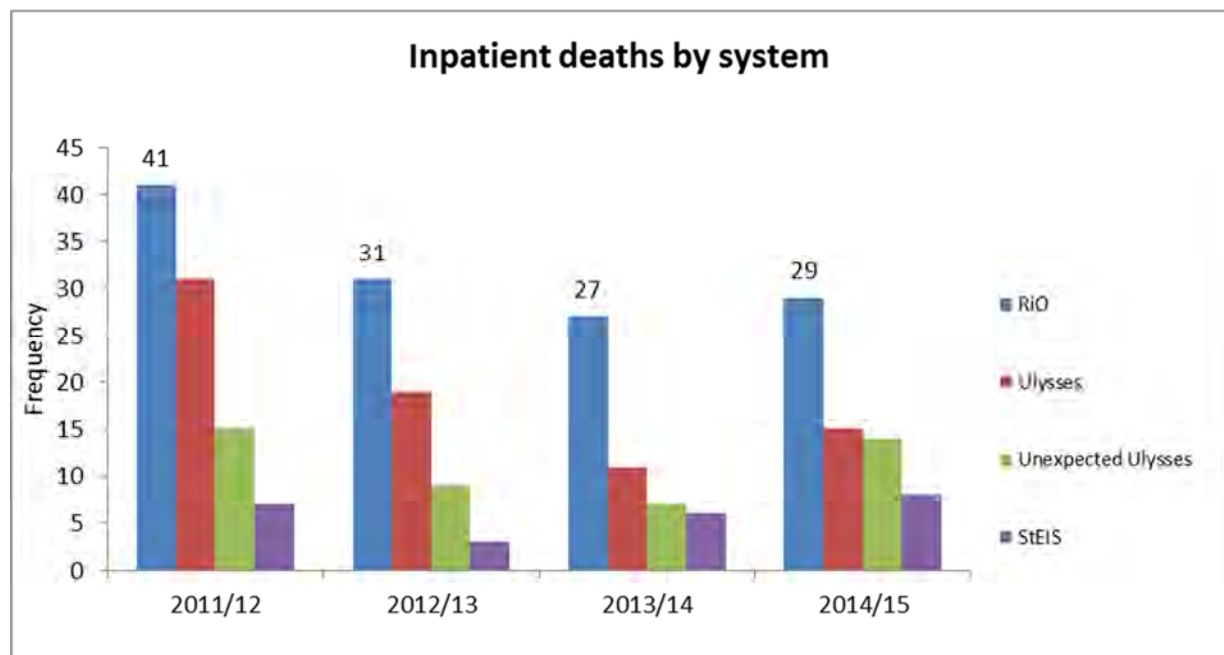


Figure 78: Inpatient deaths reported by system

NB: The numbers of unexpected Ulysses reports in 2014/15 are likely to reduce as deaths become re-categorised following coroner decisions.

The deaths can be broken down into four groups: there were 18 deaths in Adult Mental Health inpatient units, 104 Older People Mental Health units; three Learning Disability inpatients at the time, and three Secure unit service users.

The table below shows how many of the deaths were investigated (CIR or SIRI) and how many were not. Of the 128 inpatients who died 24 were subsequently investigated as a SIRI relating to the unexpected death. A further seven CIRs were undertaken. 60% of Adult Mental Health deaths were investigated. 12 of those in Older Peoples Mental Health services were investigated as a CIR or SIRI (StEIS)

	Total	Investigated	Not investigated	StEIS
Older People MH	104	12	92	9
Adult Mental Health	18	15	3	12
Learning Disability	3	2	1	1
Secure Services	3	2	1	2
Total	128	31**	97	24

Figure 79: Numbers of inpatient deaths not investigated by service

** Includes seven Critical Incident Reviews

There have been no reviews of Mental Health or Learning Disability inpatient deaths undertaken by the Trust as a group or within divisions including in Learning Disability during the period.

There were three inpatient deaths of people with a Learning Disability. One was subject to an IMA; one subject to an IMA then a CIR (sent to the review team in October 2015. (The Trust states in December 2015 this was a SIRI but has not yet provided it); and one was subject to a SIRI. The deaths of inpatients investigated as a CIR (and SIRI) each year is small. The table shows the total numbers below:

	AMH	OPMH	LD	SS	Total
2011/12	4	4			8
2012/13	3	2		1	6
2013/14	3	4	2		9
2014/15	5	2		1	8
Total	15	12	2	2	31

Figure 80: Inpatient deaths reported as CIRs or SIRIs by year

The graph below shows the number of deaths by ward and the proportion that are investigated in Older People Mental Health wards. Of 104 Older People Mental Health inpatient deaths nine were investigated as SIRIs and reported through StEIS (8.5%).

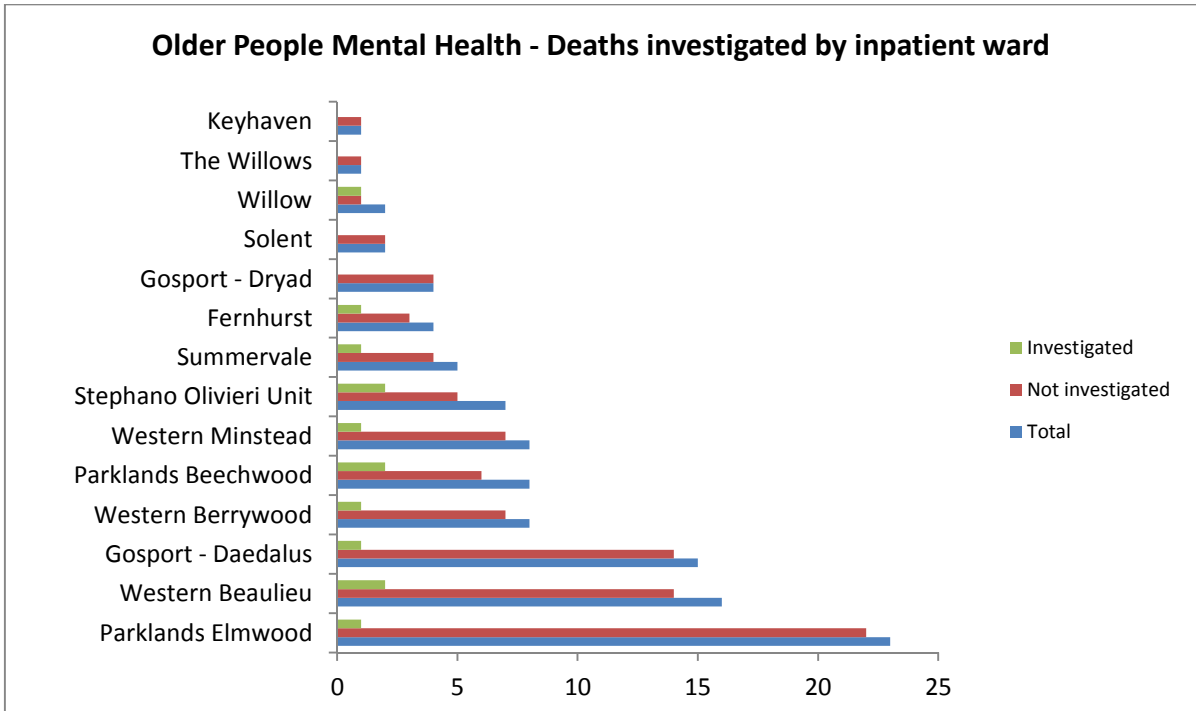


Figure 81: Deaths of OPMH inpatients by ward and whether investigated

The graph below shows the deaths occurring on Adult Mental Health Inpatient units and the proportion that were investigated and those that were not. 83% of Adult inpatient deaths were investigated through a CIR or SIRI of which 80% were reported through SteIS as SIRIs.

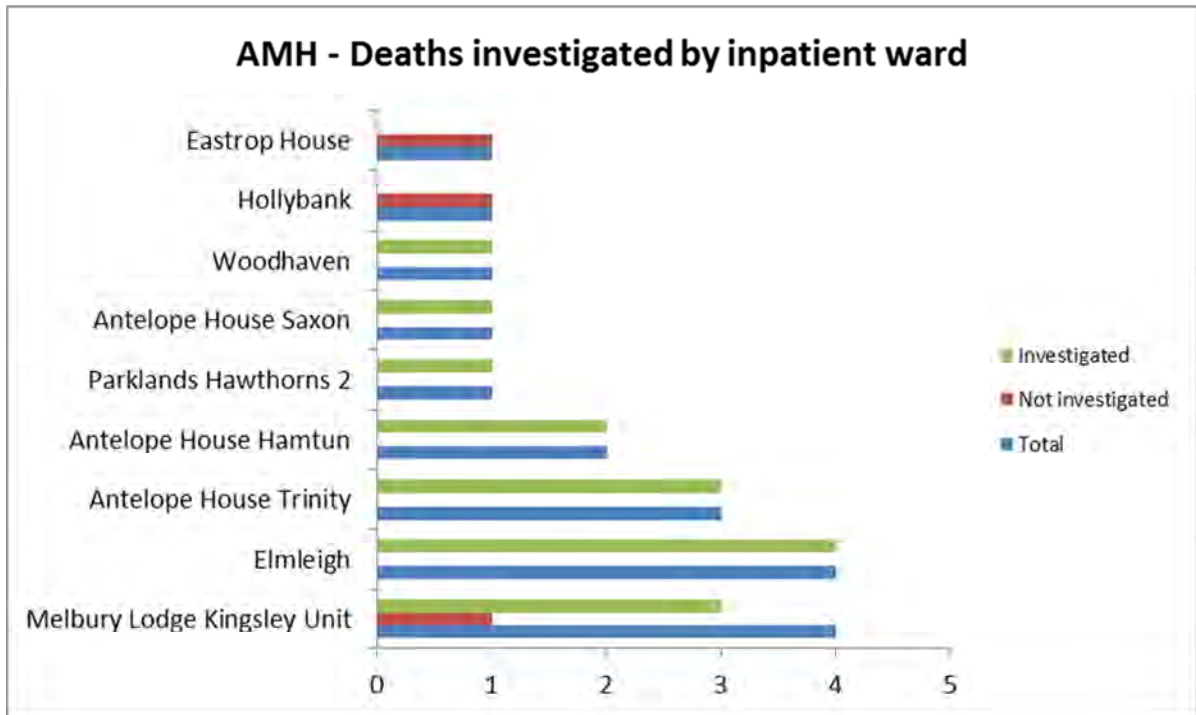


Figure 82: Deaths of AMH inpatients by ward and whether investigated

The patterns highlighted in Figures 81 and 82 could have a variety of explanations but this would need further analysis to provide assurance to the Board that inpatient deaths are properly investigated.

There were a number of themes arising from the SIRIs and CIRs of inpatients.

Older People Mental Health

- The SIRI cases relating to Older People Mental Health service users raise serious issues. Of the nine cases four had no inquest, one is still outstanding. Given the highly challenging nature of the care needed for this group of service users it is surprising that so few are subject to an IMA, as those that are investigated give cause for concern.
- The quality of the SIRI investigations that were undertaken in the above cases were of a poor quality. Six were considered to be of a very poor standard with a combination of grammatical errors and lack of challenge, two were well written but lacked challenge or a sense of seriousness of the situation. The remaining SIRI report from 2013 was a report into two falls on one unit within two days of each other - one of which resulted in a death as a result of the fall. A further CIR provided to us in factual accuracy checking was also a fall which made no mention of the subsequent death.
- There were three CIRs provided to the team in Older People Mental Health services - including a sudden death which needed reviewing given delay in assessing his serious condition. Sudden unexpected deterioration leading to death with transfer to acute or liaison with acute is a feature in a number of cases. As part of factual accuracy processes the Trust stated there were a further three CIRs completed for OPMH. The number of CIRs completed in OPMH services remains small.
- The Trust provided information that suggests more IMAs were undertaken in OPMH inpatient units. This appears to be about 56 but has not been verified. Two IMAs were provided as part of the factual accuracy process after the Trust had told the team these were reported to StEIS as SIRIs when it transpired they had not been.

Learning Disability

- There were three deaths of Learning Disability service users as inpatients.
- There were two further service users who had been discharged from inpatient units but subsequently died. Both were subject to previous or current safeguarding or incident investigations and both were being cared for Trust staff - one in a hospice and one in acute care.

Adult Mental Health

- There were three CIRs - all died from serious physical health complications in acute care

Inpatient Case studies:

Below are some anonymised cases which serve to demonstrate some of the themes arising from the scenarios in inpatient care that have been investigated or not.

Detained patients sudden deterioration and transfer to acute care

A detained patient transferred to acute care and died. The death was not investigated in line with guidance used by the Trust.

Observations not being undertaken by agency staff

Patients not having observations undertaken or recorded according to care plan. A patient had many incidents recorded involving many falls and required neurological observations; the subsequent SIRI was of a very poor standard.

Busy wards

The Ulysses record states that there was high clinical activity and reduced staffing levels when this service user died and observations were not done every 15 minutes. No investigation to establish exact circumstances and impact of staffing levels.

Frail elderly patients investigations, restraint and the need to ensure accurate information is provided to the coroner

Patient found dead. Many documented incidents of aggressive behaviour. No inquest was held or post mortem. There were no contemporaneous records of the death and this was identified as a significant risk to the Trust by the SIRI author; the doctor who spoke to the Coroner appears not to have had all information to hand - the SIRI report states ... 'would have had a different conversation' if he had. Poor SIRI report.

Patients on Mental Health units as acute care unable to manage

Patient with complex physical health needs. Debates about where best to care for him as Acute services unwilling to manage him; yet Mental Health nurses expected to manage difficult physical care needs. Numerous moves between acute and Mental Health care wards in the preceding few months. The SIRI report was of a poor standard.

Elderly service user dies after a fall

Patient dies after a fall. The SIRI report refers to two service users both having fallen and suffered fractures. One service user dies following surgery for repair. The SIRI makes no reference to the subsequent death and therefore the CCG has limited information available to it.

Conclusions:

128 service users died in inpatient units over the four year period. Of these the circumstances of the deaths were investigated in 24 cases.

The majority of deaths of Mental Health and secure unit service users between 18-65 years are investigated. Few deaths of Older People in Mental Health services are subject to an IMA or investigated.

Not all deaths constitute a SIRC or can be considered a Critical Incident. However, there a number of themes arising from the available information which would indicate the need for regular review of all inpatient deaths and for themes to be considered.

Deaths immediately post discharge and those requiring emergency transfer to a medical ward are not all formally reviewed. A number of the reports highlight sudden service user deterioration, a requirement for CPR, observations not being carried out, a requirement for transfer under the Mental Health Act, sudden unexpected death post discharge where risk assessments may need improving and cases where physical health care management has been provided in a Mental Health setting often with high risk and frail service users.

There is a need to ensure that a review of inpatient deaths is undertaken to share insight into how services can be improved - in particular between providers with complex cases. This insight into inpatient deaths is an insight into some of the most complex and challenging cases where there is considerable risk of failure or care problems that require robust and detailed investigation processes that are shared with commissioners.

Deaths in detention and notification to Care Quality Commission (CQC) under Regulation 17

The guidance being used by the Trust relating to the national Serious Incident framework in force at the time of this review requires all deaths in detention to be reported as a SIRI. The Trust has reported 16 out of 27 deaths of detained patients. 11 deaths were not reported to StEIS.

The Trust uses a 2010 national document developed by the NPSA to guide NHS bodies as to what other organisations should be informed of specific serious incidents. It uses this document to decide what to investigate as a serious incident. The document is used by the Trust locally and appears not to be prescribed national guidance despite being referenced in the 2010 framework. It states that all deaths of persons subject to the MHA 1983 receiving care from Mental Health services should be reported as a serious incident. All deaths are reported to CQC but not all are subject to an IMA or investigated in line with the Trust's guidance or best practice.

The Trust has reported all deaths in detention to CQC in line with their duties under Regulation 17. There were 29 relevant deaths that were required to be reported. Two were the responsibility of the local authority to report under Guardianship orders and they were reported to CQC.

The Trust had no complete list of all notifications as these are seen as a local MHA administrator responsibility. The Trust was unable to provide a full and accurate list, on request, of all service users who had died whilst in detention - either as an inpatient or in the community. The Trust had to undertake further enquiries to clarify their reporting duties with reference to the section status of patients whilst producing information for this review. The list provided to us by the CQC was also incomplete.

If a service user dies immediately post discharge from the Act there is no requirement to report under Regulation 17. These deaths will therefore be reported as usual through the incident or NRLS system (Regulation 16) if seen as relevant. There is therefore the risk that there are deaths that occur immediately after a period of detention which do not need to be reported under the regulation but would have benefited from further investigation.

The 2010 National Framework for Reporting and Learning from Serious Incidents was issued in 2010 by the NPSA. Alongside this a separate document was issued and referred to in the 2010 Framework as a further guide to help organisations understand what other agencies may need to be notified of serious incidents in addition to the NPSA. It is a detailed list of serious incidents and has been in use by the Trust locally for the full period of this review to guide what to report as a SIRI. It states that all deaths in detention should be reported as SIRIs and is the supporting guidance in use by the Trust. However, not all deaths are being investigated in line with this document.

There is, however, no statutory requirement to investigate all deaths in detention under the Mental Health Act 1983 as a SIRI, although the 2005 Independent Investigation of Adverse Events in Mental Health services document also references the need to independently investigate cases where the State may be responsible for a death.

There is a statutory responsibility to notify all deaths in detention to CQC under Regulation 17. However, our review has identified that the Trust's systems do not allow tracking of these accurately. An original list provided by the Trust was inaccurate and demonstrated an inability to produce this important information.

We requested Regulation 17 notification forms for all deaths in detention for the period of the review from both the Trust and the CQC. The Trust could not immediately provide all notifications from one data source and relied on local Mental Health Act administrators at each of the different locations to provide them. All notifications were eventually provided after we identified all the individual cases from other data. It took some time to reconcile both lists as there were inaccuracies in dates of death for example which needed to be reviewed individually

The list received from the CQC at the end of March 2015 contained 18 notifications. This list did not include nine notifications sent by the Trust.

We ultimately identified 27 deaths in detention for whom the Trust was responsible for the service user at the time of death.

There is not a reliable system in place to track all notifications in the Trust. All cases were found to have been reported correctly and within the correct timescale but record keeping was inadequate. There was some lack of clarity as to what was required under Regulation 17 and the Trust needed to look into this further before being able to answer a number of questions. This included whether certain section status were reportable and also which section patients were under. This involved individual interrogation of the RiO system. In one case there was conflicting information about whether a patient was on S17 or S19 leave. The CQC notifications were not provided when requested and repeated individual requests had to be made to secure them as we identified relevant patients. This leads us to form the view that, had the Board requested, the information it would have been at risk of not being accurate.

There were 29 deaths under detention reportable under Regulation 17. Of these two were under Guardianship Orders and were reported by the Local Authority as required and this was confirmed directly with CQC.

Of the remaining 27 service users – three were under Community Treatment Orders, one person had just been discharged as an inpatient but remaining subject to the Act whilst waiting for CTO paper work which had not been completed and 23 were current inpatients. All appear to have been notified to the CQC within the time period required although four forms were undated.

16 of the 27 detention deaths were investigated or reported as a SIRI/CIR: all the younger age groups; fewer of the older ages.

All 12 deaths of people under the age of 65 were investigated. 11 were reported as SIRIs and one had a CIR.

11 of 15 deaths over the age of 65 were not investigated. Three were reported as SIRIs and one had a CIR.

12 of the deaths could be considered expected from physical causes such as cancer and known concerns or were unexpected but could be explained as natural causes based on available information. However, guidance and good practice indicates that all death in detention should be reported to StEIS and investigated.

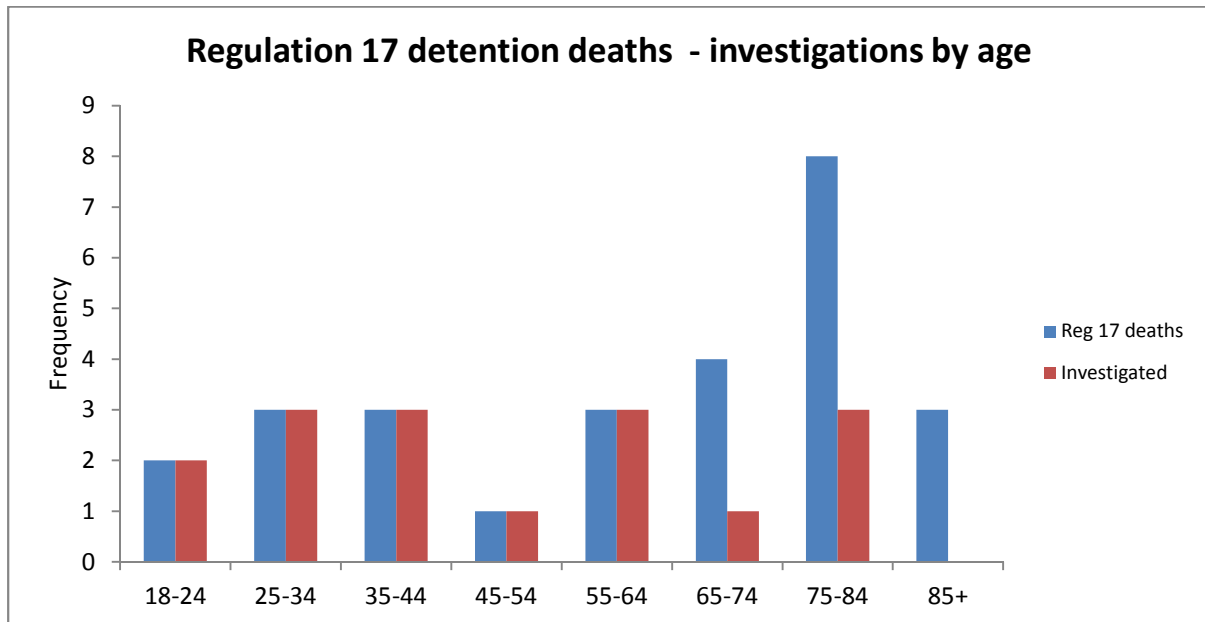


Figure 83: Regulation 17 deaths by age band

There was no thematic review of deaths in detention in the period. Deaths of service users detained occurred in the following places:

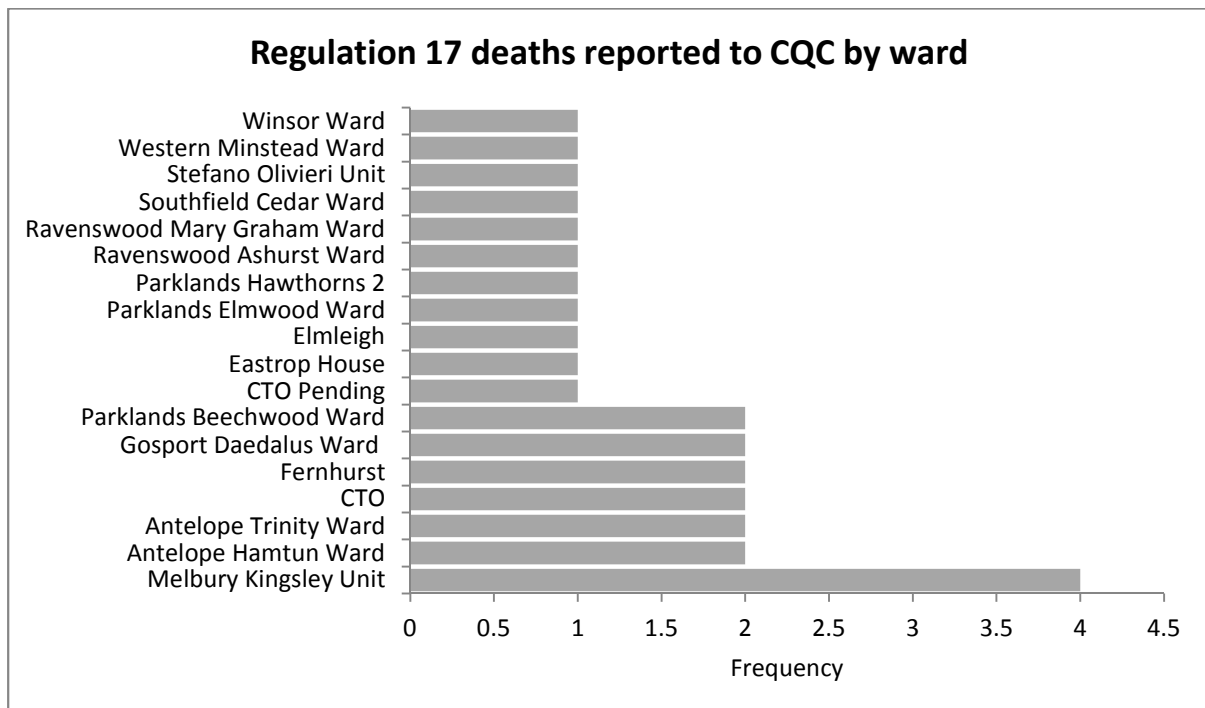


Figure 84: Regulation 17 deaths by ward

Types of sections

Type	Number	Section 17 leave	Notes
S2	8	3	2 S17 for medical treatment
S3	12	7	5 S17 for medical treatment
S5(2)	1	-	-
S37 or S37/41	2	1	1 S17 for medical treatment

Figure 85: Regulation 17 deaths by type of Mental Health Act section

There were three deaths of service users granted S17 home or escorted leave who died whilst away from the ward and a further death where the S17 leave was directly related to the death back on the ward.

There were a number of deaths of service users very recently discharged under the Act which means they do not need to be reported under Regulation 17. It would seem to be good practice to investigate these deaths given a recent detention and discharge.

Conclusions:

Unexpected deaths of service users under detention under 65 are investigated. However, there are a number of Older People's deaths that have not been subject to an IMA or investigation when they should have been. Whilst a number of these can be clearly classified as either expected or from natural causes, it would appear that there is no opportunity to reflect on the care provided when liberty is restricted. Some very long term service users are fully dependent on the Trust and without investigation it is unclear whether everything necessary had been done in providing physical care in the period leading up to their death in a Mental Health setting.

Some of the cases involve acute providers being unable to manage service users in a medical ward setting and therefore service users with complex needs having to be cared for in a Mental Health setting. Other cases involve sudden deterioration and transfer to acute care in the immediate period pre-death including resuscitation.

It is well known that service users are at risk post discharge from an inpatient unit. One service user was discharged from the MHA and from an inpatient unit and died the following day. This death was not investigated at all as he was no longer detained. Other service users died very soon after discharge from the MHA and were also not investigated.

The Trust investigates those that are clearly unexpected and sudden with non-natural causes. Investigations of other deaths are less likely to occur and the opportunity for review and learning lost.

The national guidance produced by the NPSA that is in use by the Trust is clear that all deaths of people under the Mental Health Act 1983 should be reported as SIRIs, and recognising this is not nationally prescribed, this appears not to have been done in all cases.

Involvement with Coroners and Inquests

The Trust has been involved in at least 375 Mental Health or Learning Disability inquests in the last four years. Staff are regularly called to give evidence or provide reports to the coroner.

The Trust has a duty to provide accurate information to the coroner which is of a high standard.

Detail about the coronial system is available online and it is only due to its impact on decisions to investigate deaths, the timescales of those investigations and the concurrent investigations and information that is provided to the Coroner by the Trust that we discuss it here.

There are legal processes that are required when an unexpected death occurs which we are not outlining in detail here. A detailed list of when a death should be reported to a coroner is at Appendix 8.

However, an unexpected death in the community often involves the police and the GP. A discussion with a coroner will ensue and a decision taken to issue a death certificate, undertake a post-mortem examination to ascertain the cause of death and finally a decision to go to inquest or not. As can be seen from the list at Appendix 8 many deaths of the Trust's service users require at least a conversation with the coroner or an inquest – sometimes requiring a Jury inquest.

A discussion with the coroner will often take place. For inpatients this will be with the Consultant in charge of the case; in community settings this is often out of the hands of the Trust as it is usually the GP that speaks with the coroner or the police. It is imperative that the coroner is provided with accurate information relating to the circumstances of the death to enable a decision to be taken.

On one occasion it is clearly noted in the SIRI report that the Consultant did not have all the information to hand and would have had a different conversation if he had.

A GP should have all relevant information available relating to a death in the community and this may involve a conversation with a number of professionals. Whilst we have not undertaken a full review of engagement with GPs, it is clear from the reports we reviewed that there are some conversations held with GPs to establish cause of death to inform the decision whether to investigate further.

There was no evidence of any IMA being shared with a GP and there is no expectation in any guidance that it would be. This is likely to be a national issue, but as some of the IMAs contain relevant information or raise care questions, we consider that better liaison with GPs may be required in these early stages in particular in relation to deaths in residential or nursing home care of people with a Learning Disability.

Investigation reports are an important document for the coroner as it may be requested directly or form the basis of the report to the coroner by the Consultant in charge.

In total the Trust has been/is involved in around 375 Mental Health/Learning Disability inquests over the period. An inquest was held or due to be held in at least 175 of the 195 Mental Health/Learning Disability SIRIs cases we reviewed.

This means that a large number of cases are heard at inquest, but the Trust will not have produced any formal investigation documents in terms of CIRs. Coroners reports are produced as a separate exercise.

A post-mortem will either confirm the cause of death sufficiently to issue a certificate and no inquest will be required. However, sometimes an inquest will be required where the circumstances need further investigation through the coronial system. The Trust will often wait for the inquest before starting a CIR investigation.

One complexity is that the coroner may decide that the death is from natural causes – this often results in no further investigation taking place by the Trust. It is important to note that a natural causes death does not always mean it is expected. A natural causes death can occur earlier than anticipated and does not mean that there is no learning to be had as a result of care and service delivery problems. This part of the process risks a missed opportunity to learn and share service delivery problems with commissioners and others.

Staff witnesses are required as well as coroner reports. Coroner reports are often prepared by Consultants within the Trust and are seen as a professional medical responsibility. Consultants are offered support and guidance if needed. Any oversight of these reports remains within the divisions.

On the whole few Learning Disability deaths appear to go to inquest but it is not possible to say how many conversations with the coroner take place as the majority of these will be the GPs responsibility. We were able to identify six cases of people with a Learning Disability that went to an inquest.

Commissioners involvement in SIRIs

Commissioners learn of an unexpected death investigation if the Trust informs them. This can either be directly or through StEIS. Decisions as to whether to report a death onto StEIS relies on the Trust providing accurate information to the CCG within a short timeframe. Given the poor quality of IMAs and the lack of robust decision-making there is a risk that commissioners do not receive sufficient information to make a correct assessment.

Commissioners review all SIRIs at closure panels held regularly. The closure panel process can take place some months post incident adding to the timescales to close a SIRI case. Evidencing actions being taken is a key part of the closure process.

The lead CCG have had to return SIRIs for poor quality, have found delays in reports being completed and have had to reopen cases for further investigation.

The Serious Incident Framework 2013 and responsibilities of Commissioners

Actions for Commissioners are clearly laid out in the 2013 NHS Serious Incident Framework. These are summarised below:

Responsibility	Comment
Ensure providers have robust reporting arrangements in place;	The Trust have had inadequate reporting processes in place; serious incidents are not reported to StEIS in a timely manner.
That providers report incidents to commissioners within 2 working days of identifying an incident;	Some serious incidents take months to be reported. The Trust does not complete the majority of its Initial Management Assessments within two days.
That providers report to NRLS and other appropriate organisations, never events and safeguarding incidents;	The Trust reports very few Category 5 deaths to NRLS and there is inconsistent categorisation of other death incidents. The data cannot be reconciled.
That incidents be managed and investigated in a transparent manner. The investigation should be of good quality and use robust methodologies that link recommendations to findings;	The Trust's investigations are of a poor quality and have been for some time. There have been a number of warnings from at least one Commissioner and the Coroner.
Close an incident when they are satisfied with the investigation, recommendations and action plans have that have been submitted. Action points should address each root cause and contributory cause;	Some incidents are closed before actions are fully implemented. Action plans have been generally weak and recommendations and evidence often are not linked.
Decisions on closure are based on objective and measurable evidence; If there is uncertainty about a root cause then a Further Action Required field is available to facilitate the rapid identification of issues with an organisations analysis capabilities which can be addressed through contracts;	Root causes are rarely (20%) identified by the Trust in investigations. The Trust's investigation capabilities have been weak throughout the period of the review.

Action plans have named leads and review dates;	Action plans have named leads and review dates
Learning is embedded and demonstrated through regular thematic reviews;	Thematic reviews relating to deaths have been limited in the last four years other than an annual suicide analysis.
Investigations are quality assured and independent;	Investigations are largely in-house and undertaken within the same area team. The quality assurance of investigations has been inadequate within the Trust and the CCG closure process had not resulted in the required improvements.

Closure panels

All SIRIs should be sent to the Commissioner for review and closure. SIRIs are only closed when assurance can be secured that action plans are complete or substantially complete. We tracked the SIRIs going to closure panels in 2014/15.

There were two cases of incidents occurring in 2012 that were being discussed in March and April 2015.

Nine cases occurring between April and December 2013 were still being discussed in 2014/15.

Table showing some of the closure timescales between date of incident and date of closure panel

Month of incident	Observations
November 2012	Closure panel March 2015
December 2012	Closure panel April 2015
April 2013	Closed in August 2014 – inquest outstanding
June 2013	Closure panel January 2015
June 2013	Escalated by CCG to the Trust after 2 years
August 2013	Closure panel January 2015
September 2013	Closure panel January 2015
October 2013	Closed October 2014
November 2013	Closure panel November 2014 – police investigation
November 2013	Closure panel September 2014
December 2013	Closed in October 2014
January 2014	Returned to the Trust due to poor quality and report closed April 2015

Figure 86: Examples of timescales between incidents and SIRI closure

On average SIRIs took ten months to close from the date of the incident. This timescale had come down to seven months for the most recent 50%. There were 13 cases that took over a year to close. Six cases had to be returned or reopened due to poor quality or further information coming to light.

The Trust's commissioners are informed through the StEIS system and an alert raised when the Trust decides a death constitutes a SIRI. There are some cases where the CCG and the Trust discuss the case directly to decide if it is SIRI reportable. This relies on accurate information at the time of the discussion at the right level of seniority and may involve an IMA having been completed.

Sometimes the Trust is not aware of a death until informed by the Coroner or the National Confidential Inquiry into Suicides or it is discovered by chance e.g. through caseload review/GP notification or through RiO. Occasionally therefore deaths can be reported to StEIS some months post death. The usual cut off in these circumstances is 12 months.

For the Trust, West Hampshire CCG is the lead commissioner for Hampshire. There are several other CCGs and commissioners of services from the Trust. The NHS England Area team will be informed of all Grade 2 SIRIs. However, the Trust is largely left to deal with all SIRIs and the CCG will be provided with the report (that is then not service user identifiable) at a closure panel held by the CCG. The Trust is responsible for providing all the evidence at the panel.

Until very recently the SIRI report had to be reviewed by the CCG based on whatever had been put on StEIS by the Trust. However, this has changed (July 2015) and the full report with all embedded documentation is now provided to the panel a week in advance.

There is a tendency not to report to StEIS immediately and there can be considerable delay between the date of the incident and it being reported to StEIS.

We reviewed all SIRI closure panel minutes for the year May 2014 to April 2015 as provided by West Hampshire CCG. 49 cases were considered during this time.

- 12 cases during the year had not yet been reviewed by the panel as at May 2015.
- A number of 2013 cases had taken between 16 and 24 months to be closed in StEIS.
- In October 2013 a case was returned for poor quality; for another the CCG were still waiting for an action plan; another was reopened after further contradictory information came to light from Safeguarding; another case was reopened and an external review commissioned.
- In May 2015 the quality of a report was again so poor that the CCG had to write to the Trust expressing its concerns. This report had been through Trust processes and signed off through the virtual process but was still of poor quality.

Conclusions

The CCG is dependent on information being provided to it relating to Serious Incidents.

There can be considerable delay in reporting a serious incident to StEIS.

The CCG has not been effective in securing the necessary co-operation and improvement from the Trust to improve reporting, the quality of investigations or securing thematic reviews.

Contextual and comparative information

There is a range of data available that might further investigations into unexpected deaths and their causes. These have not been fully explored.

The report identifies some initial issues that warrant further analysis. Consideration should be given to the development of a data set/dashboard of data that will allow providers and commissioners to readily identify issues and which (through publication) will enable greater transparency.

Some of our work has involved compiling and using data for the first time nationally. We drew from the HSCIC data link between ONS data on death and the Mental Health Minimum Data Set. This is the first time that this information has been presented and we recommend that there is a wider discussion about how the data can be analysed and interpreted.

There are barriers to the ready access to data. This is partly due to explicable reasons around information governance and to a lack of familiarity of what is available (knowing where to look). There is considerable scope to make better use of data which exists locally and nationally (as demonstrated by this report).

Our findings suggest that the relatively low level of reporting of deaths by the Trust is related to local practice on reporting rather than a lower level of unexpected or other deaths.

Undertaking a detailed statistical analysis of the significance of this data was not part of the scope and would be required before further action was taken. Statistical significance is not normally undertaken in benchmarking exercises. The findings shared below intend to highlight areas for further investigation and to draw parallels with other findings in the report where this is relevant.

As part of its brief, the review team was asked to: “provide a contextual view” using benchmarking data to compare death rates of people in receipt of services from Southern Health with comparable organisations. The brief noted that “While a benchmark only identifies ‘norms’ or ‘averages’ rather than best practice, it will be possible to identify whether Southern Health is an outlier”. This was seen as “using routine data which is collected”. We have therefore taken a benchmarking approach which does not use statistical significance as accepted practice.

To complete this work, Mazars has drawn data from a number of sources - see Appendix 4. While most/all of the data is routinely collected, the experience of the review has been that much of it is not routinely used and some of it isn’t published publicly. While the review team received excellent co-operation from colleagues in NHS England (NHSE), from the Health and Social Care Information Centre (HSCIC) and others, obtaining the data took several months. It will be important to better facilitate the use of this data in the future to enable the enhanced focus on death and its reporting that the report recommends.

With the agreement of the Expert Reference Group, the focus of the review developed to take account of a range of factors: from practical issues around data, to the emerging findings of the review overall. For example, our review of the regional data reported to the Strategic Executive

Information System (known as StEIS) provides an important perspective to the attrition in reporting we found within the Trust.

Whenever the data we obtained enabled it, we have followed the agreed, national categorisations e.g. around “unexpected deaths”.

Some of our work has involved compiling and using data for the first time nationally. We drew from the HSCIC data link between ONS data on death and the Mental Health Minimum Data Set (MH MDS) to enable a comparison of death rates across Mental Health Trusts. To enable this we constructed a set of indicators and standardised the crude death rates to enable comparisons. Our methodology is attached as Appendix 10. This is the first time that this information has been presented and we recommend that there is a wider discussion about how the data can be analysed and interpreted. It should be noted that for the period this data was available, the Minimum Data Set only covered mental health services and so comparative information has not been included for people with a Learning Disability in these charts.

Nationally, a number of risk factors have been identified where there might be a correlation between characteristics of a service and the level of deaths amongst its service users. The National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness (NCISH) identifies a number of observational correlations between higher suicide rates and, for example, higher rates of: non-medical staff turnover; patient complaints; safety incidents and of detained inpatients. There is a range of data available on these risk factors. It is not part of this review to assess the services provided by the Trust. Our review of Serious incidents does identify a number of recurrent issues that were involved in the period before each service users death. If a dashboard around mortality is developed then consideration should be given to including data on these triggers/early-warning indicators.

Findings

Note on the charts

Southern Health is the *active trust*

Comparisons are made to a regional average of other Mental Health Trusts in the charts drawing on data from STEIS (shown as cohort average line), and to a national average in other charts as indicated (shown as average).

Findings on national and regional reporting

The report describes a comparatively low level of reporting by the Trust to national incident reporting systems of patient deaths.

The Strategic Executive Information System (StEIS) is a record of reported Serious Incidents, so its data implies that an investigation has taken place though it is recognised that investigations are sometimes undertaken which may not be reportable to StEIS. The review was given access to StEIS data by the NHS England Thames Valley Area Team for the Mental Health Trusts in its area of the South Region. Therefore, the comparisons in the following two charts are regional not national ones

and compare the Trust to nine other Mental Health Trusts in the South. These Trusts provide a variety of different services and this needs to be kept in mind when making comparisons. The comparison could be done nationally and involve different cohorts if the data for other regions is made available.

The Trust reported relatively few unexpected deaths of service users to regional and national systems. This could mean that strategically and externally with commissioners and regulators, decisions on risk and safety are made which may be based on an incomplete assessment.

Deaths on StEIS per 1000 Mental Health service users and as a percentage of all reports.

The Trust reported a lower level of deaths on to StEIS than other Mental Health Trusts in the region (shown by the cohort average line), see Figure 87. The significance of the finding needs to be assessed in the context of other data (such as that on death rates below) and of the attrition in investigation and reporting the review has noted within the Trust overall. The values are relatively small.

The Trust has reported fewer deaths per 1,000 Mental Health service users and at a declining rate compared to nine other Mental Health Trusts regionally.

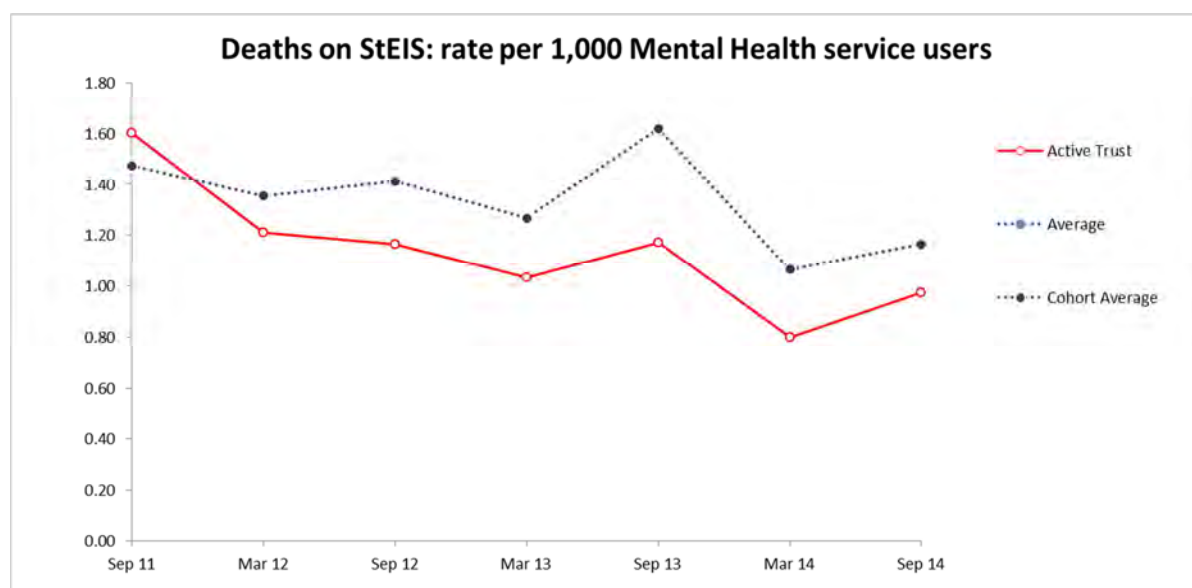


Figure 87: Deaths reported to StEIS per 1000 Mental Health service users

We looked at the proportion of StEIS reports that were for people who had died. Compared with the average for the other nine regional Trusts, the Trust had fewer reports. We excluded all pressure ulcer reports. This is because reports of pressure ulcers constitute a very high proportion (75% approximately) of all StEIS reports and by removing them we can see more easily what other reports there are.

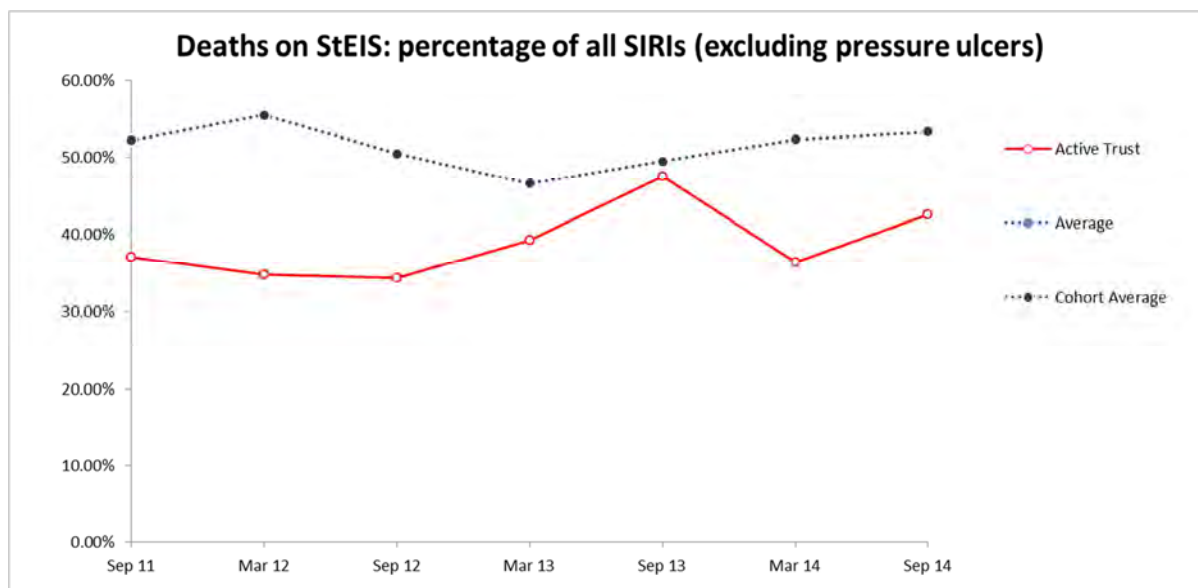


Figure 88: Percentage of incidents reported to StEIS that were deaths

Reports of deaths, which are uploaded to the National Reporting and Learning system (NRLS)

The data reported to the National Reporting and Learning system (NRLS) was reviewed.

While we noted that the published data highlighted a low reporting of deaths by the Trust, there are some difficulties with the system nationally including differing interpretation of what to report by individual Mental Health Trusts. We have been advised by the NRLS team not to use national data to benchmark individual Trusts to identify under-reporting Trusts as some Trusts over-reported and so we have excluded our analysis from this report as a consequence.

The values for the Trust in the last three published reporting periods for deaths reported under the category “degree of harm death” were:

- October 13 to March 14 – 1
- April 14 September 14 – 7
- October 14 to March 15 – 0

Findings on comparative death rates

To undertake the review of death rates we obtained data from the experimental link established by the HSCIC between data from the ONS and the Mental Health Minimum data set. The information on death is currently only available up to the calendar year 2012/13; while data on Learning Disabilities was only added to the MHMDS in late 2014. This means that our analysis of national data on comparative death rates is for Mental Health service users only.

When comparing death rates it is important to note that variation may be associated with a range of factors including local demography as well as service provision. In turn, a provider such as the Trust only provides part of the services needed by people with a Mental Health problem. The service user experience of and access to primary care or substance abuse services for example will have a profound impact (see the service issues identified through our review of serious incidents above). We report below variations in the death rates of service users of the Trust. These variations are not

necessarily a consequence of any particular aspect of the Trust’s approach: they do however provide an important context to the review and a starting point for further investigation.

Undertaking a detailed statistical analysis of the significance of this data was not part of our brief and would be required before further action was taken as a consequence. However, we highlight below where we consider the Trust should focus based on quartile and adjusted death rate analysis. The findings shared below are intended to highlight areas for further investigation (as is usual in benchmarking exercises) and to draw parallels with other findings in the report where this is relevant.

To provide a context to the information on the death rates amongst service users of the Trust we reviewed key contextual data. This included indicator 5.1 of the NHS Outcomes Framework, which rates the excess under 75-mortality rate in adults with serious mental illness for the years 2011/12 and 2012/13 for the CCG population. This shows that excess mortality in the seriously mentally ill across Hampshire and Southampton is not significantly higher than the England average.

The spine charts below summarise the data on death rates comparing the Trust with the national average of all other Mental Health NHS Trusts. The spine chart detail explaining the data is provided below to provide more interpretation of the information:

Indicator name	Trust Value	National average	Spine Chart				
			0 th	25 th	50 th	75 th	100 th
I7 Crude death rate: rate per 1,000 Mental Health service users	72.78	58.17					
I8 Standardised death rate: rate per 1,000 Mental Health users	58.91	57.06					
I9 Premature (under 75) death rate: rate per 1,000 Mental Health service users (under 75)	17.39	15.77					
I10 Unexpected deaths : percentage of all deaths	0.22	0.22					
I11 Unexpected death rate: rate per 1,000 Mental Health service users	15.99	12.84					

Figure 89: Spine charts showing position of the Trust against an average for all Mental Health Trusts for 2012/13

Standardised death rate

The average age of the Trust’s Mental Health service users is higher than in other Mental Health Trusts. The Trust’s standardised death rate for 2012 /13 is very similar to the national average (i.e. at 57 per 1000 service users - see Figure 89). This means that the death rate is close to that expected if the Trust had the same age distribution as other Mental Health Trusts in England.

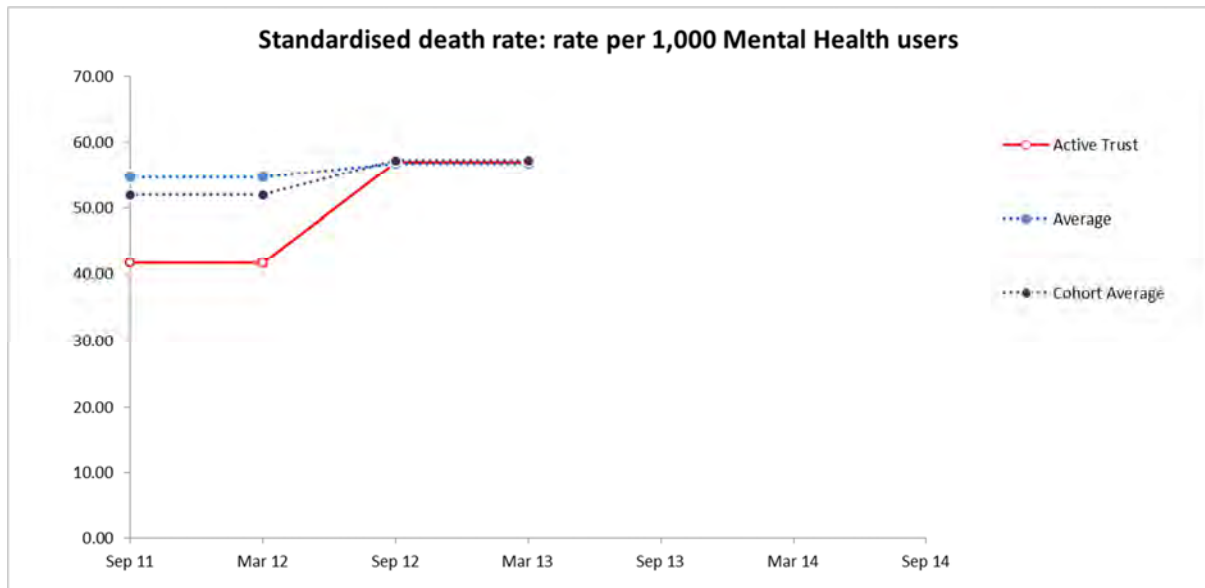


Figure 90: Standardised death rate per 1000 Mental Health service users

Crude death rate

We found that the crude death rate in 2012/13 for the Trust was above average compared to all the other Mental Health Trusts. See Figure 91. (As already noted this difference disappears when age profiles are allowed for by standardisation). This is important when considering the rate at which the Trust reports deaths. A comparatively high level of deaths might be expected to lead to a comparatively high level of reporting though there will be other factors that affect this.

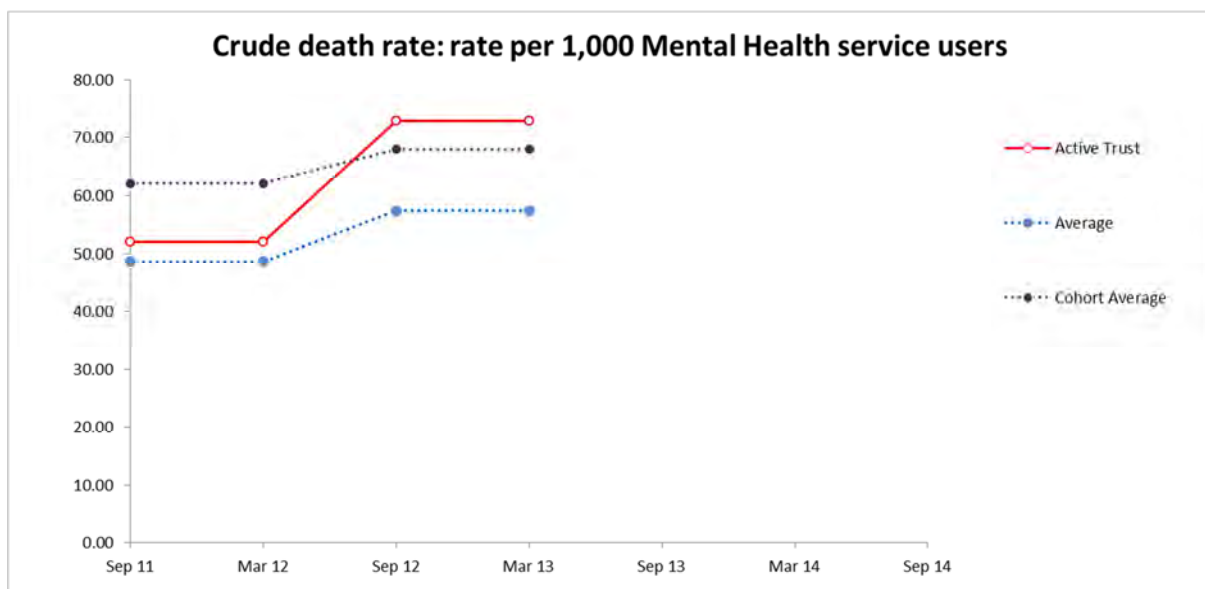


Figure 91: Crude death rate: rate per 1000 Mental Health service users

Premature Deaths

There was a slightly higher level of premature deaths amongst the Trust's Mental Health service users when compared to other Mental Health Trusts.

To calculate the premature death rate, we took the number of deaths of Mental Health service users below the age of 75 with a contact with a Mental Health service in the 12 months prior to their death compared to the total number of service users.

The premature death rate is marginally raised lying a little below the upper quartile. Because by definition, deaths in the highest age groups are excluded we cannot completely attribute this to age factors and we recommend that it is kept under review.

The proportion of users under 75 who are between 65 and 74 is a little higher for the Trust than England (15% vs 12%). This could be a partial explanation for this slightly higher premature death rate.

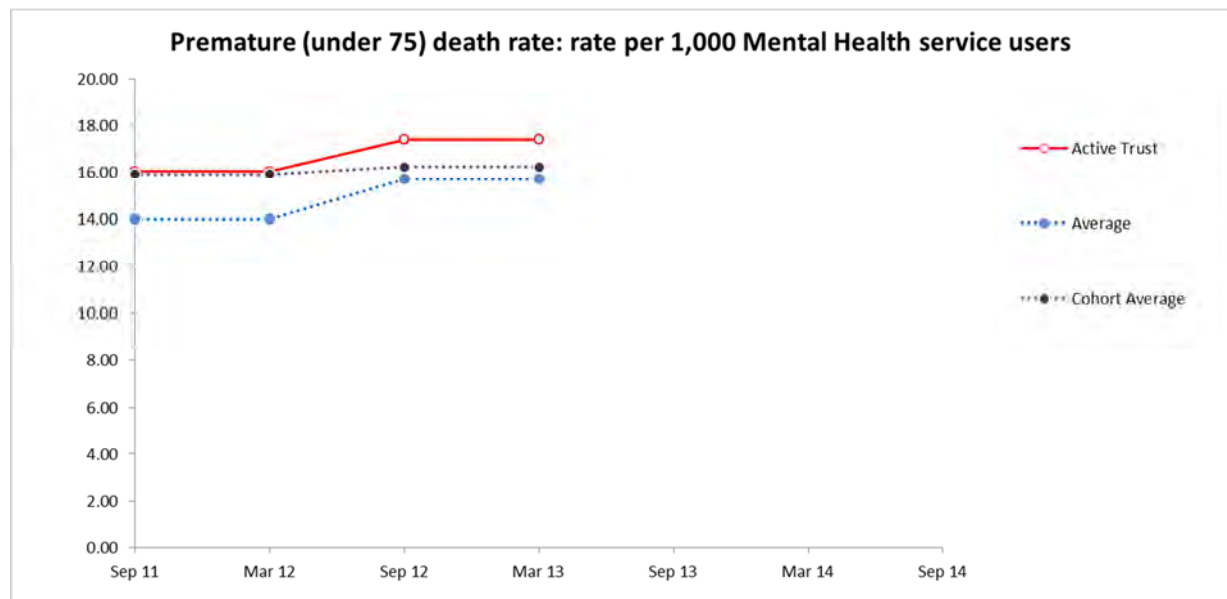


Figure 92: Premature (under 75 years) death rate per 1000 Mental Health service users

Unexpected death rate

We analysed death rates against the diagnostic codes used by the CIPOLD team and sourced from the End of Life Care Intelligence Network as “unexpected deaths”. These codes cover death caused by a range of usually physical conditions including:

- Acute myocardial infarction
- Pulmonary embolism
- Pulmonary aneurysm
- Sudden cardiac death
- Cerebrovascular disease
- Aortic aneurysm
- Acute Respiratory disease includes influenza, pneumonia
- Injury, poisoning, other consequences of external causes
- External causes

ONS data suggests a higher than average level overall of unexpected deaths in the Trust. See Figure 93. This was also the case across the regional cohort though. However, the proportion of deaths of the Trust's service users which are unexpected is the same as the average for England. This is likely to be because of the older average age of Trust service users.

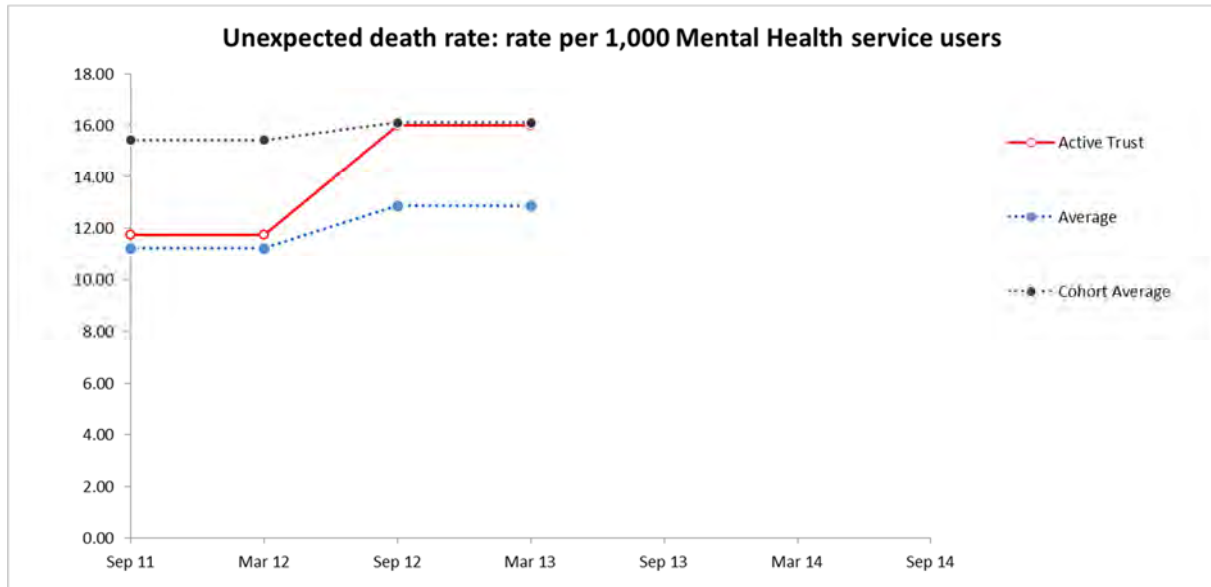


Figure 93: Unexpected death rate per 1000 Mental Health service users

ICD10 Chapters

We analysed death data by ICD 10 chapter as above and identified four (V, VI, IX and XX) that are comparatively high and which need to be closely monitored by the Trust. These are:

- Chapter V Mental and behavioural disorders e.g. organic, mood and behavioural disorders and dementia (which might be expected given the comparatively older cohort in the Trust). However, even taking into account age standardisation this is still higher.
- Chapter VI Diseases of the nervous system e.g. Inflammatory and degenerative diseases of the central nervous system
- Chapter IX Diseases of the circulatory system e.g. Pulmonary heart disease and diseases of pulmonary circulation
- Chapter XX External causes e.g. injured in accidents, Intentional self-harm

The chapters relating to 'Mental and behavioural disorders' e.g. organic, mood and behavioural disorders and 'Diseases of the nervous system' cover a range of dementia related conditions which may in part explain the high level given the elderly population in Hampshire.

The spine chart below shows the position of all 20 ICD10 chapters from which the four above are highlighted as being both in the upper quartile and above a rate taking into account the crude death rate.

Indicator name	Trust Value	National average	Spine Chart				
			0 th	25 th	50 th	75 th	100 th
I12 Chapter I (certain infectious and parasitic diseases) death rate: rate per 1,000 Mental Health service users	1.04	0.49					
I13 Chapter II (neoplasms) death rate: rate per 1,000 Mental Health service users	8.84	7.75					
I14 Chapter III (diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism) death rate: rate per 1,000 Mental Health service users	-	0.00					
I15 Chapter IV (endocrine, nutritional and metabolic diseases) death rate: rate per 1,000 Mental Health service users	0.78	0.78					
I16 Chapter V (mental and behavioural disorders) death rate: rate per 1,000 Mental Health service users	16.12	11.74					
I17 Chapter VI (diseases of the nervous system) death rate: rate per 1,000 Mental Health service users	9.23	5.48					
I18 Chapter VII (no deaths) death rate: rate per 1,000 Mental Health service users	-	0.00					
I19 Chapter VIII (no deaths) death rate: rate per 1,000 Mental Health service users	-	0.00					
I20 Chapter IX (diseases of the circulatory system) death rate: rate per 1,000 Mental Health service users	18.85	14.09					
I21 Chapter X (diseases of the respiratory system) death rate: per 1,000 Mental Health service users	9.23	8.62					
I22 Chapter XI (diseases of the digestive system) death rate: per 1,000 Mental Health service users	2.60	2.68					
I23 Chapter XII (diseases of the skin and subcutaneous tissue) death rate: per 1,000 Mental Health service users	0.28	0.00					
I24 Chapter XIII (diseases of the musculoskeletal system and connective tissue) death rate: per 1,000 Mental Health service users	0.38	0.23					
I25 Chapter XIV (diseases of the genitourinary system) death rate: per 1,000 Mental Health service users	1.17	1.13					
I26 Chapter XV (no deaths) death rate: per 1,000 Mental Health service users	-	0.00					
I27 Chapter XVI (no deaths) death rate: rate per 1,000 Mental Health service users	-	0.00					
I28 Chapter XVII (congenital malformations, deformations and chromosomal abnormalities) death rate: rate per 1,000 Mental Health service users	-	0.00					
I29 Chapter XVIII (symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified) death rate: rate per 1,000 Mental Health service users	1.04	1.10					
I30 Chapter XIX (no deaths) death rate: rate per 1,000 Mental Health service users	-	0.00					
I31 Chapter XX (external causes of morbidity and mortality) death rate: rate per 1,000 Mental Health service	2.99	2.32					

Figure 94: Spine charts showing 2012/13 ICD 10 rate for the Trust compared with England average

Conclusions:

The Trust reports relatively few deaths to national systems. It reports fewer deaths to StEIS compared to the other Mental Health Trusts in the region per 1,000 Mental Health service users. Published national data indicated that the Trust reported a reducing number of deaths under the "Degree of Harm Death" category for the period. The numbers being reported reduced over the last three years, so that in the last published reporting period no deaths were reported under "Degree of Harm Deaths". On further interrogation, the Trust stated it had reported 11 deaths (8 for Mental Health and Learning Disabilities) for the whole period. We conclude that the Trust reports a very small number of deaths under the highest degree of harm category.

This is not because of there being fewer premature or unexpected deaths amongst its service users. It is likely to be related to practice in reporting.

The consequences are:

- That its Board is not fully sighted on the level and trends in deaths at the Trust
- The national data the CQC uses for its intelligent monitoring may not be accurate. The incidents uploaded by the Trust to the NRLS may not include all deaths that the Trust should be reporting under statutory requirements to report certain deaths to the CQC via the NRLS.
- The relationship between the Trust categories in Ulysses and those in NRLS need further investigation.

There are some ICD10 Chapters which indicate that the Trust has a higher than expected rate of deaths in four chapters - which are in the highest quartile and even accounting for age are high. These should be kept under review when the 2013/14 data becomes available.

The national context and reports relating to mortality in Mental Health and Learning Disability

There have been national reports and research undertaken into the mortality of people with a Learning Disability and those in need of Mental Health care. The reports highlighted below are significant and make very clear recommendations. The issues they raise are well publicised and will be well known to all Mental Health and Learning Disability care providers and commissioners. We would expect providers and commissioners of Mental Health and Learning Disability services to be fully cognisant of the risk of prematurity in death and the prevailing health inequalities that exist for people with these care needs.

Our review of the Serious Investigations in the period up to March 2015 suggests that many of the issues highlighted in national studies prevail across the area served by the Trust. This includes:

-A number of incidents in which the physical care made available to people with a mental health problem and or a learning disability was insufficient and which should be subject to review and closer monitoring

-Delays in treatment by the health system in responding to the needs of people with a Learning Disability

-Early deaths of people with a Learning Disability, which are, on average, younger than the CIPOLD cohort

-A lack of joined up health and social care provision and adjustments for people with both Learning Disability and Mental Health needs

-A lack of challenge in investigations into death and poor quality reporting

-A lack of advocacy for vulnerable people in a number of 'groups'

-A lack of transparency in investigations into deaths in detention or at times any investigation

-Little involvement of families in investigations including in inpatient deaths

What do key national reports tell us?

There are important national contexts relevant to the findings of the review at Southern Health, including:

- The concerns identified in a number of published national reports about the premature death of some people with a Learning Disability;
- A similar acknowledgment that people with a serious mental illness, such as psychosis, also die some 15 to 20 years earlier than members of the population overall;
- An acceptance, that the data available on the deaths of people with a Learning Disability is incomplete and fragmented along with some evidence of under reporting;
- The increased focus across the NHS on transparency and on "candour";

Our review has focused on Southern Health NHS Foundation Trust and has identified a number of themes around care prior to death and the subsequent reporting of those deaths. It is important though that these findings are seen in a broader context and, for that reason, we provide a summary of the relevant national work below. This context begins to answer two key questions:

- Are the issues identified at the Trust typical of the sector as a whole?
- Do the reviews findings and recommendations have a relevance to other providers and commissioners of services to people with a Mental Health problem and/or a Learning Disability?

The review cannot assess the arrangements in each Mental Health NHS Trust and so cannot determine if all the findings from our work are typical across the sector. Our review does not cover much of what these studies do but does overlap in a couple of key areas. The reports below highlight that in many cases the issues we have identified are present elsewhere.

Death by Indifference – Mencap March 2007

The report uses case studies to identify that the real, underlying cause of many deaths of people with a Learning Disability “is the widespread ignorance and indifference throughout our healthcare services towards people with a Learning Disability, and their families and carers”. This is seen as “institutional discrimination” e.g. something that goes beyond the acts or omissions of individuals and reflects a corporate mind-set and indeed one which prevails more widely in society. It means that the practice, policy, procedures and systems followed by healthcare staff are not grounded in a proper knowledge of the needs of people with a Learning Disability: a collective failure.

The report follows on from Mencaps Treat Me Right! Report and campaign in 2004, which exposed the unequal healthcare that people with a Learning Disability, receive from healthcare professionals. It quotes the chairman of the Disability Rights Commission that “early deaths in these groups are not acceptable” and that they had encountered “complacency and a lazy fatalism that these groups just do die younger”.

The report notes that people with a Learning Disability have poorer health than the general population. This is partly due to:

- Conditions that can be related to their disability (for example, epilepsy, thyroid problems, sight and hearing problems)
- Socio-economic factors – people with a Learning Disability are generally poorer

But it is also due to a poor standard of treatment within NHS services, which (the authors maintain) often seems to stem from ignorance and prejudice among healthcare professionals towards people with a Learning Disability.

The Confidential Inquiry into the deaths of people with learning disabilities (CIPOLD) March 2013

One of the demands made in Treat Me Right and Death by Indifference above was for a confidential inquiry into premature deaths of people with a Learning Disability.

The Confidential Inquiry into the deaths of people with learning disabilities (CIPOLD) was tasked with investigating the avoidable or premature deaths of people with learning disabilities through a series

of retrospective reviews of deaths. Its aim was to review the patterns of care that people received in the period leading up to their deaths, to identify errors or omissions contributing to these deaths, to illustrate evidence of good practice, and to provide improved evidence for avoiding premature death.

CIPOLD investigated the sequence of events leading to all known deaths of people with disabilities (aged four years and older) in five Primary Care Trust (PCT) areas of South West England; the area had a mixture of urban and rural communities and a population of 1.7m. These PCTs did not include Hampshire or Oxfordshire but were close neighbours within the same region.

The inquiry reviewed the deaths of 247 people with learning disabilities over a two-year period in 2010–2012, approximately 2½ times the number expected. Of note is that the CIPOLD Overview Panel identified some additional deaths that they thought should have been reported to the Coroner, and expressed concerns about some Coroners' reviews of deaths.

Using the same definition as is used in the child death review process, 43% of the deaths of people with learning disabilities were classified as unexpected. Using ICD-102 data on conditions that are commonly known to be unexpected (e.g. myocardial infarction, pulmonary embolus, cerebrovascular disease), there was no significant difference between people with learning disabilities and the general population. (We can't relate this to our findings on benchmarked unexpected deaths as the data is currently only for mental health service users).

A death was considered as premature if, *'without a specific event that formed part of the "pathway" that led to death, it was probable that the person would have continued to live for at least one more year'*. This allowed the Overview Panel to take account of both lifestyle and co-morbidity in assessing the potential significance of events or omissions in the care of the person concerned, regardless of their age. Of the 238 deaths of people with learning disabilities for which agreement was reached by the Overview Panel, 42% were assessed as being premature. The most common reasons for deaths being assessed as premature were:

- delays or problems with diagnosis or treatment; and
- problems with identifying needs and providing appropriate care in response to changing needs.

As above the benchmarked data in this report isn't directly comparable, though our analysis of RIO suggests an earlier death for service users in the Trust we couldn't replicate the CIPOLD work without doing a full retrospective case review.

The report explored issues identified in the deaths of people with learning disabilities that had been found to have directly contributed to premature deaths. The central issue was that of delays in the care pathways of people with learning disabilities, specifically relating to investigations, diagnosis and treatment. However, CIPOLD also identified 3 associated factors that enhanced the vulnerability of people with learning disabilities:

- a lack of reasonable adjustments to help people to access health services,
- a lack of coordination across and between the different disease pathways and service providers, and
- a lack of effective advocacy.

The median age of death for the 247 people with learning disabilities was 65 years for men and 63 years for women. Thus the men with learning disabilities in the CIPOLD study died on average 13 years earlier than in the general population, while the women with learning disabilities died 20 years earlier. Nearly a quarter of people with learning disabilities in the CIPOLD study were under the age of 50 when they died compared with approximately 9% of the general population (In SHFT 39% were under 50 years old).

Of the deaths reviewed by CIPOLD, it was estimated that over a quarter (27.5%) were amenable to better-quality healthcare. Just under half would be considered to be avoidable using the Office for National Statistics (ONS) definition.

The inquiry concluded that:

- The quality and effectiveness of health and social care given to people with learning disabilities had been shown to be deficient in a number of ways.
- Despite numerous previous investigations and reports, many professionals are either not aware of, or do not include in their usual practice, approaches that adapt services to meet the needs of people with learning disabilities.
- There was continuing need to identify people with learning disabilities in healthcare settings, and to record, implement and audit the provision of 'reasonable adjustments' to avoid their serious disadvantage.

Finally, it recommended the routine collection and review of data that provides intelligence about the mortality of people with learning disabilities and the establishment of a National Learning Disability Mortality Review Body to take forward the reviews of deaths of people with learning disabilities, in order to learn from experience and continue to provide a driver to reduce inequalities in care for this vulnerable population.

Equality and Human Rights Commission report - Preventing Deaths in Detention of Adults with Mental Health conditions February 2015

The report concerns deaths in police custody, special hospitals and prisons. Between 2010 and 2013 367 adults with Mental Health conditions died of 'non-natural' causes while in state detention in police cells and psychiatric wards. Another 295 adults died in prison of 'non-natural' causes, many of these had Mental Health conditions. Since 2013 that number has risen considerably.

The report concludes that the absence of any obligation to investigate a death is damaging particularly for families and makes four recommendations about: learning lessons; raising the profile of staff responsibility to keep people safe, better transparency particularly for families and using the Human Rights Framework across settings.

It further concludes that:

"...openness and transparency and learning from mistakes are just about getting the basics right.

By listening and responding to individuals and their families organisations can improve the care and protection they provide and prevent further unnecessary and avoidable harm."

It recommends the circumstances in which there should be an independent investigation into a death and the factors to be taken into account in deciding who should carry it out should ensure:

- The involvement of families throughout the process, including input to the Terms of Reference, being sent the report and having the opportunity to discuss it
- A clear requirement on commissioners to ensure that providers follow the guidance and monitor investigations to ensure that they are independent, objective and robust
- All reports are published and open to public scrutiny to ensure transparency.

Investigating NHS incidents - parliamentary committee March 2015

The Parliamentary committee report doesn't focus specifically on the investigation of incidents in Mental Health or Learning Disabilities services but its findings provide an important context to this review.

It notes how when investigations occur service users generally have "a feeling of vulnerability and a fear of victimisation".

The committee concludes that all too often there is a culture of defensiveness, poor family involvement, and poor quality investigations in the aftermath of a serious incident. "The quality of investigators in the NHS caused concern to some of our witnesses. We heard a variety of evidence suggesting that NHS bodies needed to deploy more and better qualified staff on the investigation of complaints and clinical incidents."

"A good quality RCA investigation was said to be "characterised by a systems approach (i.e. looking at the role of systems in the incident rather than solely looking at the role of individuals)... However, we were told that the term is now used to mean little more than 'do an investigation', and that many local investigations over-rely on RCA, rather than simpler and potentially more effective methods such as The Human Factors Analysis Classification System."

The report identifies a range of factors for "reducing the risk", one of which is accountability for improvement.

Health and Social Care Information Centre - 2013 findings from the first experimental linkage of data¹²

This identifies that:

- Mortality among Mental Health service users aged 19 and over in England was 3.6 times the rate of the general population in 2010/11.
- People in contact with specialist Mental Health services had a higher death rate for most causes of death, especially mental and behavioural disorders and diseases of the nervous system such as Alzheimer's disease. However a much higher level of mortality (considering

¹² <http://www.hscic.gov.uk/article/2543/Mortality-rate-three-times-as-high-among-mental-health-service-users-than-in-general-population>

people between the ages of 19 and 74) also occurred for lifestyle - related diseases, including:

- Nearly four times the general population rate of deaths from diseases of the respiratory system (at 142.2 per 100,000 service users, compared with 37.3 per 100,000 in the general population).
- Just over four times the general population rate of deaths from diseases of the digestive system (at 126.1 per 100,000, compared with 28.5 per 100,000 in the general population).
- 2.5 times the general population rate of deaths from diseases of the circulatory system (at 254.0 per 100,000 compared with 101.1 per 100,000 in the general population).

Within these disease areas specific conditions that accounted for a high proportion of deaths among service users (under the age of 75) were:

- Diseases of the liver; at 7.6 per cent of deaths (1,430 in total)
- Ischaemic heart diseases; at 9.9 per cent of all deaths (1,880 in total)

Key findings from the new mortality analysis show that in 2010/11:

- The mortality rate was 4,008 per 100,000 (83,390 deaths in total) for Mental Health services users, compared to the general population rate of 1,122 per 100,000.
- By age, the difference in mortality rates was largest among people aged 30 to 39; at almost five times that of the general population, 300 per 100,000 service users (520 in total) compared to 63 per 100,000 in the general population.
- By underlying cause of death, the proportionate difference in mortality rates was greatest for mental and behavioural disorders (where the main cause of death was unspecified dementia) at just over twelve times that of the general population at 556 per 100,000 service users (11,570 in total) compared to 46 per 100,000 in the general population.

Conclusion:

These reports, taken together, provide a clear framework for good practice for all providers and commissioners. This national context has guided our methodology when reviewing all investigations into deaths within the scope of this review. We found that the issues raised in all the reports were replicated across the Trust.

The national policy context – services for people with a Learning Disability

In May 2011, following the exposure of abuse of service users at the Winterbourne View Hospital, the Department of Health set out its action plan in the 'Winterbourne View Concordat'.

The Winterbourne View Concordat charged NHS commissioners with achieving a substantial reduction in reliance on inpatient care for people with learning disabilities or autism. There was one central commitment: by 1 June 2014, if anyone with a Learning Disability and challenging behaviour would be better off supported in the community, then they should be moved out of hospital. As a consequence, the government expected to see a dramatic reduction in hospital placements and large Mental Health hospitals closed, so a new generation of inpatients did not take the place of people then in hospital.

Progress nationally since the Concordat has been widely recognised as insufficient with a limited success in bringing people in to local and community focused services. This has been highlighted in the National Audit Office report "Care services for people with learning disabilities and challenging behaviour" published in February 2015. The report highlights a number of reasons for poor progress including issues around the data and how the government underestimated the complexity and level of challenge involved in meeting its commitments. When it published the Concordat, the government did not know the size of the challenge to increase the capacity of community placements. It had little information on whether local commissioners could put in place the bespoke community placements and personalised care plans required to manage risks and prevent readmissions. The government had not analysed why new service users were referred to hospitals (including the impact on the total inpatient population) nor did it quantify the resources needed to accelerate discharge.

In response, NHS England commissioned Sir Stephen Bubb, to review how best to increase local community provision and move people with learning disabilities out of hospital care. His independent report of November 2014 (Winterbourne View – Time for Change) made a number of recommendations. His report has now largely been accepted in the policy statement "Transforming Care for People with Learning Disabilities – Next Steps", in the Forward View and in the 12 week consultation initiated by the Health Minister on the 6th March on the Green paper "No voice unheard, no right ignored".

The Green Paper wants to see four things:

- people in charge, supported by family and friends;
- Inclusion and independence in the community;
- the right care in the right place;
- Very clear accountability and responsibility throughout the system.

This is proposed through giving people five rights, expressed as I/my statements:

- My right to be independent, to be part of a community, and to live in a home I've chosen

- My right to be listened to and have my wishes acted upon. My right to challenge decisions about me.
- My rights under the Mental Health Act
- My right to control my own support and services with a personal budget. My right for my NHS and Local Authority to work together for my benefit.
- I want to know who is responsible for supporting my physical as well as my Mental Health

Appendix 1 - Original Terms of Reference for the review

Southern Health Specification

Introduction

The death of Connor Sparrowhawk while under the care of Southern Health Foundation Trust was a terrible tragedy. Arising from his death three areas of work have been agreed to assure safety and continue service improvement within the Trust and more broadly.

These areas work are:

1. The Learning Disability Commissioning Pathway Project
2. An external independent investigation into the death of Connor Sparrowhawk
3. An external independent investigation into all service users who died whilst receiving Mental Health or Learning Disability services at Southern Health Foundation Trust (SHFT), since the trust was formed in April 2011.

This specification is for the third area of work, the independent investigation into all service users who died whilst receiving Mental Health or Learning Disability services at SHFT

Overview – Outcomes and outputs to be delivered through this specification

The outcomes and outputs from the independent review into Mental Health and Learning Disability service users who died while receiving care from Southern Health NHS Foundation Trust will include:

Tangible Outputs

- A document summarising the findings with respect to all deaths in the Mental Health and Learning Disability services provided by Southern Health NHS Foundation Trust. This will be contextualised in relation to both national and local intelligence about correlates (e.g., of health risk) and local organisational issues in NHS and social care services.
- A set of recommendations arising including, as appropriate, action plans, briefing workshops, advice and/or a framework for ongoing assurance.
- Information to feed in to the work of the Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD). In this way, the work will represent an early implementation of recent CIPOLD proposals.
- Information to feed in to the Equalities and Human Rights Commission Inquiry into the non-natural deaths of people with Mental Health conditions in state detention.
- Evidence on key data items that correlate with safe care and adverse care indicators.

Outcomes

- A shared view across all the key players of risks within Southern Health services, of improvement action required, and plans to deliver change.
- Advice to the CCGs about Learning Disability commissioning, data management and analysis, and adverse events indicators.

There will be four elements to the work

1. User, family and carer input

As required further discussion with people who have used services, families and carers to identify areas of concern, types of incidents, categorisation by geography, services type and client group, and assurance that these continue to be identified, as required, throughout this piece of work.

2. Review of all deaths

Review of every serious incident leading to a death of whatever nature and however categorised since 2011. The aim of this element is to confirm that all such deaths were correctly identified, notified to the appropriate agencies and then to ensure that processes are in place to review, action plan and ensure lessons are learnt from them.

3. Benchmarking data

To provide a contextual view, key benchmarking data items will be used to compare death rates of people in receipt of services from Southern Health with Mental Health Trusts. While a benchmark only identifies 'norms' or 'averages' rather than best practice, it will be possible to identify whether Southern Health is an outlier. This information will be used to identify any common themes and trends and any common contributory factors.

4. Adverse events indicators

Information about patterns in these data may help to identify key indicators of risk for avoidable death (e.g., by suicide or from avoidable physical health-related causes). Such information, if available, will be summarised to inform service users, carers, commissioners and providers about care quality.

Governance

An independent panel will be established to assure the content and process of this third area of work. It will report to the Oversight and Assurance Group of the NHS England, Thames Valley and Wessex QSGs.

The independent panel will include the NHS England lead, a lay representative nominated by the family of Connor Sparrowhawk, Southern Health NHS Foundation Trust lead, Oxfordshire CCG lead, a Monitor representative,¹³ Service User / Carer representative, 2 independent clinical experts (one in Learning Disability one in suicide) – one of these expert members will act as the Chair of the panel. The panel will meet for the launch of the work and as required during the work. When the work has been completed, the panel will review all information gathered, including about cause of death, and the panel will make recommendations as to whether further investigations are required.

Timescale

The work specified is expected to be concluded within four months from the start.

¹³ This is the original terms of reference. NHS England decided in the process of setting up this meeting that the Trust and CCG would not form part of the panel as the focus changed to an expert reference group and it was therefore appropriate to revise the membership.

Appendix 2 - Documents reviewed

Main documents reviewed

All documents are internal Southern Health NHS Foundation Trust documents unless stated otherwise. The list is not exhaustive.

Corporate Governance

Annual Report and Accounts 2011/12, 2012/13, 2013/14, 2014/15
Board papers April 2012 – July 2015
Medical Director Board Report – March 2015 - May 2015
Quality Improvement and Development Forum – May 2014 - May 2015
Quality and Safety Committee Tracking Report – May 2014 - March 2015
Quality and Governance Committee: Divisional Governance and Assurance Statement – January 2013
Mental Health – Report for Service Performance Reviews – September 2013

External Reviews

Verita - Independent Investigation into the Death of CS Redacted (February 2014)
West Hampshire Clinical Commissioning Group - Report on Review of Serious Incidents Requiring Investigation at Southern Health NHS FT (January 2014)
Contact Consulting - Quality and safety assurance review at Oxfordshire Learning Disability NHS Trust for NHS South of England (South Central) (September 2012)
RSM Tenon - Serious Incident Management Internal Audit at Southern Health NHS FT (August 2013)
Care Quality Commission Report - Quality Report (February 2015)
Care Quality Commission Report - Intelligence Monitoring Report (November 2014 and June 2015)
NHS National Reporting and Learning System - Organisation Patient Safety Incident Reports April 2011 to March 2015

Incident Reports

All IMAs into Learning Disability Deaths April 2011 – March 2015
All IMAs into Adult Mental Health Deaths April 2011 – March 2015
All CIRs for Learning Disability Deaths April 2011 - March 2015
All CIRs for Adult Mental Health Deaths April 2011 - March 2015
All SIRs into Deaths April 2011 – March 2015
A sample of IMAs and CIRs for Older People Mental Health Deaths

Incident Reporting policies, procedures and guidance

Receipt and Scrutiny of Statutory Forms under the Mental Health Act 1983 (as amended) (April 2012)
Procedure for the Management of Serious Incidents (2011, 2012, September 2014)
Procedure for Reporting and Managing Incidents (2011, September 2014)
Incident Reporting FAQs
Guide to Logging in to Ulysses

Guide to Reporting an Incident on Ulysses
Managing Incidents – hints, tips and guidance
Duty of Candour Reporting Guidance Notes
Briefing note which describes the evolution in management of SIRIs in the MH and LD divisions over the last few years
Adult Mental Health Division: Guidance on Completing a SIRI

Management Information

Learning Disabilities Performance Suite (April 2015)
Mental Health Community Performance Suite (April 2015)
Mental Health Inpatient Performance Suite (April 2015)
Learning Disabilities Incident Reports February 2015 - April 2015
Mental Health Incident Reports February 2015 - April 2015
TQ21 Incident Reports February 2015, March 2015, April 2015
Analysis of Suicides 2011/12, 2012/13, 2013/14, 2014/15

Safeguarding

Adult Statutory Review Tracker 2015
Safeguarding reports (2)

SIRI Governance Documents

Corporate SIRI Panel Papers - April 2015 - June 2015
AMH: Area Report for Integrated Governance – January 2013, February 2013
AMH: CIR Panel Briefings – June 2012 - December 2013
Action Plan for SIRI Themes – April 2015
AMH: SIRI Closure Panel Minutes (with West Hampshire CCG) – May 2014 – April 2015
SIRI Investigators Training Log
Mental Health West Area SIRI Tracker
Pressure Ulcer Weekly Update – June 2015

Thematic Reviews

Dual Diagnosis (including a review of CIRs)
Fires in Inpatient Services in the MH Division
Electric Firefighters review
Bluebird House
Clozapine Investigation
Unexpected IMA Deaths Relating to Physical Health
Seclusion Facilities within the Mental Health Division
Draft notes thematic review - LD division December 2014

Epilepsy learning documentation

CAP Launch Poster Epilepsy Complex Health
Epilepsy case study 090115
Epilepsy divisional could it happen here 090115
Epilepsy map quality conference June 2015
Epilepsy paper for QRM August 2015 and review of work plan

Epilepsy workshop 7th July 2015
Epilepsy work plan August 2015
Headlines - epilepsy clinical map
QSM CAPS feedback Epilepsy Dec ember 2014
Staff Epilepsy guidance Final
TQ21 Toolkit of Epilepsy resources Nov 2014

Other

Organisational Learning Strategy 2014/15 Implementation Plan

Other additional documents provided during factual accuracy process:

CIPOLD updated - Trust exercise on Learning Disability dependency compared with CIPOLD
Trust Governance Flash report.msg
Trust CQRM MHL 150826 minutes see points 3.9 and 6.1
Case studies - review by Head of Legal services
Report demonstrating inpatient v outpatient care
Alton Update Mortality review 12 months 16 10 14
CIR panel meeting 101012
Item 8 - Mortality report assessing avoidable deaths
Item 11 - Southampton Suicide Review 2014-2015
Item 17 - QID report End of Life Jan 2015

Policies and procedures:

2011 (April) Procedure for Reporting, and Investigating Incidents in Mental Health,
Learning Disability Services and TQtwentyone NCP 16
2012 (August) Policy for managing incidents SH NCP 16
2012 (August) Procedure for reporting incidents on incident forms SH NCP 19

Panel minutes and governance processes

Area CIR and IMA sign off DISR 15 10 07 no PID
Documents about SIRI process in AMH
CIR Panel briefing Oct 2012
Enc 9 CIR panel review meeting notes 101012 AMH
CIR panel LD June 2014.doc
Divisional assurance report Jan 13 see Section B pg 4
Area report Jan 13
Area report Feb 13
East area report Sept 13
Duty of Candour Audit 1
Duty of Candour Audit 2
Duty of Candour Audit 3
Duty of Candour Audit 4

Quarter 1 15/16 SIRI and Incident report (August 2015)
DISR agenda 15 10 07 - blank agenda template October 2015 for IMA/SIRI panels

Learning documents

8 April 14. 140326 QID Org learning 14 15
15 09 04 MH Learning Hot spots
1505 Learning Network Monthly Poster May 2015
Assurance and lessons learned in LD after review
Case study EISD
Item 7 - CCG SIRI and organisational learning FINAL QID 1.0
MH Learning Hotspots 10.10.14
MH Learning Hotspots 10.3.14
MH Learning Hotspots 20.6.14
Quality Conference pre-poster v 1 for 9th December 15

Additional analytical evidence provided for factual accuracy

Benchmarking FOI LD - Trust exercise on FOI for reporting on LD deaths in other Trusts
Master list of patient deaths with degree of LD 30 9 15 - Trust exercise on dependency levels in LD
All SIRIs family involvement and time frame LT - analysis of Trusts SIRI list by Trust
Flash report December 22 2014
NEW 24 Aug 15 Flash
New SIRI and incident flash report Draft 17.7.15
13 July 2015 Flash report
OPMH Death - 109
Summary of OPMH Death review
Analysis of OPMH deaths split by over and under 85
Full Death Ulysses Data Amalgamated
Inpatient v outpatient SIRI and Inquest data combined without PID
Mazars proportions investigated
Number of patients who died within an inpatient setting - 21 September
Ulysses complete data set for SHFT Mazars amended LT

Bibliography

National guidance documents in place for the period under review

Name:	National Framework for Reporting and Learning from Serious Incidents Requiring Investigation
Source:	National Patient Safety Agency: National Reporting and Learning Service
Link:	No live link
Year:	2010

Name:	Serious Incident Framework March 2013
Source:	NHS Commissioning Board
Link:	https://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf
Year:	2013

Name:	Information resource to support the reporting of serious incidents
Source:	NPSA
Link:	No live link (Gateway ref 2010/009)
Year:	2010
Note:	Only in use by the Trust locally. Document supports by identifying other agencies to report incidents to in addition to the NPSA

Name:	Independent Investigation of Adverse Events in Mental Health Services
Source:	Department of Health
Link:	http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/publicationsPolicyAndGuidance/DH_4113575
Year:	2005

Background documents

Name:	A Guide to Reporting Deaths to H.M. Coroner and Death Certification
Source:	H.M. Coroner Plymouth and S.W. Devon
Link:	http://www.plymouth.gov.uk/a_guide_to_reporting_deaths_to_h.pdf
Year:	2003

Name:	A Study to Investigate the Barriers to Learning from Serious Case Reviews and Identify Ways of Overcoming These Barriers
Source:	Department of Education
Link:	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/331658/RR340.pdf
Year:	2014

Name:	Actually Improving Care Services for People with Learning Disabilities and Challenging Behaviour
Source:	Ryan and Julian, Justice for LB

Link:	http://justiceforlb.org/tag/actually-improving-care-services-for-people-with-learning-disabilities-and-challenging-behaviour/
Year:	2015

Name:	Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD)
Source:	Norah Fry Research Centre – University of Bristol
Link:	http://www.bristol.ac.uk/cipold/reports/
Year:	2013

Name:	Coroners Statistics 2012
Source:	Ministry of Justice
Link:	https://www.gov.uk/government/statistics/coroners-statistics
Year:	2012

Name:	Death by Indifference
Source:	MENCAP
Link:	https://www.mencap.org.uk/death-by-indifference
Year:	2007

Name:	Epilepsy 12, National Report, Round 2
Source:	Healthcare Quality Improvement Partnership
Link:	http://www.rcpch.ac.uk/improving-child-health/quality-improvement-and-clinical-audit/epilepsy12-national-audit/national-rep
Year:	2014

Name:	Estimating the Current Need/ Demand for Supports for People with Learning Disabilities in England
Source:	Emerson and Hatton, Institute for Health Research, University of Lancaster
Link:	http://www.improvinghealthandlives.org.uk/uploads/doc/vid_7008_Estimating_Current_Need_Emerson_and_Hatton_2004.pdf
Year:	2004

Name:	Notifications required by the Health and Social Care Act 2008 - Guidance for NHS Providers
Source:	Care Quality Commission
Link:	http://www.cqc.org.uk/sites/default/files/documents/statutory_notifications_for_nhs_bodies_-_provider_guidance_v6.pdf
Year:	July 2013

Name:	Human Rights and Social Compliance
Source:	Mazars
Link:	http://www.mazars.co.uk/Home/Our-Services/Consulting/Business-and-Human-Rights
Year:	2013

Name:	Intelligent Monitoring – Trusts that Provide Mental Health Services – Frequently Asked Questions
Source:	Care Quality Commission
Link:	http://www.cqc.org.uk/content/monitoring-trusts-provide-mental-health-services
Year:	2014

Name:	Intelligent Monitoring – Trusts that Provide Mental Health Services – Indicators and Methodology
Source:	Care Quality Commission
Link:	http://www.cqc.org.uk/content/monitoring-trusts-provide-mental-health-services
Year:	2014

Name:	Intelligent Monitoring – Trusts that Provide Mental Health Services – Statistical Methodology
Source:	Care Quality Commission
Link:	http://www.cqc.org.uk/content/monitoring-trusts-provide-mental-health-services
Year:	2014

Name:	Investigating Clinical Incidents in the NHS
Source:	House of Commons: Public Administration Select Committee
Link:	http://www.publications.parliament.uk/pa/cm201415/cmselect/cmpublicadm/886/88602.htm
Year:	2015

Name:	Learning Disabilities: A Working Definition
Source:	Public Health England
Link:	https://www.improvinghealthandlives.org.uk/publications/931/Working_definition_of_learning_disabilities
Year:	2010

Name:	Learning Disability: The National Perspective
Source:	NHS England
Link:	No live link
Year:	2014

Name:	Making Families Count
Source:	Vimeo
Link:	https://vimeo.com/hundredfamilies
Year:	2015

Name:	Monitoring the Mental Health Act in 2013/14
Source:	Care Quality Commission
Link:	http://www.cqc.org.uk/content/mental-health-act-annual-report-201314
Year:	2015

Name:	Mortality Rate Three Times as High among Mental Health Service Users than in General Population
Source:	Health and Social Care Information Centre
Link:	http://www.hscic.gov.uk/article/2543/Mortality-rate-three-times-as-high-among-mental-health-service-users-than-in-general-population
Year:	2013

Name:	NHS Data Gaps for Learning Disabilities
Source:	Glover, Emerson and Barnes, Learning Disabilities Observatory
Link:	http://www.improvinghealthandlives.org.uk/uploads/doc/vid_11422_IHAL2011-06-NHSDataGaps.pdf
Year:	2011

Name:	No voice unheard, no right ignored
Source:	Department of Health
Link:	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/409816/Document.pdf
Year:	2015

Name:	Predicting Death: Estimating the Proportion of Deaths that are 'Unexpected'
Source:	National End of Life Care Intelligence Network
Link:	http://www.endoflifecare-intelligence.org.uk/resources/publications/predicting_death
Year:	2011

Name:	Preventing Deaths in Detention of Adults with Mental Health Conditions
Source:	Equality and Human Rights Commission
Link:	http://www.equalityhumanrights.com/publication/preventing-deaths-detention-adults-mental-health-conditions
Year:	2015

Name:	Public Health England: Progress Report
Source:	Glover, Learning Disabilities Health Intelligence Network
Link:	No live link
Year:	2014

Name:	Reducing the Risk of Choking for People with a Learning Disability
Source:	Hampshire Safeguarding Adults Board
Link:	http://documents.hants.gov.uk/adultservices/safeguarding/Reducingtheriskofchokingforpeoplewithalearningdisability.pdf
Year:	2012

Name:	Regulation 20: Duty of Candour
Source:	Care Quality Commission

Link:	http://www.cqc.org.uk/content/regulation-20-duty-candour
Year:	2015

Name:	Report on Review of Serious Incidents Requiring Investigation
Source:	West Hampshire Clinical Commissioning Group
Link:	No link
Year:	2014

Name:	Review of Suicide Data from StEIS Database
Source:	Lawrence Moulin and Nick Adams, NHS West Midlands
Link:	No live link
Year:	2010

Name:	Root Cause Investigation Tools
Source:	National Patient Safety Agency: National Reporting and Learning Service
Link:	No live link
Year:	2008

Name:	Serious Incident Framework - The Serious Incident Framework: Supporting Learning to prevent recurrence (NHS England, 2015)
Source:	NHS England
Link:	http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/
Year:	2015

Name:	Statutory Notification – Regulations 16 and 20 Care Quality Commission (Registration) Regulations 2009 Death of a Person Using the Service (since updated)
Source:	Care Quality Commission
Link:	http://www.cqc.org.uk/file/4733
Year:	2009

Name:	Suicide Prevention Benchmarking Report
Source:	NHS England
Link:	No live link
Year:	2014

Name:	The Duty of Candour, Fundamental Standards and Fit and Proper Persons Test
Source:	Hempsons
Link:	http://www.hempsons.co.uk/category/dutyofcandour-2/
Year:	2015

Name:	The Report of the Morecambe Bay Investigation
Source:	Dr Bill Kirkup CBE
Link:	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf
Year:	2015

Name:	Transforming Care for People with Learning Disabilities – Next Steps
Source:	NHS England
Link:	http://www.england.nhs.uk/wp-content/uploads/2015/01/transform-care-nxt-stps.pdf
Year:	2015

Name:	Winterbourne View Concordat
Source:	Department of Health
Link:	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213217/Concordat.pdf
Year:	2012

Name:	Winterbourne View – Time for Change
Source:	NHS England
Link:	http://www.england.nhs.uk/wp-content/uploads/2014/11/transforming-commissioning-services.pdf
Year:	2014

Appendix 3 - Template for SIRI review

Name of reviewer	Comment	Physical health issues?	
Title of reviewer	Comment	Yes / No	Comment
Quality of report		RiO issues	
Satisfactory / Unsatisfactory	Comment	Yes / No	Comment
Root cause identified		Risk assessment issues?	
Yes / No	Comment	Yes / No	Comment
Was an action plan developed?	Comment	CPA/care planning/joint assessment issues?	
Is there evidence of lessons learned?	Comment	Yes / No	Comment
Delays in reporting? (if yes, not length of delay in comment box please)		Carer needs addressed?	
Yes / No	Comment	Yes / No	Comment
Language of report - bias?		Evidence of dismissing service user concerns?	
Yes / No	Comment	Yes / No	Comment
Is reporting on severity provided according to Trust policy?		Withdrawal of service pre-death?	
Yes / No	Comment	Yes / No	Comment
Are actions arising 'sanitised'/process?		Staff sickness/capacity?	
Yes / No	Comment	Yes / No	Comment
Linking recommendations with evidence?		Failure to follow up as a result of DNA/lack of engagement	
None / Partial / Complete	Comment	Yes / No	Comment
Coroner?		MHA issues?	
Yes / No	Comment	Yes / No	Comment
Staff available for investigation?		Childcare safeguarding issues	
Yes / No	Comment	Yes / No	Comment
Family involvement in investigation		Other issues	
Yes / No	Comment	Yes / No	Comment
Consultant availability?		Does this case need highlighting/further questions?	
Yes / No	Comment	Yes / No	Comment

Appendix 4 - Source data

RiO

Data source:	RiO
Description:	Trust's electronic patient record system
Data requirement:	All service users who died within 12 months of last contact with the Trust
Parameters – period:	1 st April 2011 – 15 th March 2015
Exclusions:	IAPT services Substance misuse services

RiO data items:	Field contents	Number of complete fields (10296 records)
NHS number	Unique identifier	93.8% (9653/10296)
Date of Birth	Date	100% (10296/10296)
Date of Death	Date	100% (10296/10296)
Date of last appointment	Date	99.8% (10278/10296)
Division	The four divisions and a placeholder for non-Trust services. <ul style="list-style-type: none"> - Adults Mental Health - Older Persons Mental Health - Learning Disabilities - Specialised Services - Exclude Not Our Service 	99.9% (10295/10296)
Service line	The 47 service lines within the four divisions.	99.9% (10295/10296)
Area	The nine geographical areas throughout which the Trust operates. <ul style="list-style-type: none"> - Bucks - East - Hampshire - North - Oxford - Southampton - Swindon - West - Wilts 	99.9% (10295/10296)
Team name	The 131 teams that operate within the four divisions.	99.9% (10295/10296)

Ulysses

Data source:	Ulysses
Description:	Trust's risk management system
Data requirement:	All deaths recorded as incidents
Parameters – period:	1 st April 2011 – 15 th March 2015
Exclusions:	None

Ulysses data items:	Field contents	Number of complete fields (1454 records)
Ulysses reference number	Unique identifier	99.9% 1453/1454
Department directorate	The seven directorates used to categorise incidents within Ulysses. <ul style="list-style-type: none"> - Corporate - Research & Development - East ISD - Learning Disabilities - Mental Health - Non-Shft Service - Southampton And West ISD - TQtwentyone 	100% (1454/1454)
Department site	The 62 department sites where deaths on Ulysses have been recorded.	100% (1454/1454)
Department	The 113 departments where deaths on Ulysses have been recorded.	100% (1454/1454)
Location	Free text with narrative of location of death, for example, patient home address, nursing home	59.1% (860/1454)
Incident date	Date	100% (1454/1454)
Cause group	The five incident cause groups used where deaths on Ulysses have been recorded <ul style="list-style-type: none"> - Abscond, Escape Attempt Or Missing Person - Slip, Trip Or Fall - Service User - Treatment Or Care Related Issue - Unexpected Death - Investigation Complete - Unexpected Death - Under Investigation <p>All deaths, including deaths where the incident type was 'expected' have been categorised as one of the five cause groups above</p>	100% (1454/1454)
Incident type	The 19 incident types used for deaths on	99.9%

	Ulysses, which are types of the following six categories: <ul style="list-style-type: none"> - Expected deaths - Falls - Incorrect or delayed treatment or care - Missing service user - Possible suicides - Unexpected deaths 	(1452/1454)
Actual impact	The 5 levels of impact as prescribed by the National Reporting and Learning System <ul style="list-style-type: none"> - 1 No Harm / Damage / Loss - 2 Low / Minimal Harm, On-Site First Aid - 3 Moderate, Medical Treatment/Short Term Harm - 4 Major, Permanent/long Term Harm - 5 Catastrophic / Death 	100% (1454/1454)
Details of incident	Free text with narrative of the incident	100% (1454/1454)
Additional details of incident	Free text with more detailed narrative of the incident	100% (1454/1454)
NHS number – where completed	Unique identifier	68.8% (1000/1454)

StEIS

Data source:	Strategic Executive Information System (StEIS)
Description:	The NRLS system for recording all serious incidents
Data requirement:	All deaths recorded as serious incidents
Parameters – period:	1 st April 2011 – 15 th March 2015
Exclusions:	All deaths recorded as Southern Health were captured under eight death categories - this initially excluded some deaths not reported under these categories but which have been subsequently identified under other categories to form the final dataset of 195 death incidents.

StEIS data items:	Field contents	Number of complete fields (195 records)
Log No	Unique identified	100% (195/195)
Created on	Date	100% (195/195)
Reporting Organisation	The name of the organisation reporting organisation (Southern Health NHS Foundation Trust)	100% (195/195)
Reporting Organisation Code	The NHS code of the organisation reporting (RW1)	100% (195/195)
CCG/CSU Name Status	Only for the 103 records reported after 1 st April 2013	100% (103/103)
Date of Incident	Date	100% (195/195)
Time of Incident	Time	100% (195/195)
Site of Incident	Free text with narrative on the site where the incident occurred	100% (195/195)
Location of Incident	Free text with narrative on the location where the incident occurred	98.4% (192/195)
Reporter Name	Free text with the name of reporter	100% (195/195)
Care Sector	The two sectors <ul style="list-style-type: none"> - Mental Health - Learning Disabilities 	100% (195/195)
Clinical Area	The 5 clinical areas <ul style="list-style-type: none"> - Forensic Psychiatry - Learning Disability - Mental Illness - Old Age Psychiatry - Rehabilitation 	100% (195/195)
Patient(Date of Birth)	Date	96.4% (188/195)
Patient Type	The 3 patient types	100%

	<ul style="list-style-type: none"> - In patient - Out patient - Community patient 	(195/195)
Patient Gender	Gender	100% (195/195)
Patient Ethnic Group	Ethnic group	100% (195/195)
Type of Incident	<p>The types of incidents resulting in death</p> <ul style="list-style-type: none"> - Suicide by Outpatient (in receipt) - Unexpected Death (general) - Unexpected Death of Community Patient (in receipt) - Unexpected Death of Inpatient (in receipt) - Unexpected Death of Inpatient (not in receipt) - Unexpected Death of Outpatient (in receipt) - Unexpected Death of Outpatient (not in receipt) - Deaths in custody* - Further death incidents identified by the team following review/or sent by the Trust under other categories of incidents in particular, slips/trips and falls and Safeguarding Vulnerable Adults <p>* there was only one death reported under this category and it was not for Southern Health.</p>	100% (195/195)
Incident Grade	<p>The two SIRI grades</p> <ul style="list-style-type: none"> - One - Two 	100% (195/195)
Description of what happened	Free text with narrative description	100% (195/195)
Independent Investigation Required	Denotes by tick box whether an independent investigation is required	100% (195/195)
Immediate action taken:	Free text with narrative description	100% (195/195)

NRLS

Data source:	National Reporting and Learning System
Description:	The NRLS database of patient safety incident reports - web links provided below
Data used with the comparative benchmarking	<ul style="list-style-type: none"> - Number of incidents where the Trust classified the impact of the patient safety as a level 5 – catastrophic/ death - Number of incidents reported - Number of disruptive, aggressive behaviour incidents reported

	<ul style="list-style-type: none"> - Number of patient accident incidents reported - Number of self-harming incidents reported - Number of patient abuse incidents reported
Parameters – period:	1 st April 2011 – 31 st March 2015

NRLS WEBLINKS

<http://www.nrls.npsa.nhs.uk/resources/>

Release date	Data period	Link
Sept 2015	1/10/2014 – 31/3/2015	http://www.nrls.npsa.nhs.uk/resources/?entryid45=135465
April 2015	1/4/2014 – 30/9/2014	http://www.nrls.npsa.nhs.uk/resources/?entryid45=135387
Sept 2014	1/10/2013 – 31/3/2014	http://www.nrls.npsa.nhs.uk/resources/?entryid45=135261
April 2014	1/4/2013 – 30/9/2013	http://www.nrls.npsa.nhs.uk/resources/?entryid45=135255
Sept 2013	1/10/2012 – 31/3/2013	http://www.nrls.npsa.nhs.uk/resources/?entryid45=135195
April 2013	1/4/2012 – 30/9/2012	http://www.nrls.npsa.nhs.uk/resources/?entryid45=135147&p=2
Sept 2012	1/10/2011 – 31/3/2012	http://www.nrls.npsa.nhs.uk/resources/?entryid45=134579&p=2
April 2012	1/4/2011 – 30/9/2011	http://www.nrls.npsa.nhs.uk/resources/?entryid45=133427&p=2

NRLS Source Data provided 2nd November 2015 as updated NRLS reported degree of harm deaths

NRLS Reference:	Dataset	NRLS Cleansed
3649	Data Parameter	"Incidents reported as occurring between 01 April 2011 and 31 March 2015 and exported to the NRLS on or before 27Oct2015 (based on the date the incident was reported to have occurred)"
	Categorical filter	Degree of harm equal to Severe harm or Death and Trust code equals 'RW1' (Southern Health NHS Foundation trust) Organisation changes have been applied with output showing the original reporting trust code.

MHMDS

Data source:	Mental Health Minimum Data Set
Description:	The Mental Health provider monthly return
Data used with the comparative benchmarking	<ul style="list-style-type: none"> - Number of people in contact with services - People subject to the Mental Health Act - People with a crisis plan in place - People on CPA - People on CPA for 12 months - Discharges from hospital net - Discharges from hospital net followed up within 7 days - Number of bed days in reporting period - Number of days of delayed discharge in reporting period - Number of people in contact with services - Open hospital spells
Parameters – period:	1 st April 2011 – 30 th September 2014
Caveats	MHMDS was not collected for September 2014, therefore the data has been extrapolated from the 5 months 1 st April -31 st August 2014. Excludes both Learning Disabilities and CAMHS.

ONS-MHMDS

Data source:	Office of National Statistic Mortality Data and Mental Health Minimum Data Set Data Link
Description:	The mapping between the ONS Mortality Data and MHMDS undertaken by the Health and Social Care Information Centre
Data used with the comparative benchmarking	<ul style="list-style-type: none"> - Total number of deaths of service users by age and gender - Total number of unexpected* deaths - Total number of deaths by ICD chapter code
Parameters – period:	1 st April 2011 – 31 st March 2013
Caveats	<p>*The following ICD codes were used to identify 'unexpected' deaths:</p> <ul style="list-style-type: none"> - Acute myocardial infarction I21*, I22* - Pulmonary embolism I26* - Pulmonary aneurysm I281 - Sudden cardiac death I461 - Cerebrovascular disease I60-I69 - Aortic aneurysm I71* - Acute Respiratory disease (includes influenza, pneumonia J10-J29, J85-J86, J91-J96) - Injury, poisoning, other consequences of external causes S00-T98 - External causes V01-Y98

Data for indicators used from HSCIC and ONS - Metadata Appendix

ICD 10 information from HSCIC

I1	Numerator	StEIS	<p>Total number of deaths on StEIS - all deaths with incident dates within the parameters. Deaths defined as one of the following categories: The eight types of incidents resulting in death</p> <ul style="list-style-type: none"> - Suicide by Outpatient (in receipt) - Unexpected Death (general) - Unexpected Death of Community Patient (in receipt) - Unexpected Death of Inpatient (in receipt) - Unexpected Death of Inpatient (not in receipt) - Unexpected Death of Outpatient (in receipt) - Unexpected Death of Outpatient (not in receipt) - Deaths in custody* <p>Deaths under other categories (for example, slips/trips/ falls) have not been included in this comparison as using the above categories was most consistent.</p> <p>*There was only 1 death in this category for all 10 Trusts across all 4 years.</p>
	Denominator	MHMDS	<p>Number of MH users - this is a 6 monthly snapshot, taken on the last day of the 6 month period. It includes all patients on an active caseload for MH service included within the MHMDS definition. This excludes CAMHS and LD.</p>
	Data Quality		<p>StEIS data is based on self-reporting of serious incidents. Although there is guidance on the reporting of serious incidents, this can be open to interpretation and can lead to different practices in reporting.</p> <p>Deaths may appear under other categories: our review of the data suggests that there are small numbers readily identifiable.</p>
	Notes		<p>An alternative metric of deaths per 1,000 bed days was suggested. However, different clinical practices across the MH sector mean that there is a wide variety of ratios between inpatients and outpatients. Therefore bed days is not suitable as a proxy of organisational size. In addition, many reported SIRIs are for outpatient or community patients.</p>
I2	Numerator	StEIS	<p>Total number of deaths on StEIS - all deaths with incident dates within the parameters. Deaths defined as one of the following categories: The eight types of incidents resulting in death</p> <ul style="list-style-type: none"> - Suicide by Outpatient (in receipt)

			<ul style="list-style-type: none"> - Unexpected Death (general) - Unexpected Death of Community Patient (in receipt) - Unexpected Death of Inpatient (in receipt) - Unexpected Death of Inpatient (not in receipt) - Unexpected Death of Outpatient (in receipt) - Unexpected Death of Outpatient (not in receipt) - Deaths in custody* <p>Deaths under other categories (for example, slips/trips/ falls) have not been included in this comparison as using the above categories was most consistent. *There was only 1 death in this category for all 10 Trusts across all 4 years.</p>
	Denominator	StEIS	All incidents on StEIS - with incidents within the date parameters. Pressure ulcer incidents have been excluded.
	Data Quality		StEIS data is based on self-reporting of serious incidents. Although there is guidance on the reporting of serious incidents, this can be open to interpretation and can lead to different practices in reporting. Deaths may appear under other categories: our review of the data suggests tat there are small numbers readily identifiable.
	Notes		This indicator excludes pressure ulcers SIRIs as RW1's reporting of pressure ulcers is atypical and make it difficult to compare StEIS reporting with other Trusts.

13	Numerator	NRLS	Deaths reported to NRLS - Trusts report the degree of harm to NRLS. If an event is reported as a 'death' it is included.
	Denominator	MHMDS	Number of MH users - this is a 6 monthly snapshot, taken on the last day of the 6 month period. It includes all patients on an active caseload for MH service included within the MHMDS definition. This excludes CAMHS and LD.
	Data Quality		NRLS is not a live system, once a submission is made to NRLS it cannot be amended, this leads to a lower quality of data.

14	Numerator	StEIS	Total number of suicides on StEIS - all deaths with incident dates within the parameters. Suicides defined as one of the following categories: suicide; suspected suicide
	Denominator	MHMDS	Number of MH users - this is a 6 monthly snapshot, taken on the last day of the 6 month period. It

			includes all patients on an active caseload for MH service included within the MHMDS definition. This excludes CAMHS and LD.
	Data Quality		STEIS data is based on self-reporting of serious incidents. Although there is guidance on the reporting of serious incidents, this can be open to interpretation and can lead to different practices in reporting. Classifying deaths as suicides on STEIS can also be variable. Trusts are not allowed to classify deaths as a suicide until this has been confirmed by the coroner. Different practice occurs before this point with some Trusts classifying the incidents as 'suspected suicides' and some as 'unexpected deaths'. This is further compounded by the category not being changed once the coroner findings are released.

17	Numerator	ONS-MHMDS	Number of deaths - this is the number of deaths of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death

18	Numerator		Standardised death rates is calculated as the number of deaths a Trust would have had if the age distribution of its service users matched that of the England Average divided by the total number of service users. See Methodology for standardisation.
	Denominator		See 17 and the Methodology for standardisation.

19	Numerator	ONS-MHMDS	Number of premature deaths - this is the number of deaths of MH service users below the age of 75 with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users under 75 who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death

I10	Numerator	ONS-MHMDS	<p>Number of unexpected deaths - this is the number of unexpected deaths of MH service users with a contact with a MH service in the 12 months prior to their death. Unexpected deaths are those classified to be one of the following ICD-10 codes:</p> <p>Acute myocardial infarction I21*, I22*</p> <p>Pulmonary embolism I26*</p> <p>Pulmonary aneurysm I281</p> <p>Sudden cardiac death I461</p> <p>Cerebrovascular disease I60-I69</p> <p>Aortic aneurysm I71*</p> <p>Acute Respiratory disease includes influenza, pneumonia J10-J29, J85-J86, J91-J96</p> <p>Injury, poisoning, other consequences of external causes S00-T98</p> <p>External causes V01-Y98</p> <p>This is the listing used in the CIPOLD work and was sourced from the End of Life Care Intelligence Network.</p>
	Denominator	ONS-MHMDS	<p>Number of deaths - this is the number of deaths of MH service users with a contact with a MH service in the 12 months prior to their death.</p>
	Notes		<p>This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period.</p> <p>Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death</p>

I11	Numerator	ONS-MHMDS	<p>Number of unexpected deaths - this is the number of unexpected deaths of MH service users with a contact with a MH service in the 12 months prior to their death. Unexpected deaths are those classified to be one of the following ICD-10 codes:</p> <p>Acute myocardial infarction I21*, I22*</p> <p>Pulmonary embolism I26*</p> <p>Pulmonary aneurysm I281</p> <p>Sudden cardiac death I461</p> <p>Cerebrovascular disease I60-I69</p> <p>Aortic aneurysm I71*</p> <p>Acute Respiratory disease includes influenza, pneumonia J10-J29, J85-J86, J91-J96</p> <p>Injury, poisoning, other consequences of external causes S00-T98</p> <p>External causes V01-Y98</p> <p>This is the listing used in the CIPOLD work and was sourced from the End of Life Care Intelligence Network.</p>
	Denominator	ONS-MHMDS	<p>Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.</p>
	Notes		<p>This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period.</p> <p>Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death</p>

I12	Numerator	ONS-MHMDS	<p>Number deaths in chapter I - this is the number of deaths recorded to ICD10 chapter I of MH service users with a contact with a MH service in the 12 months prior to their death.</p>
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	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death

I13	Numerator	ONS-MHMDS	Number deaths in chapter II - this is the number of deaths recorded to ICD10 chapter II of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom

			deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death
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I14	Numerator	ONS-MHMDS	Number deaths in chapter III - this is the number of deaths recorded to ICD10 chapter III of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death

I15	Numerator	ONS-MHMDS	Number deaths in chapter IV - this is the number of deaths recorded to ICD10 chapter IV of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.

	Notes		<p>This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period.</p> <p>Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death</p>
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I16	Numerator	ONS-MHMDS	Number deaths in chapter V - this is the number of deaths recorded to ICD10 chapter V of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		<p>This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period.</p> <p>Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death</p>

I17	Numerator	ONS-MHMDS	Number deaths in chapter VI - this is the number of deaths recorded to ICD10 chapter VI of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS model. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death

I18	Numerator	ONS-MHMDS	Number deaths in chapter VII - this is the number of deaths recorded to ICD10 chapter VII of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12

			resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death
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119	Numerator	ONS-MHMDS	Number deaths in chapter VIII - this is the number of deaths recorded to ICD10 chapter VIII of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death

120	Numerator	ONS-MHMDS	Number deaths in chapter IX - this is the number of deaths recorded to ICD10 chapter IX of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are

			two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death

121	Numerator	ONS-MHMDS	Number deaths in chapter X - this is the number of deaths recorded to ICD10 chapter X of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death

I22	Numerator	ONS-MHMDS	Number deaths in chapter XI - this is the number of deaths recorded to ICD10 chapter XI of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death

I23	Numerator	ONS-MHMDS	Number deaths in chapter XII - this is the number of deaths recorded to ICD10 chapter XII of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12

			resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death
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124	Numerator	ONS-MHMDS	Number deaths in chapter XIII - this is the number of deaths recorded to ICD10 chapter XIII of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death

125	Numerator	ONS-MHMDS	Number deaths in chapter XIV - this is the number of deaths recorded to ICD10 chapter XIV of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are

			two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death

128	Numerator	ONS-MHMDS	Number deaths in chapter XVII - this is the number of deaths recorded to ICD10 chapter XVII of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death

129	Numerator	ONS-MHMDS	Number deaths in chapter XVIII - this is the number of deaths recorded to ICD10 chapter XVIII of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period. Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death

131	Numerator	ONS-MHMDS	Number deaths in chapter XX - this is the number of deaths recorded to ICD10 chapter XX of MH service users with a contact with a MH service in the 12 months prior to their death.
	Denominator	ONS-MHMDS	Number of MH Service users - this is the number of MH service users who have had a contact with a MH service (excluding LD and CAMHS) within the 12 month period. This differs from the snapshot approach used in the MHMDS indicators. There are two reasons for this difference: 1) it is a 12 monthly not 6 monthly indicator, 2) this is the metric that is commonly calculated and used by HSCIC who supplied us with the data.
	Notes		This is a 12 month, not 6 month indicator. For consistency across the model, the annual performance has been replicated twice, once for each 6 month period within the large 12 month period.

			Significant changes to the MHMDS dataset and to the way it was processed between 2010/11 and 2011/12 resulted in the reported number of people in contact with services during the year increasing from around 1.3 million to 1.6 million (a). This means that the mental health service user population for whom deaths are counted in 2011/12 is much smaller than the population for whom deaths are counted in 2012/13, because the scope of deaths includes people in contact with services up to a year before the registered date of death
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Appendix 5 - Criteria for reporting to Ulysses

SHFT criteria for reporting to Ulysses - relevant extracts as they relate to deaths

The Ulysses guidance provides detailed information on what to report. However, relevant extracts relating to deaths are below:

- *Adult safeguarding concern, even if the person is under someone else's care*
- *Incidents where Southern Health staff were present, involved in or witnessed the incident*
- *If the incident relates directly to treatment, care or support the Trust is providing*
- *All incidents where the Trust is the sole provider of care or the service user is being seen on a regular basis (at least weekly)*
- *Suicide or suspected suicide of a person who was a current user or had care in last 6 months*
- *An unexpected death where an act or omission may have caused or contributed to the outcome*

Some exceptions exist which do not require reporting according to Trust policy:

- *If the incident is caused by another provider (exceptions above). The provider must be informed of the incident.*
- *The service user is in a residential or nursing home not managed by the Trust or the service user is being seen regularly at last 3 times a week for personal care (with exceptions above)**
- *Expected deaths of service users - passed away in an expected time frame and by an expected cause.*

*The Trust states it is reviewing this criterion since we brought it to their attention as having an unintended potentially negative impact on reporting for some people

Appendix 6 - Criteria for reporting a SIRI (as relevant only to deaths from NPSA 2010 information resource to support the reporting of serious incidents issued as part of the 2010 National Framework and in use by the Trust locally throughout the period)

Southern Health NHS Trust used the following guidance to inform their decisions on SIRIs during the period of this review. It gives flexibility and latitude to investigate most unexpected deaths. We have extracted only the aspects as relevant to adult deaths of Mental Health and Learning Disability service users in receipt of Mental Health or Learning Disability services (as this is the scope of the review).

Information Resource to support the reporting of Serious incidents NPSA 2010

Gateway reference 2010/009

Definitions and supplementary terms in the guidance
<i>A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in:</i>
<ul style="list-style-type: none"> • <i>Unexpected or avoidable death of one or more patients</i>
<ul style="list-style-type: none"> • <i>Serious harm to one or more patients or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy, or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm)</i>
<ul style="list-style-type: none"> • <i>Allegations of abuse</i>
<ul style="list-style-type: none"> • <i>Adverse media coverage or public concern for the organisation or the wider NHS</i>
<ul style="list-style-type: none"> • <i>One of the core set of @Never Events; as updated on an annual basis</i>
<i>Supplementary terms</i>
<ul style="list-style-type: none"> • <i>Incident - an event or circumstance which could have resulted, or did result in unnecessary damage, loss or harm such as physical or mental injury to a patient (Reference World Health Organisation (2009) The Conceptual Framework for the International Classification for Patient Safety. Version 1.1)</i>
<ul style="list-style-type: none"> • <i>NHS-funded services and care - healthcare that is partially funded or fully funded by the NHS regardless of location (Reference NPSA 2009) Data Quality Standards. Guidance for organisations reporting to the reporting and learning system</i>
<ul style="list-style-type: none"> • <i>Unexpected death where natural causes are not suspected. Local organisations should investigate these to determine if the incident contributed to the unexpected death</i>
<ul style="list-style-type: none"> • <i>Permanent harm - directly related to the incident and not related to the natural course of the patient's illness or underlying conditions, defined as permanent lessening or bodily functions (Reference NPSA 2004 Seven Steps to Patient Safety, Your guide to safer patient care.</i>
<ul style="list-style-type: none"> • <i>Prolonged pain - pain or harm that a service user has experienced, or is likely to experience for a continuous period of 28 days (Reference CQC 2009 Essential Standards of Quality and Safety, The Care Quality registration regulations effective 1st April 2010)</i>
<ul style="list-style-type: none"> • <i>Severe harm - a patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care</i>
<ul style="list-style-type: none"> • <i>Abuse - act of neglect or omission to act (See No Secrets 2000, Care Quality Commission guidance about compliance (as above)</i>

<i>Relevant categories are:</i>
<i>Death or injury to a vulnerable adult where abuse or neglect is suspected to be a factor</i>
<i>Regulation 28 Care Standards Act for independent provider organisations registered with CQC where a death is reported in an establishment, during treatment or as a consequence of treatment</i>
<i>Media - if police are involved or media, sudden unexpected incidents</i>
<i>Medical devices - including human error or Any medical device related incident that causes unexpected effects (see mhra.gov.uk)</i>
<i>Suspected or actual serious side effects or adverse drug reasons from a medicine</i>
<i>Homicide by service user in receipt of Mental Health or Learning Disability services</i>
<i>Service users detained under MHA AWOL and who present a danger to themselves or others</i>
<i>The criteria below will at times duplicate criteria already stated but are included to remind those delivering mental health services of the need to report them:</i>
<ul style="list-style-type: none"> • <i>Homicide or suspected homicide by a patient who has received mental health services</i> • <i>Inpatient who goes missing from secure unit if not detained</i> • <i>All deaths within secure settings (to be dealt with as a death in custody)</i> • <i>All deaths of persons who are subject to MHA 1983 or equivalent legal restriction who has or is receiving care and treatment from the mental health services</i>
<i>Clusters of unexpected or unexplained deaths</i>
<i>Where the death results in adverse comments from a Coroner</i>
<i>Suicide of any person currently in receipt of NHS services on or off NHS premises or who has been discharged within the last twelve months Suicide is defined as: obvious or strong suspicion of self harm; may not apply initially but where emerges after a clinical review of the case or discussion at incident monitoring group</i>
<i>Verdict of suicide or an open verdict</i>
<i>Death with foul play suspected</i>
<i>Inpatient suicide using non-collapsible rails</i>
<i>Death of prisoner in custody, prison, probation hostels</i>
<i>Unexpected deaths where service user suffering unexpected death in receipt of health services</i>
<i>Unexpected death to whom the organisation owes a duty of care</i>

Appendix 7 - Criteria for reporting a death to the Coroner - Trust Policy

Extract from SHFT Policy on reporting a death to the Coroner

SHFT policy guidance summarises this as:

- Cause of death is unknown
- Deceased not seen after death or within 14 days prior to death by a doctor
- Death may have been caused by violence, trauma or physical injury - intentional or otherwise
- Death by poisoning
- Death as a result of intentional self-harm
- Death the result of neglect or failure of care
- Related to a medical procedure or treatment
- Due to an injury or disease from employment or industrial poisoning
- Occurred in custody or state detention
 - Under MHA 1983
 - Subject to DOLs
 - Deprived of liberty by court of protection

Appendix 8 - Full guidance on reporting deaths to HM Coroner and death certification

The following is an example of guidance on reporting a death to the Coroner:

GUIDE TO REPORTING DEATHS TO H.M. CORONER AND DEATH CERTIFICATION

A death is reportable to the **CORONER** if:-

1. You are in **ANY DOUBT** at all as to **THE CAUSE OF DEATH**

2. A death can be caused or contributed to or accelerated by any event, process, intervention or act and such does not have to be the main or predominant cause and the test for the Coroner (not you) is whether it contributes to the death which is more than minimally, trivially or negligibly. A death should be referred if:-

(a) any unnatural event, process, intervention or act has or may have contributed to the death more than minimally, trivially or negligibly and/or

(b) where there has been a loss of opportunity to give timely treatment to a potentially effective cause of the death

3. Deaths which are **SUDDEN, UNEXPLAINED** or **SUSPICIOUS**

4. Deaths not due or not entirely due, to natural causes, e.g. all **ACCIDENTS** including late deaths from consequences of **MEDICAL MISHAPS**, deaths occurring **DURING AN OPERATION** or as a **CONSEQUENCE OF THE OPERATION** or **BEFORE RECOVERY** from the effect of an **ANAESTHETIC**

5. All deaths within **24 hours** of admission to Hospital, or after any procedure, operation, treatment or anaesthetic, or discharge from Hospital and **ALL** deaths of persons under 18 years of age.

6. Deaths due or contributed to all **FRACTURES OR FALLS**

7. Deaths due or contributed to by a **DEFECT OR A FAILURE IN A SYSTEM OR PROCEDURE** or where **DEMENTIA** is involved

8. **ALL ALLEGED MEDICAL OR NURSING MISHAPS** (n.b. appropriate procedures, properly executed, are natural deaths but still reportable) or **INAPPROPRIATE TREATMENT** or where a **CRITICAL INCIDENT PROCEDURE** has, is or will be recorded

9. Any case of possible **LATE DIAGNOSIS** (e.g. meningitis) or **TREATMENT**

10. Deaths **DUE** to or **CONTRIBUTED TO** by **DRUGS** (including therapeutic) where overdose, idiosyncrasy, poisoning or addiction is involved.

11. Acute alcohol poisoning (but not chronic alcoholism)

12. Where there is any doubt as to a **STILLBIRTH** e.g. any evidence that foetus breathed or showed any other signs of life. A separate guide to the reporting and/or certification is available

13. Any deaths caused or contributed to by **NEGLECT** or **SELF-NEGLECT**

14. All deaths due to **SUICIDE, MALNUTRITION, HYPOTHERMIA**

15. Any death caused or contributed to by **UNUSUAL DISEASES** (e.g. old or new variant Creutzfeldt-Jakob disease, AIDS)

16. Deaths due to or contributed to by **OCCUPATIONAL INJURY** or **DISEASE** from whatsoever cause or suspected cause e.g. pneumoconiosis, mesothelioma, farmer's lung, Weils's disease, bladder cancer etc.). This means any death which you suspect could possibly be caused or contributed to by the deceased's occupation.

17. Any deaths where there is a history of recent contact with the **POLICE** or **PRISON** or possibly **ABUSED DEPENDENCY** situations such as the **MENTALLY ILL** and any death where the individual is a detained service user under the Mental Health Act 1983 or a voluntary service user in Hospital.

18. Deaths due to **TETANUS, SEPTICAEMIA** or **GANGRENE** without the known underlying cause being identified, **HEPATITIS IN A DOCTOR, DENTIST OR SIMILAR**

19. Deaths **where there is, or may be, a complaint concerning the care** of the deceased whilst in the care of **Hospital, residential home, nursing home, general practitioner or other person or persons.**

Death Certification by Doctors

A licensed qualified Medical Practitioner should not sign a Certificate of Death in respect of a Death from wholly natural causes unless:-

1. He or she has attended (this means treated and/or assessed and not just saw the deceased) the service user in, and for the service user's last illness, **and**
2. Within 14 days before death **and**
3. Has seen the body after death **and**
4. Is satisfied as to the cause of death **and**
5. Is satisfied that the death is wholly from natural causes **and**
6. Is not otherwise reportable to the Coroner

Please remember that a doctors legal requirements differ between burial and cremation. The best practice is always to assume it will be a cremation and fill in the Cremation Certificate in full.

Please remember:-

1. Not to confuse modes of dying (cardiac arrest, renal failure, shock, uraemia, multiorgan failure, etc.) with the pathological cause of death
2. Never use "possible" or "probable"
3. Never guess or surmise a cause of death

4. Do not promise relatives a Certificate unless you know that you can deliver
 5. You are very often the only person who can decide if a death is reportable or not so it is wise for you to attend after every death (even if a burial is intended)
 6. It is an offence to move or otherwise interfere with, a body or the surrounding evidence, without leave of the Coroner where death has occurred in circumstances which may lead him to hold an Inquest
 7. The Registrar of Deaths is required by law to refuse registration, and to report a death to the Coroner if the Certificate of death does not comply with the legal requirements. Such refusal by the Registrar causes distress and inconvenience to relatives, and, possibly, the postponement of the funeral with all its attendant consequences.
 8. These notes are provided for guidance only. They are not conclusive. If you have any doubts or are in need of help or advice as to whether or not a particular death should be reported, please contact either myself or one of my Officers.
- Never be afraid to seek advice. I and my Officers are always willing to discuss a case. We always try to help, (even if only by confirming what you already think) and agree the procedure over the telephone.
9. Please have the notes with you when you contact us

H.M. CORONER PLYMOUTH & S.W. DEVON

Dated: 1st November 2003

Appendix 9 - Members of the Independent Panel / Expert Reference Group

Anne Richardson, Independent Chair

Members:

Beverly Dawkins OBE, previously of Mencap, now Chief Executive, Generate

Dr George Julian, Family representative

Julie Kerry, Associate Director of Nursing, NHS England (to September 2015)

Karen Lascelles, Suicide Prevention (part)

Dr Justin Wilson, Medical Director, Berkshire Healthcare NHS Foundation Trust

Appendix 10 - Methodology used for standardising mortality data

Method used to age standardise the Southern Health Mortality rate

Following accepted methodology¹⁴, the data for the mortality of Southern Health and England service users in each of 2011-12 and 2012-13 were grouped into 5 year bands according to age at death. The data comprised numbers of deaths, numbers of users in contact in the past 12 months and consequently the crude death rates derived from the ratio of deaths to users in contact. For each age band these crude death rates are subsequently labelled age specific death rates.

The motivation for standardisation is to avoid an unfair comparison between SH and England death rates due to any difference in the age distribution of those in contact with services. Clearly if one of the two populations, say A, has a much higher proportion of very old people than the other population, B, we would automatically expect A to have the higher death rate. This would be the case even if the age specific death rates were identical for A and B. In this case a higher crude death rate for A should be ascribed no significance and an age standardised rate is required for a fair comparison.

The basic principle applied was to ensure that the age distribution for SH service users was the same across all age bands as that in the England service user population. This is done separately for each of the two years. This is the key step in producing standardised death rates for SH which are directly comparable to the unadjusted crude death rates for England¹⁵

Details of the calculation:

Calculation of the lower age band: to avoid a problem of some suppressed death counts in SH age bands below 40, the aggregate deaths for persons below 40 were calculated by subtracting the total above 40 from the total number of SH deaths.

- 1) The age bands are then: 15-39, 5 year bands from 40 to 84 including, and 85 plus.
- 2) For each age band the age specific death rates for SH were worked out as above.
- 3) Using the distribution of the England service users across age bands and the total number of SH users, a standardised distribution of SH users across age bands was calculated.
- 4) The standardised numbers of deaths in each age band for SH were calculated by multiplying the age specific death rates by the numbers of SH users in the band calculated at 4) above.
- 5) The total standardised number of deaths was found by simple summation of deaths in each band from 5) above
- 6) Finally the standardised death rate is derived by dividing the standardised number of deaths by the total number of users in contact

¹⁴ Breslow N.E. Statistical Methods in Cancer Research Vol. II International Agency for Research on Cancer, WHO, Lyon, 1987. Also guidance provided by London Knowledge and Intelligence team at PHO, England (2005).

¹⁵ The crude death rate and standardised death rate for England are identical because the England age distribution is taken to be the standard one.

Appendix 11 - CQC Regulations 16, 17 and 18

Notification of death of service user - Regulation 16

16.—(1) *Except where paragraph (2) applies, the registered person must notify the Commission without delay of the death of a service user—*

(a) whilst services were being provided in the carrying on of a regulated activity; or

(b) as a consequence of the carrying on of a regulated activity. (Section 1a and b not relevant to NHS bodies)

(2) Subject to paragraph (4), where the service provider is a health service body, the registered person must notify the Commission of the death of a service user where the death—

(a) occurred—

(i) whilst services were being provided in the carrying on of a regulated activity, or

(ii) as a consequence of the carrying on of a regulated activity; and

(b) cannot, in the reasonable opinion of the registered person, be attributed to the course which that service user's illness or medical condition would naturally have taken if that service user was receiving appropriate care or treatment.

(3) Notification of the death of a service user must include a description of the circumstances of the death.

(4) Paragraph (2) does not apply if, and to the extent that, the registered person has reported the death to the National Patient Safety Agency⁽²⁾.

(5) This regulation does not apply where regulation 17 applies.

(N.B: note the National Patient Safety Agency has been superseded by NHS England as the host for the NRLS)

Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983 - Regulation 17

17.—(1) The registered person must notify the Commission without delay of the death or unauthorised absence of a service user who is liable to be detained by the registered person—

(a) under the Mental Health Act 1983⁽³⁾ ("the 1983 Act"); or

(b) pursuant to an order or direction made under another enactment (which applies in relation to England), where that detention takes effect as if the order or direction were made pursuant to the provisions of the 1983 Act.

(2) Notification of the death of a service user must include a description of the circumstances of the death.

(3) In this regulation—

(a) references to persons "liable to be detained" include a community patient who has been recalled to hospital in accordance with section 17E of the 1983 Act⁽⁴⁾, but do not include a patient who has been conditionally discharged and not recalled to hospital in accordance with section 42⁽⁵⁾, 73⁽⁶⁾ or 74⁽⁷⁾ of the 1983 Act;

(b)“community patient” has the same meaning as in section 17A of the 1983 Act(8);

(c)“hospital” means a hospital within the meaning of Part 2 of that Act(9); and

(d)“unauthorised absence” means an unauthorised absence from a hospital.

Notification of other incidents - Regulation 18

18.—(1) Subject to paragraphs (3) and (4), the registered person must notify the Commission without delay of the incidents specified in paragraph (2) which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.

(2) The incidents referred to in paragraph (1) are—

(a)any injury to a service user which, in the reasonable opinion of a health care professional, has resulted in—

(i)an impairment of the sensory, motor or intellectual functions of the service user which is not likely to be temporary,

(ii)changes to the structure of a service user’s body,

(iii)the service user experiencing prolonged pain or prolonged psychological harm, or

(iv)the shortening of the life expectancy of the service user;

(b)any injury to a service user which, in the reasonable opinion of a health care professional, requires treatment by that, or another, health care professional in order to prevent—

(i)the death of the service user, or

(ii)an injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a);

(c)any request to a supervisory body made pursuant to Part 4 of Schedule A1 to the 2005 Act by the registered person for a standard authorisation, including the result of such a request;

(d)any application made to a court in relation to depriving a service user of their liberty pursuant to section 16(2)(a) of the 2005 Act;

(e)any abuse or allegation of abuse in relation to a service user;

(f)any incident which is reported to, or investigated by, the police;

(g)any event which prevents, or appears to the service provider to be likely to threaten to prevent, the service provider’s ability to continue to carry on the regulated activity safely, or in accordance with the registration requirements, including—

(i)an insufficient number of suitably qualified, skilled and experienced persons being employed for the purposes of carrying on the regulated activity,

(ii) an interruption in the supply to premises owned or used by the service provider for the purposes of carrying on the regulated activity of electricity, gas, water or sewerage where that interruption has lasted for longer than a continuous period of 24 hours,

(iii) physical damage to premises owned or used by the service provider for the purposes of carrying on the regulated activity which has, or is likely to have, a detrimental effect on the treatment or care provided to service users, and

(iv) the failure, or malfunctioning, of fire alarms or other safety devices in premises owned or used by the service provider for the purposes of carrying on the regulated activity where that failure or malfunctioning has lasted for longer than a continuous period of 24 hours.

(3) Paragraph (2)(f) does not apply where the service provider is an English NHS body.

(4) Where the service provider is a health service body, paragraph (1) does not apply if, and to the extent that, the registered person has reported the incident to the National Patient Safety Agency.

(5) In this regulation—

(a) “the 2005 Act” means the Mental Capacity Act 2005(10);

(b) “abuse”, in relation to a service user, means—

(i) sexual abuse,

(ii) physical or psychological ill-treatment,

(iii) theft, misuse or misappropriation of money or property, or

(iv) neglect and acts of omission which cause harm or place at risk of harm;

(c) “health care professional” means a person who is registered as a member of any profession to which section 60(2) of the Health Act 1999(11) applies;

(d) “registration requirements” means any requirements or conditions imposed on the registered person by or under Chapter 2 of Part 1 of the Act;

(e) “standard authorisation” has the meaning given under Part 4 of Schedule A1 to the 2005 Act;

(f) “supervisory body” has the meaning given in paragraph 180 (in relation to a hospital in England) or paragraph 182 (in relation to a care home) of Schedule A1 to the 2005 Act;

(g) for the purposes of paragraph (2)(a)—

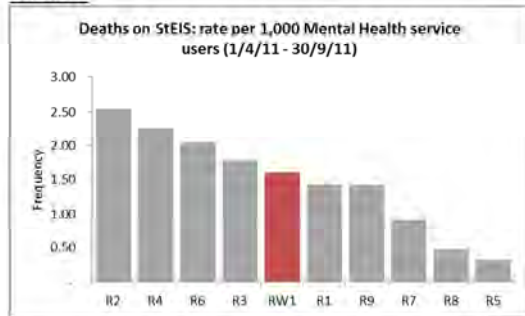
(i) “prolonged pain” and “prolonged psychological harm” means pain or harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days, and

(ii) a sensory, motor or intellectual impairment is not temporary if such an impairment has lasted, or is likely to last, for a continuous period of at least 28 days.

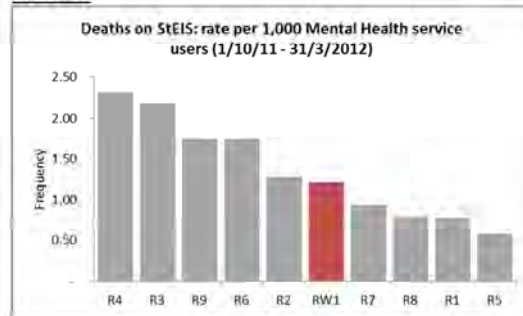
Appendix 12 - StEIS benchmarking pack

Deaths on StEIS for all deaths reported under eight categories relating directly to unexpected death or suicide (As per Appendix 4) - rate per 1,000 Mental Health service users

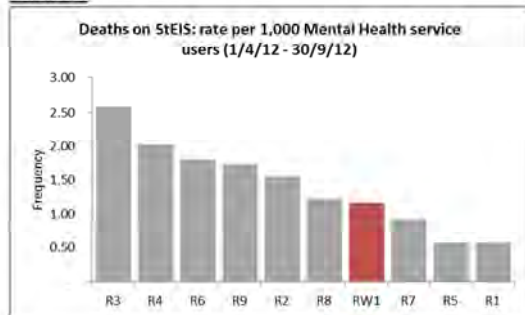
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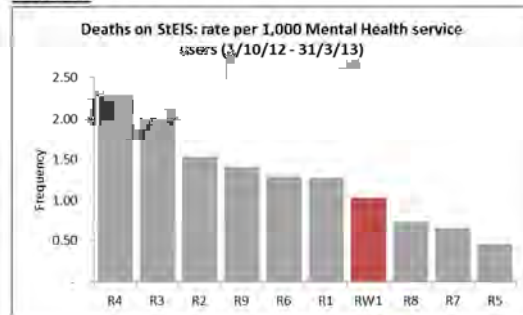
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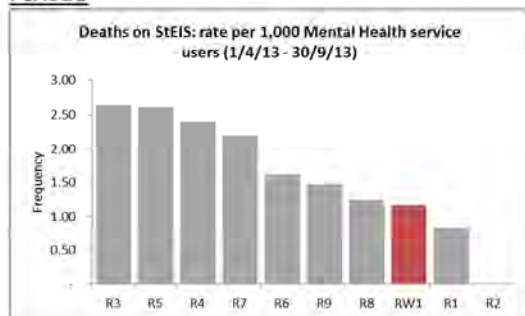
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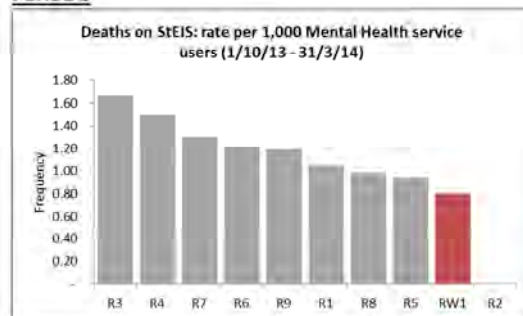
Period 4



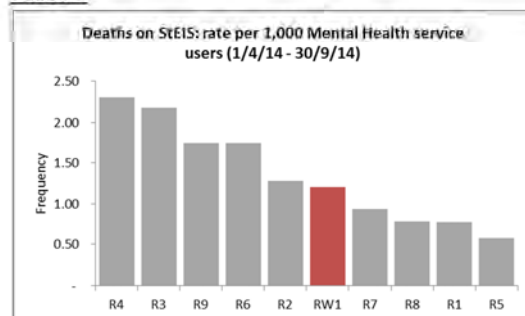
Period 5



Period 6

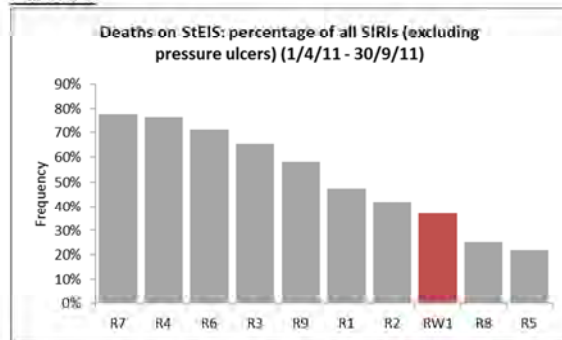


Period 7

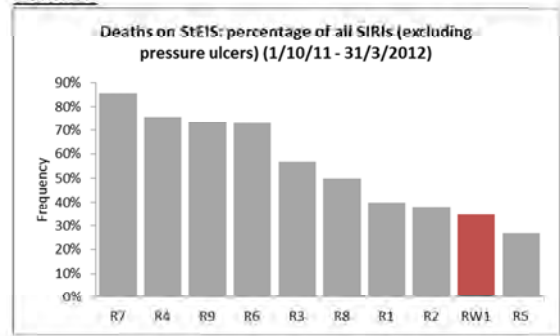


Deaths on StEIS for all deaths reported under eight categories relating directly to unexpected death or suicide (As per Appendix 4) - Percentage of all SIRIs

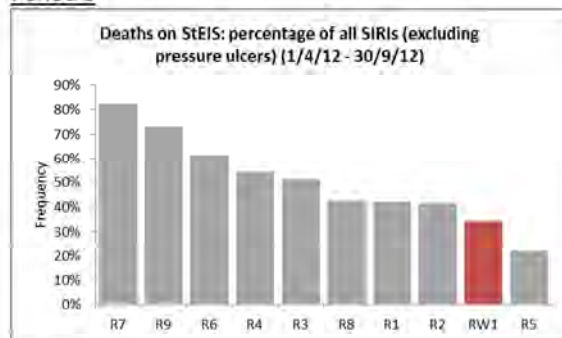
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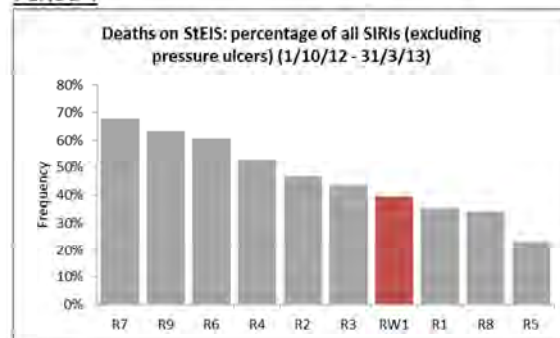
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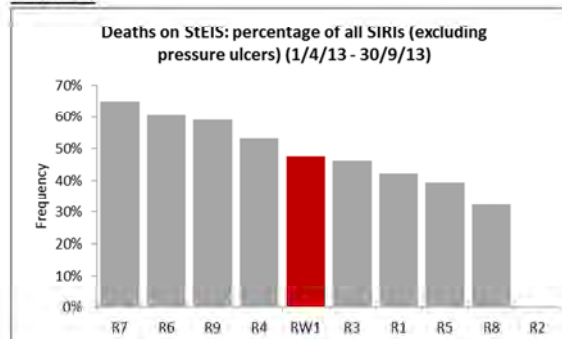
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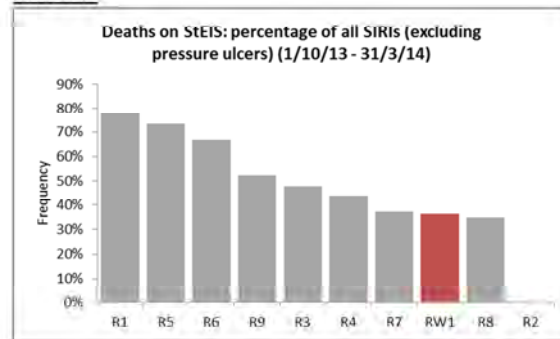
Period 4



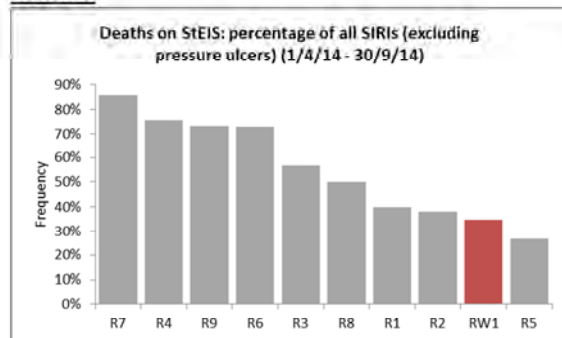
Period 5



Period 6



Period 7



Appendix 13 - Detailed methodology

Our work was subject to a quality assurance process which involved an External Reference Group which met six times during the course of the review and with which our analytical framework and emerging findings were shared and discussed. We met with NHS England (Regional team) on one occasion and had three meetings with National Directors.

Data collection

(Precise definitions and data sources as well as data quality measures are provided in Appendix 4)

- Secure Office for National Statistics (ONS)/Mental Health Minimum Data Set (MHMDS) data from the experimental data linkage to compare the total deaths reported by the Trust and those reported nationally. This was a bespoke extract.
- Secure ONS/Health and Social Care Information Centre (HSCIC) data on the numbers of deaths by NHS Trust including the crude death rate of each Trust, the number of unexpected deaths (identified by specific ICD 10 chapter) including age, gender and the ICD 10 code cause of death for all service users with a Mental Health contact in the previous 12 months.
- Secure extract of all deaths of service users in Mental Health and Learning Disability services in the Trust from RiO (the Trust's patient administration system) where the service user had been in touch with the Trust in the preceding 12 months before death and the death occurred between 1st April 2011 and 16th March 2015. Clean and identify any missing deaths from the various extracts provided.
- Secure extract of all deaths reported to the Trust's incident management system (Ulysses) between 1st April 2011 and 16th March 2015
- Secure extract of all deaths of Mental Health and Learning Disability service users within TQ21 - the social care arm of the Trust.
- Clean all data sets to remove duplications
- Assign a division to all cases not already allocated to one of four divisions - AMH, OPMH, LD and SS.
- Confirm, using the department fields in Ulysses, the remaining 'unallocated' deaths and confirm directly with the Trust where not identifiable - to a division.
- Using data matching software (IDEA) match all Ulysses records to RiO; work with the Trust to identify those left unmatched
- Secure extract of all incidents reported as a Serious Incident for the Trust and 9 other regional Mental Health NHS Trusts from NHS England area team through the StEIS system. Regional Trusts were used as comparators as these were the Trusts that the Area Team's permissions enabled. We then identified deaths from this extract using the eight categories relating to deaths as per Appendix 4 for all deaths and also for only the Mental Health and Learning Disability care sectors.
- Secure from CQC a list of all deaths reported under CQC Regulation 17 (deaths in detention) and notifications from the Trust for the same
- Access data published on the National Reporting and Learning System (NRLS) under 'degree of harm death'.

- Download other relevant publically available information e.g. CQC surveys, NHS staff survey.
- Map the final StEIS datasets (SIRI reports) to those on the Trusts inquest tracker as at July 2015
- Map final StEIS datasets (SIRI reports) to the Trust's Safeguarding reports tracker as at July 2015
- Following a request from ERG, secure extract of all incidents for all patients who died in the lead up to the death
- Request data from NRLS regarding the most upto date reported information as at October 2015 to confirm current numbers of deaths reported under 'degree of harm death'.

Benchmarking and data analysis

- Apply for and secure data from the Health and Social Care Information Centre through the MHMDS for all Mental Health Trusts. (see Appendix 4)
- Apply for and secure data from the ONS HSCIC MHMDS experimental data linkage on ICD 10 codes (cause of death) (see Appendix 4)
- Use associate with experience in Mental Health indicators to determine validity of indicators to be used in model.
- Create and benchmark all indicators as above including NRLS and StEIS data to provide comparisons based on size of Trust (as determined by per 1,000 Mental Health service users); benchmark with a regional and national cohort of all Mental Health NHS Trusts
- Meet with HSCIC Mental Health team to demonstrate final indicator model and confirm approach

Review all reports relating to deaths

- Secure all Serious Incident reports relating to deaths of service users occurring between 1st April 2011 and 16th March 2015 and create a confirmed data set - 195 reports. These cases were identified through an initial download of all incidents on StEIS and then filtered for all deaths under suicide and unexpected death categories. We reviewed other cases for obvious evidence of death using a word search - death, suicide, died, dead. The final database for the SIRI review was developed further from this initial data collation by cross-referencing other information sent by the Trust, IMAs, CIRs, inquest information, internet searches and Ulysses records to identify deaths not reported under death categories to develop a complete list of all deaths in scope regardless of StEIS category.
- As there was a gap between the number of deaths from RiO and Ulysses and the number investigated as a Serious Incident we requested all Initial Management Assessments and Critical Incident Reports for Adult Mental Health and Learning Disability deaths. The scope of the review excluded looking at all IMAs and CIRs for OPMH.
- Read every IMA, CIR and SIRI (excluding 4 SIRIs not provided as at August 2015)
- Through a pilot exercise create an assessment template using a random sample of 20 SIRIs.
- The remainder of the SIRIs read by two reviewers assess each against the template developed.
- Read each CIR and IMA and review to identify any themes arising.

- An initial review of IMAs in both AMH and LD identified areas of clinical concern. Re-reviewed 35 AMH IMA/CIRs and all LD IMAs with a GP for another clinical opinion. A further review was held with a CPN for a more specialist opinion of some MH cases.
- The themes arising from these were shared with the NHS England Regional team
- Established a Clinical Review Group to further review a sample of Learning Disability cases from a clinical perspective with members nominated by NHS England. The clinicians at this group were the GP that did the first clinical review, the Medical Director of the Trust and the Medical Director (Consultant in Learning Disability - Berkshire Healthcare NHS Trust) who was on the ERG.
- Reviewed a sample of cases as being any case that did not have an acute hospital location of death with a range of issues and ages arising.
- Analyse all reports for other patterns
- Undertake a specific age analysis on the Learning Disability cohort including deaths in TQ21. Data provided from TQ21 was cleaned by matching directly to RiO to ensure no duplications and agreed a final data set from which to establish average and median ages.
- Analyse all available information to create a list of all inpatient deaths.
- Analyse all available information to create a list of all deaths in detention.

Governance

- Review all publically available board reports and associated documents from April 2012 to March 2015
- Review all relevant policies and procedures applicable throughout the period of the review relating to Serious Incident reporting and local incident reporting
- Review all information provided by the Trust in relation to area, divisional and corporate panel review processes
- Review and map all CCG closure panel minutes and relevant SIRIs from May 2014 to September 2015
- Review the Trust's Safeguarding Tracker as at July 2015, inquest tracker July 2015 and map all IMAs and CIRs to these to identify where else deaths were reported.

Issues arising:

The development of the final datasets were iterative. Throughout the work we identified inaccurate data, duplications and missing information which required repeated requests for data and needed repeat data matching and mapping. This also meant that the data analysis was frequently updated and amended using the latest available information.

Detailed mapping identified further information that had not been provided.

One result of this exercise was that the governance issues arising from the iterative process were identified and are reported here.

The final datasets on which our analysis is based were completed in August 2015 and these were shared with the Trust as part of the Factual Accuracy process in September 2015 through the provision of a full list of all identified cases on RiO, Ulysses and StEIS.

As part of the factual accuracy process, we mapped and matched all spreadsheets provided by the Trust to us against our own analyses and spreadsheets.

Overall

We used the information available to create final datasets for analysis - all deaths, all reported deaths to Ulysses and all deaths subject to an IMA, CIR or SIRI. Data sets were cross-referenced and detailed work undertaken to map all deaths to all systems.

This included matching deaths to the safeguarding tracker, inquest tracker and to all the area and corporate panel notes provided as well as CCG closure panel notes to provide a full picture of the governance processes in place.

We shared and explained our methodology with researchers from the University of Bristol.

We responded to all comments raised on the draft report in a 6 week factual accuracy process.

Appendix 14 - NRLS full definitions of categories of harm (Seven Steps to Patient Safety: full reference guide (NPSA 2004))

No harm (Impact prevented) – Any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care.

No harm (impact not prevented) - Any patient safety incident that ran to completion but no harm occurred to people receiving NHS funded care.

Low harm - Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons receiving NHS-funded care.

Moderate harm - Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Severe harm - Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.

Death - Any unexpected or unintended incident that directly resulted in the death of one or more persons. NB: The death must relate to the incident rather than to the natural course of the patient's illness or underlying condition.

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Southern Health NHS Foundation Trust

Update following Independent Review of Deaths of People with a Learning Disability or Mental Health Problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015

- 1.1** The Independent Review of Deaths of People with a Learning Disability or Mental Health Problem in contact with Southern Health NHS Foundation Trust highlights that Southern Health's processes for reporting and investigating deaths of people with learning disabilities and mental health needs could have been better. The Trust fully accepts this and acknowledges that it did not always involve families as much as it could have. The Trust apologises unreservedly.
- 1.2** Substantial changes have already been made to the way in which Southern Health records and investigates deaths, including:
- Significantly strengthening executive oversight of the quality of investigations and ensuring appropriate measures are in place to address any issues identified, and that all learning is shared and implemented across the Trust. New executive level doctors and nurses joined the Trust Board from July 2014.
 - Setting up a new central investigation team which is improving the quality and consistency of investigations and learning.
 - Capturing conclusions of inquests more effectively to identify and act swiftly on areas for improvement.
 - Launching a new system for reporting and investigating deaths in consultation with our commissioners to increase monitoring, scrutiny and learning.
 - Providing every family with the opportunity to be involved in investigations relating to a death of a loved one.
- 1.3** The report looked at the way the Trust recorded and investigated deaths of people with mental health needs and learning disabilities who had been in contact with Southern Health at least once in the previous year. The report did not consider the quality of care provided by the Trust to the people the Trust serves.
- 1.4** Healthcare regulator Monitor has decided to take action against Southern Health, utilising its powers under section 106 of the Health and Social Care Act 2012. Monitor is providing expert support to improve the way the Trust investigates and reports deaths. Southern Health has agreed with Monitor to take a number of steps to show how the Trust is improving. These are:
- Implement the recommendations of the Mazars report through a comprehensive action plan (**attached as Appendix 3**)
 - Get assurance from independent experts on this action plan
 - Work with an Improvement Director appointed by Monitor who will support and challenge the Trust as it makes the necessary changes
- 1.5** The Care Quality Commission (CQC) carried out a follow-up inspection of Southern Health services in January, focusing on improvements within mental health and learning disability services, in particular acute mental health inpatient wards, learning units for people with learning disabilities,

crisis/community mental health teams and child and adolescent inpatient and secure services. The inspection also focussed on focusing on our progress against comprehensive improvement plans we have in place following publication of the review.

- 1.6** Southern Health fully accepts the need to continue to make changes and will continue to work closely with commissioners and regulators to make the improvements required. The Trust's focus continues to be on ensuring that everyone who relies on services provided by Southern Health receives the best possible care.

Version No: 4

Date: 14.01.16

Issue No.	What is the issue to be addressed?	Current Risk/ Priority	Action/s to be taken	Evidence of the completion of each action	Action Timescale	Action Progress	Evidence of the achievement of the required improvement	Progress with achieving required improvement	Who is responsible for completing the action	Who is accountable for ensuring the action is completed?
		Low, Med, High				Blue=Complete Green=Begun & On Track Amber= Risk of slippage Red=Overdue		It should be noted that whilst individual actions may be completed, a number of these will need a few months 'bedding in time' before the required improvement is seen. This column provides progress updates on achieving the actual improvements rather than completion of individual actions Red = improvement overdue or at risk of being overdue Amber = improvement partially achieved or not yet achieved but on track Green = improvement achieved Blue = improved position maintained consistently over 3 month period	Name & Job Title	Name & Job Title
			Number							
1	Ensure that Serious Incident investigation reports adhere to national timescales.	high	1.1 Weekly 'flash' report to be developed to describe the status and timelines for every SIRI investigation - this will be embedded into the Trust BI System. 1.2 Executive team to review the governance 'flash' report every week. 1.3 Serious Incident Investigation Training to include the National timescale requirement. 1.4 Lead Investigators to be appointed for each Division who will track compliance to timescales and support investigators to achieve this. Job Description to be standardised with a 20% Corporate and 80% Divisional governance focus and an initial priority objective to deliver clearance of any SIRI backlogs which will be evidenced in the Flash report. 1.5 Executive support to be sought and agreed to ensure that investigators are given sufficient time to investigate serious incidents as part of their job plans. If improvement trajectories are not being met a divisional review of capacity will take place. 1.6 All incident trackers to form part of the Ulysses Safeguard system rather than stand-alone spreadsheets. 1.7 Implement the new death reporting process. 1.8 Increase compliance to 48hr panel process. 1.9 All deaths of patients detained under the Mental Health Act to be reported via the Death reporting process and have system 'flag' to ensure that all are investigated as Serious Incidents.	1.1 Weekly Flash produced in new format. 1.2 Weekly Flash is reviewed by TEG every week 1.3 Investigators training includes reporting timescales. 1.4 Centralised lead investigation team in post (register of names / divisions to be supplied) and role specification. 1.5 Monitoring of the percentage improvements in the ability to complete quality investigations within 60 days. 1.6 All investigations to be input on to the Ulysses system as of the 1st January 2016, a dual process will be in place until 1st April 2016 when the trackers will be closed down. This will be monitored by the Ulysses System Analyst. 1.7 Death / mortality reporting process implemented and compliance to use in practice. These will audited against the Tableau mortality reports. 1.8 Monitor compliance to 48 hr panels on a monthly basis aiming to achieve set improvement criteria of 75% by January 2016 and to 95% by February 2016. 1.9 System generated mortality report and Serious Incident tracking report.	1.1 Completed 1.2 Completed 1.3 Completed 1.4 Completed 1.5 30.03.16 1.6 31.03.16 1.7 31.01.16 1.8 30.06.16 1.9 31.01.16	1.1 Completed 1.2 Completed 1.3 Completed 1.4 Completed 1.5 On track 1.6 On track 1.7 Risk of Slippage Combined Tableau reports with Spine and Ulysses data not available until 03.16 1.8 Compliance being monitored - current trajectory shows risk of slippage 1.9 Combined Tableau reports with Spine and Ulysses data not available until 03.16	60% of all Serious Incident Investigation reports to adhere to national timescales by 31.03.16. 90% of all Serious Incident Investigation reports to adhere to national timescales by 30.06.16	05.01.16 42% of Serious Incident Investigation reports adhere to national timescales	Helen Ludford, Associate Director of Quality Governance Fiona Richey, Head of Business Continuity and Risk (for BI and Ulysses system developments) Sarah Pearson, Head of Legal & Insurance Services (for SIRI management team) Mayura Deshpande, Associate Medical Director (Quality), Patient Safety and Divisional Clinical Directors	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
2	Ensure that Serious Incident investigation reports are of the required quality and always identify a clear root cause.	high	2.1 All corporate panels to be chaired by an Executive director. 2.2 Recruit and train Serious Incident Investigator team. 2.3 Include NPSA guidance tools on report writing in training.	2.1 There is an Executive chair to each serious incident panel to provide scrutiny and oversight evidenced by minutes. 2.2 Recruitment process / assessment centre notes for Lead Investigation team and training course documentation. 2.3 Included in the investigators training packs and training course materials.	2.1 Completed 2.2 Completed 2.3 Completed	2.1 Completed 2.2 Completed 2.3 Completed				

			2.4 Create an investigation template for the Ulysses Safeguard system to guide investigators with the process of report writing and ensure that additional tools / supplementary documents can be stored with the investigation.	2.4 Template for electronic RCA developed in the Ulysses system.	2.4 Completed	2.4 Completed	60% of all Serious Incident Investigation reports will achieve panel approval on first submission by 31.03.16 (some minor amendments acceptable). 80% of all Serious Incident Investigation reports will achieve panel approval on first submission by 30.06.16 (some minor amendments acceptable). 95% of Serious Incident Investigations to include a root cause.	05.01.16 Monitoring process for approval at panel on first submission not yet in place. 05.01.16 87% include a root cause.	Helen Ludford, Associate Director of Quality Governance Fiona Richey, Head of Business Continuity and Risk (for BI and Ulysses system developments) Sarah Pearson, Head of Legal & Insurance Services (for SIRI management team)	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
		2.5 Provide investigation training to Divisional staff undertaking Investigating Officer roles.	2.5 Investigator training offered via LEaD bi-annually. Evidence of course content.	2.5 Completed	2.5 Completed					
		2.6 Senior clinician in a senior leadership role to lead Divisional Serious Incident report reviews prior to presentation at corporate panel.	2.6 Evidenced through death reporting process and 48hr panel compliance.	2.6 Completed - process in place	2.6 Completed					
		2.7 Ensure the Investigation training provides a definition of root causes and the investigative tools approach as to how to extract them as part of an investigation.	2.7 Included within the investigators training.	2.7 Completed	2.7 Completed					
3	Ensure that Serious Incident Investigators are adequately trained.	medium	3.1 Create and deliver a 2 day investigators course to all staff undertaking an Investigating Officer role. Ensure the course encompasses all elements of the historical NPSA course linked to SHFT policies, processes and risk management system.	3.1 Investigators course programme.	3.1 Completed	3.1 Completed	Register of active and trained Investigating Officers within each Division to ensure that outcomes for issues 1 and 2 are met.	05.01.16 Supervision session not yet developed but on track.	Helen Ludford, Associate Director of Quality Governance	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
		3.2 Create Lead Investigators roles in all Divisions to provide ongoing expert and competency assessment.	3.2 Central Lead Investigators recruitment (register of names / divisions to be supplied) objectives for the role will be assessed during appraisal.	3.2 Completed	3.2 Completed					
		3.3 Develop an investigator supervision session to be held quarterly for case study learning and updates to National guidance.	3.3 Central investigation team clinical supervision session in place but a quarterly wider meeting is still to be developed. Agendas provide evidence.	3.3 31.03.16	3.3 On Track					
4	Ensure that Corporate review panels are effective in the sign off of high quality investigation reports and that they are used to capture organisational learning.	high	4.1 Corporate panels to be held every other week with Executive Director Chair and all Serious Incident Investigation Reports to be presented and signed off through this panel (excluding pressure ulcers).	4.1. The corporate panels schedule and the minutes of the panels.	4.1. Completed	4.1. Completed	60% of reports signed off by external CCG panel on first submission by 31.03.16. 90% of reports signed off by external CCG panel on first submission by 30.06.16.	05.01.16 Monitoring data collection tool in development.	Helen Ludford, Associate Director of Quality Governance Sarah Pearson, Head of Legal & Insurance Services (for SIRI processes)	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
		4.2 Minor amendment review panels to be held every other week with Associate Director Chair to ensure timely final version reports uploaded onto STEIS.	4.2 The review panel schedule and the minutes of the panels.	4.2 Completed	4.2 Completed					
		4.3 Serious Incident panel process to be clearly and simply described in the SHFT policy.	4.3 Up to date policy.	4.3 31.01.16	4.3 On Track					
		4.4 Minutes of corporate panels to be recorded and held by the Serious Incident and Incident Team.	4.4 Process in place for the taking of, storage and Chair sign off of serious incident panel minutes. This can be evidenced by SOP.	4.4 Completed	4.4 Completed					
		4.5 The learning from Serious Incident investigations to be extracted and shared within 'Hot-Spots'.	4.5 'Hot-Spots' organisational learning tools to be shared.	4.5 Completed	4.5 Completed					
		4.6 A scoring mechanism to be added to the corporate panel minutes, scoring the quality of the reports submitted to track improvement.	4.6 Evidence of the scoring mechanism and ability to track improvement	4.6 31.01.16	4.6 On Track					
5	Ensure that Duty of Candour requirements are always met.	medium	5.1 Duty of Candour training to be delivered as part of the investigators course.	5.1 Investigators course programme.	5.1 Completed	5.1 Completed	100% compliance to the commissioned requirements for Duty of Candour compliance. 100% compliance that families or next of kin, where possible, have been involved in Serious Incident Investigations by 31.03.16 100% compliance with new procedure for writing to families where death was not a SIRI by 30.06.15.	05.01.16 Monitoring of commissioned compliance achieving 100%. Monitoring data collection tool of family involvement in Serious Incident Investigations in development.	Briony Cooper, Head of Quality Contracts and Quality Performance	Dr Lesley Stevens, Medical Director - Executive sponsor of the Patient Engagement workstream
		5.2 Leaflet to be created which explains the Duty of Candour requirements to service users / patients / staff / next of kin.	5.2 Leaflet created approved by the Patient Engagement workstream prior to launch, evidence provided in minutes.	5.2 31.03.16	5.2 On Track					
		5.3 Ulysses Safeguard screens to be further developed to map the Duty of Candour requirement and to record full compliance with each stage.	5.3 Ulysses capture screens - screen shots.	5.3 Completed	5.3 Completed					
		5.4 Data from Ulysses Safeguard to be used to report the Duty of Candour compliance to Commissioners via CQRM process.	5.4 Informatics report and validation process. Serious Incident panel minutes will capture that the Duty of Candour has been met for all Serious Incidents.	5.4 Completed	5.4 Completed					
		5.5 Role description for the Lead Investigator (centralised team) to include the specific role of oversight of communication and involvement of families.	5.5 Role description.	5.5 Completed	5.5 Completed					
		5.6 Duty of Candour policy to be reviewed and rewritten to be specific about the involvement of families in investigations.	5.6 Up to date policy.	5.6 31.03.16	5.6 On Track					

			5.7 Process to be developed (and included in first revision of new Death reporting procedure) which formally invites any concerns from families to be raised following a death that meets the criteria set out in the new procedure and advises families as to whether an investigation will take place. (this will be over and above the actions already required by Trust policy when it is clear from the outset that the death constitutes a SIRI and Duty of Candour is engaged as well as the requirement to invite families to participate in the investigation)	5.7 Process to be defined and guidance letter templates developed. Reference to these to be included in first review of new Procedure for Reporting and Investigating Deaths.	5.7 31.01.16	5.7 On track				
			5.8 Root Cause Analysis investigation template to be amended in order that the section which outlines what involvement/contact there has been with the families is more structured and requires specific details (currently a free text box).	5.8 Corporate panel meetings to review on ongoing basis	5.8 31.03.16	5.8 on track				
6	Ensure that there is evidence of the rationale of the decision making process of whether to conduct an investigation into a death and that it is clearly recorded.	high	6.1 Provide a clear definition of the decision making process surrounding what constitutes a serious incident. Incorporate this process in Serious Incident training and document it within the new Procedure for the Reporting and Investigation of Deaths.	6.1 Copy of the Procedure for the Reporting and Investigation of Deaths and evidence of sign off by the Mortality Working Group.	6.1 Completed	6.1 Completed	There will be a robust audit trial of the decisions to investigate a death which is 60% correct without need for central moderation by 31.03.16 and 95% correct by 30.06.16.	05.01.16 Audit in development, to be added to the Internal Audit timetable.	Helen Ludford, Associate Director of Quality Governance Fiona Richey, Head of Business Continuity and Risk (for BI and Ulysses system developments)	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
		6.2 Develop and launch a Ulysses death reporting form. This will commence a process with a senior clinical sign off as to whether a death should be investigated and what level of investigation would be required. This will all be tracked and monitored within the system.	6.2 Screen shot of death reporting form.	6.2 Completed	6.2 Completed					
		6.3 Provide Trust wide communication of the new process ahead of 'go live' using bulletin and intranet communications.	6.3 Evidence of Trust communication team circulating the new process ahead of the 'go-live' date.	6.3 Completed	6.3 Completed					
		6.4 Monitoring of compliance with this process to be undertaken by the Mortality Working Group under Executive leadership.	6.4 Minutes of the Mortality Working Group and Ulysses extraction to provide assurance of reporting.	6.4 31.01.16	6.4 On Track					
7	Ensure a systematic approach to cross organisational learning from deaths through formal Mortality review processes at Divisional and Trust level through Mortality Meetings and themes and trends are clearly identified and acted on.	high	7.1 Divisions to introduce regular Mortality Meetings (minimum of once a quarter).	7.1 Schedule of Mortality Meetings.	7.1 31.03.16	7.1 On Track	That themes from Serious Incident Investigations will be discussed at Division level and shared with the wider clinical group. Improvements to care delivery / patient pathways can be linked to thematic evidence.	05.01.16 Thematic review and reporting to be developed by the Organisational Learning workstream of the Quality Improvement Programme - meeting scheduled 14.01.16.	Helen Ludford, Associate Director of Quality Governance Tracey McKenzie, Head of Compliance Mayura Deshpande, Associate Medical Director (Quality), Patient Safety and Divisional Clinical Directors	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
		7.2 Terms of Reference and standardised agenda inclusive of case study review to be drawn up by the Governance Workstream of the Quality Programme and implemented within each group.	7.2 Terms of Reference and standardised agenda documents.	7.2 Completed	7.2 For final approval at Mortality Working Group - 12.01.16					
		7.3 Divisional Mortality Meetings to report into the Trust Mortality Review Group under Executive leadership (quarterly).	7.3 Minutes of the Mortality Review Group.	7.3 31.03.16	7.3 On Track					
		7.4 Divisional Mortality Meetings to be chaired by the senior clinician in a senior leadership role and the data presented by the Lead Investigator for the Division.	7.4 Minutes of the Mortality Meetings.	7.4 31.03.16	7.4 On Track					
		7.5 All Divisions to use 'Hot Spots' and 'Could it happen here?' templates to share thematic review findings and enhance organisational, divisional and team learning. This should include learning from family involvement.	7.5 Evidence of the use of 'Hot-Spots' in the Division which contain Serious Incident learning.	7.5 31.03.16	7.5 On Track					
		7.6 Data for Mortality Meetings to be produced by the Ulysses systems analyst (monthly).	7.6 Examples of the standardised reports provided.	7.6 Completed only for Spine reports in Tableau	7.6 Risk of Slippage. Combined Tableau reports with Spine and Ulysses data not available until 03.16					
		7.7 Organise and deliver bi-annual Serious Incident workshop / conference to discuss improvement progress and changes to national frameworks.	7.7 Programmes for the workshops.	7.7 Completed	7.7 Completed					
		7.8 Provide improvement report to the SOG on a quarterly basis.	7.8 Report to be provided.	7.8 Completed	7.8 Completed - 1st report submitted Nov 2015					
8	Ensure robust systematic Mortality Reporting to Trust Board and Board Sub-Committees which review mortality.	med	8.1 Develop standardised Board report templates through Mortality Task and Finish Group to include numbers, national benchmarks, case studies, themes and organisational learning.	8.1 Standardised Board and sub-committee reporting of mortality and the associated themes. Evidence will be the papers.	8.1 31.03.16	8.1 On Track	Complete and effective Board oversight and assurance. External confidence in the annual report.	05.01.16 Planning commenced for 2015/2016 report.	Sarah Pearson, Head of Legal & Insurance Services (for SIRI data) Amanda Owen, Corporate Governance Manager Briony Cooper, Head of Quality Performance and Quality Contracts	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
		8.2 The Mortality Review Groups and Mortality Meetings must identify any Mortality themes and link themes to clear risks on the risk register.	8.2 Mortality Review Group and Mortality Meeting minutes.	8.2 31.03.16	8.2 On Track					
		8.3 2015/16 Annual Report to include detail of new mortality reporting process and any early identification of themes from specialities. This will not be a complete data set which will be in place for the 2016/17 Annual Report. First draft to be shared in February 2016.	8.3 Content of the Annual Report.	8.3 31.03.16	8.3 On Track					

9	Improve thematic review across the Trust and share this process externally with the stakeholders (CCGs) for assurance.	low	9.1 Produce a thematic review template in line with best practice guidance to include lessons learnt.	9.1 Standardised template	9.1 31.01.16	9.1 On Track	Improved oversight and assurance of thematic review process.	05.01.16 in development and on track.	Tracey McKenzie, Head of Compliance Briony Cooper, Head of Quality Performance and Quality Contracts	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer, Dr Lesley Stevens, Medical Director
			9.2 Share thematic review approach, template and schedule with CCGs.	9.2 Minutes of SOG.	9.2 31.03.16	9.2 On Track				
			9.3 Review the themes which the Mortality Report suggests require further investigation such as, the role of the care coordinator. Undertake review and report to Quality and Safety Committee.	9.3 Evidence of thematic reviews.	9.3 30.06.16	9.3 On Track				
			9.4 Provide evidence of thematic review to the CCG commissioners through CORM's and SOG.	9.4 Supply thematic review papers to discussion.	9.4 30.06.16	9.4 On Track				
10	Ensure that SHFT incident reporting and management policy is aligned to the national framework and submission of data to the National Reporting and Learning Service is evidenced as correct to guidance.	med	10.1 Re-write SHFT incident policy to ensure alignment to the national framework to acknowledge process developments made during the last year.	10.1 Up to date policy.	10.1 31.01.16	10.1 On Track	Accurate national reporting aligned to the published national frameworks. Evidence that the NRLS criteria are being applied correctly.	05.01.16 Policy out for consultation and NRLS meeting being organised.	Fiona Richey, Head of Risk and Business Continuity Sarah Pearson, Head of Legal & Insurance Services	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			10.2 Governance team to meet with the NRLS centralised team to ensure that the Southern Health impact grading and uplift processes are occurring within the required criteria.	10.2 Minutes of a meeting.	10.2 31.03.16	10.2 On Track				
11	Ensure that the requirement for multi-agency retrospective and forward planned thematic reviews and Serious Incident investigations are discussed with partner organisations, CCG's and the Local Authorities to agree process.	med	11.1 Engage all stakeholders in a workshop to discuss the appropriateness, the capacity for and ownership of the terms of reference for retrospective and forward planned thematic review.	11.1 Programme for the Serious Incident workshop scheduled for 01.02.16 in which these issues will be debated.	11.1 01.02.16	11.1 On Track	SHFT to be fully engaged in multi-agency Serious Incident investigations and thematic review.	05.01.16 Workshop scheduled for February 2016.	Helen Ludford, Associate Director of Quality Governance	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			11.2 Engage all stakeholders in a workshop to discuss the process of commissioning and managing multi-agency Serious Incident investigations.	11.2 Content of the agenda for the Serious Incident workshop scheduled for 01.02.16 in which these issues will be debated.	11.2 01.02.16	11.2 On Track				
			11.3 As part of a wider stakeholder group create a process framework for undertaking multi-agency Serious Incident investigations.	11.3 Process framework for undertaking multi-agency investigations agreed by all stakeholders.	11.3 31.03.16	11.3 On Track				
12	Ensure that the physical health needs of patients in mental health and learning disability services are met.	med	12.1 Review the content of the five day physical health course which LEaD provide and ensure that there is the correct percentages of staff attending from each service.	12.1 Course content and learning outcomes which will be reviewed. Attendance data per service.	12.1 31.03.16	12.1 On Track	Compliance rates for the 5 day course will meet those stipulated for each area. Audit results of physical health care plans in MH/LD services will show 95% or above as having appropriate	Sara Courtney, Acting Director of Nursing and Allied Health Professionals and all Associate Directors of Nursing Mavura Deshpande, Associate	Dr Lesley Stevens, Medical Director Sara Courtney, Acting Director of	

GAP Analysis - Mortality Review

Helen Ludford Associate
Director of Quality
Governance

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Produced by: (Name & Job Title)

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Mazars Recommendation Theme	Mazars Recommendations Number	Current Compliance	Current Gap	Barriers to implementation of recommendation	Will the Trust implement the recommendation as suggested or is an alternative approach suggested?	Linked to action plan number
Board Leadership and Oversight	The Board needs to address the culture of lack of review and reporting of unexpected deaths, ensure staff at all levels recognise the need for timely, high quality investigation, how to include families and to ensure learning is demonstrated. a. The Board needs to ensure the processes of reporting and investigating unexpected deaths are consistent and robust throughout the organisation and to improve the quality of investigations and the involvement of families in those investigations. The Trust needs to prioritise the review of deaths as part of a wider mortality review process making better use of data available. b. The Board needs to understand and make full use of the data available and the underlying information required for assurance that unexpected deaths are being properly identified and investigated.	a. The Board receives information about deaths - weekly Flash report and CQC serious incident submission b. The Board via Quality Safety Committee receives quarterly serious incident reports which include information regarding process and deaths c. Corporate panels with Executive chair ensure that the duty of candour has been performed correctly for every incident d. Incident investigator training includes a session on the duty of candour and involving families in investigations e. There is a centralised investigation team in post to provide expert help and support to investigators to fulfil the duty of candour and involve families	a. The Board or the sub-committee do not receive a specific mortality report which captures the review of death alone.	Nil	Yes - This will be implemented for the entire Trust across all service areas not just those pertaining to this mortality review.	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 2.1, 2.2, 2.4, 2.5, 2.6, 2.7, 3.1, 3.2, 4.1, 4.2, 4.3, 4.5, 4.6, 5.6, 6.4, 7.3, 7.4, 7.5, 7.8, 8.1, 8.2, 8.3, 9.3, 10.1
Board Leadership and Oversight	The Board or its sub-committees should receive regular reports of all incidents of deaths. The report should: a. provide data on all deaths of people using a Mental Health or Learning Disability service including service users of the social care service - TQ21. b. outline how many unexpected deaths there have been and in which areas. c. outline how many IMAs have been written as a result and how many have progressed to CIR and then onto SIRI. d. include a summary of how many deaths	a. The Board receives information about deaths - weekly Flash report and CQC serious incident submission b. The Board via Quality Safety Committee receives quarterly serious incident reports which include information regarding process and deaths c. Corporate panels with Executive chair ensure that the duty of candour has taken place correctly for every incident d. Incident investigator training includes a session on the duty of	a. Statistical analysis of serious incident data is undertaken, but due to the manual nature of the process amendment is required. An automated process linked to Ulysses will be live from January 2016 b. Mortality reporting to the Board and sub committees has previously been included within the Incident Report and not as a separate paper. Stand alone reporting will be implemented into the programme of board and sub-committee	Ulysses system developments delayed the process of electronic investigation.	Yes - This will be implemented for the entire Trust across all service areas not just those pertaining to this mortality review. The only exception is in respect of recommendation b. The Trust's new procedure for reporting and investigating deaths has moved away from classifying deaths as	8.1, 8.2, 8.3, 9.1, 9.2, 9.3, 10.2, 11.1, 11.2, 11.3

	<p>are 'pending' for the purposes of investigation with a reason why. This would make the decision-making more transparent as regards to delays in reporting to StEIS.</p> <p>e. provide information to enable trends to be identified and for Board members to become familiar with the information</p> <p>f. provide information which includes the categorisation of all deaths reported to Ulysses</p> <p>g. provide data at least twice a year on all deaths. Themes should be reported on which covers at least the previous 6 quarters (or a sufficient number to provide a reasonable sample from which to identify themes). This is particularly important for the Learning Disability arena where numbers of deaths in each quarter will be low and in areas that may not meet SIRI criteria e.g. non-suicide Mental Health deaths.</p>	<p>candour and involving families in investigations</p> <p>e. There is a centralised investigation team in post to provide expert help and support to investigators to fulfil the duty of candour and involve families</p>	<p>schedules and will specifically incorporate the 6 quarter review periods.</p>		<p>'expected' or 'unexpected'. Instead, the report to the Board will outline how many deaths there have been which have warranted further investigation.</p>	
Board Leadership and Oversight	<p>The 2015/16 Annual Report should provide a more transparent breakdown of deaths including a analysis of the themes that occur for people with Mental Health and Learning Disability challenges.</p>	<p>The Trust's Annual Report already contains high level data which has met the national reporting requirements and the NHS guidance document.</p>	<p>The annual report will be developed to include a detailed breakdown of deaths and analysis of the mortality thematic reviews that have been undertaken.</p>	Nil	Yes	8.3, 11.1, 11.2, 11.3
Board Leadership and Oversight	<p>There is clear national and Trust policy guidance on reporting and investigating deaths. Trust policy includes a full set of templates and processes - the Board should ensure these policies are being followed and templates being used.</p>	<p>Policy and procedure documents are in place and specifically relate to reporting and investigating of incidents and deaths. An investigation toolkit, supported by the former NPSA and other organisations is available on the Trust intranet. Process standardisation will be achieved through the implementation of the electronic system. The Trust is compliant with the nationally mandated Serious Incident reporting framework.</p>	<p>Compliance against the reporting process will be shared. This will be provided in the quarterly incident report in line with the current timetables.</p>	<p>Nil locally however a national framework for the reporting of deaths does not exist and the only guidance is that for serious incident reporting.</p>	<p>Yes the Trust will ensure that local templates and processes are followed.</p> <p>Whilst national guidance on reporting and investigating deaths does not currently exist (aside from serious incident guidance), the Trust will comply with any new national guidance as and when it becomes available.</p>	2.3, 2.7, 4.3, 4.6, 5.3, 6.1, 6.2, 6.3, 6.4, 7.1, 7.2, 7.3, 10.1

Monitoring mortality and unexpected deaths / attrition	Unexpected deaths should be defined more clearly. We suggest the Trust uses, as a starting point, the classification outlined in this report to identify the potential need for review or investigation in each case. In particular, the definition of an 'unexpected death' needs to be refined to be more applicable to the circumstances of people with a Learning Disability regardless of setting.	The Trust, has in partnership with Commissioners, developed a process for the reporting of deaths and evidencing what level of investigation is required. This is has been built into the Ulysses Safeguard system. The Trust will not be implementing the system developed by the authors of the report.	Programme of rollout of the new process across the clinical divisions.	There was a delay in the implementation of this recommendation due to system design - Ulysses Safeguard but this has now been resolved. The widely used terminology of expected/unexpected deaths has been unhelpful as it is too subjective. SHFT has defined its own criteria for the reporting and investigating of deaths in conjunction with local commissioners.	No - alternative action proposed. The Trust has developed a new Procedure for Reporting and Investigating Deaths which will provide an evidence trail as to the level of investigation that is required. This is built into the Ulysses Safeguard system. The Trust will not be implementing the system developed by the authors of the report as the classification outlined relies on subjective judgements by frontline staff which has not previously been helpful.	6.1, 6.2, 6.3, 6.4
Monitoring mortality and unexpected deaths / attrition	<p>The Trust should develop a Mental Health and Learning Disability Mortality Review Group which includes reviewing unexpected deaths which do not constitute a serious incident.</p> <p>Clear terms of reference should be developed. This group should serve a number of purposes:</p> <ul style="list-style-type: none"> a. to provide oversight of all deaths occurring amongst the Trusts Mental Health and Learning Disability service users b. develop a mortality dashboard which is provided to stakeholders and reported in the annual report that provides a full picture of all deaths, themes, CIRs and serious incidents c. monitor causes of deaths amongst its service users by using the 2013/14 MHMDS data release to see if the ICD 10 chapters show any trend d. provide an evidence base to share with Local Authority commissioners and other providers highlighting themes that are arising relating to social care and other agencies issues e. to ensure that liaison with acute provider colleagues can take place at a clinical and managerial level where the Trust has concerns raised with it about care in acute settings f. should include a GP as part of its membership g. the formation and progress of this new group should be monitored at Board level h. the group must aim to improve the transparency of reporting levels of unexpected deaths. 	Not presently compliant although Term of Reference and Standardised Agenda frameworks have been produced to support the implementation.	The need for mortality review groups has been recognised by the Trust but are not yet in place.	Nil	<p>In part.</p> <p>The Trust will hold mortality meetings in each Division to review deaths however it cannot be responsible for monitoring improvements within other providers as this is the role of the commissioners. The Trust cannot mandate the attendance of a GP at these meetings .Concerns about GPs or other providers will be raised through the commissioners to other organisations. The quality manager from the commissioners will be invited to attend the mortality meetings.</p> <p>Recommendation c. cannot be fully implemented as ICD 10 chapters are not used consistently across non- inpatient services and it would not be appropriate to do so. Alternative categorisation of cause of death will be applied.</p>	7.1, 7.2, 7.3, 7.4, 7.5, 7.6, 7.7, 7.8, 8.1,8.3, 11.1, 11.2, 11.3

Thematic reviews	A template for a thematic review should be produced. All thematic reviews should be undertaken in an agreed format which meets best practice standards and includes follow up, evaluation and demonstration of lessons learned and practice change.		The requirement for regular rather than ad hoc thematic reviews has only recently been established within SHFT and there is not yet a standardised template to support them.	Nil	Yes	9.1, 9.2, 9.3
Thematic reviews	There should be further work undertaken to establish whether all deaths of people over the age of 65 are being appropriately reported and investigated - in particular amongst inpatients.	Reporting of deaths now takes place in accordance with the Trust's new Procedure for Reporting and Investigating deaths.	Previously there has been inconsistent practice which has been eliminated with the launch of the electronic reporting tool and new Procedure.	Nil	Yes	6.1, 6.2, 6.3, 6.4
Thematic reviews	The Trust, CCG and local authority should undertake a retrospective review of all Learning Disability unexpected deaths regardless of place of residence with particular reference to: a. the quality, timing and follow up of dysphagia assessments b. the level of support provided by hospital liaison services and the challenges faced in acute liaison c. the decision-making process for PEG insertion d. the hydration and nourishment of service users refusing to eat e. delays in decision-making for treatment - including primary care, decisions by care staff and responses in A&E and on wards f. the inclusion of carers and families in investigations g. waiting times for therapy services and community nursing h. identification of early warning signs of deterioration through behavioural change i. arrangements for attending appointments and seeing healthcare professionals j. reporting and acting on safeguarding concerns.	SHFT has evidence of undertaking some thematic reviews which have been presented to Board sub-committees.	Not applicable - this recommendation is a defined piece of work for further discussion with stakeholders. It is recognised that there could be barriers in relation to capacity for this large retrospective review across multiple organisations.	This is a large piece of retrospective work involving external partners which requires coordination and a lead organisation. Capacity to facilitate could feature as a barrier.	To be decided - further discussion is needed with external partners, particularly commissioner colleagues who will need to agree and facilitate this piece of work. SHFT cannot make the decision to undertake this review in isolation as in most instances its records will only provide a limited part of the multi-agency information required. With reference to j. there are no outstanding safeguarding concerns that have not been reported.	11.1, 11.2, 11.3

Thematic reviews	The Trust and CCG should undertake thematic reviews in Mental Health on a number of the issues raised in this review, including: a. A joint review of the circumstances of death of people with serious mental illness on long term antipsychotic drugs encompassing a review of safeguarding alerts, self-neglect and physical health management. b. A joint review of all deaths relating to people with a drug related death in conjunction with local providers encompassing a review of referral processes between agencies. c. A joint review with the CCG of recent cases of death relating to serious eating disorders to understand how services need to improve by bringing both physical and psychological management together. d. A joint review of alcohol related deaths in conjunction with local providers encompassing a review of self-referral processes.	SHFT has evidence of undertaking some thematic reviews which have been presented to Board sub-committees.	Not applicable - this recommendation is a defined piece of work for further discussion with stakeholders. It is recognised that there could be barriers in relation to capacity for this large retrospective review across multiple organisations.	This is a large piece of retrospective work involving external partners which requires coordination and a lead organisation. Capacity to facilitate could feature as a barrier. There are also concerns related to c., SHFT are not a specialist service therefore would not see sufficient patient activity in relation to eating disorders to undertake a thematic analysis.	To be decided - further discussion is required with external partners who will need to provide input into this piece of work. SHFT cannot make the decision to undertake this review in isolation as it cannot mandate involvement of other providers or the sharing of information by other providers.	11.1, 11.2, 11.3
Thematic reviews	The Trust should provide staff with regular training and guidance to help them manage physical health conditions of long-term mental health service users. Diabetes management stands out as an area for greater awareness from a number of cases we reviewed.	SHFT already has in place a physical health training course for both nurses and doctors working in the mental health field. This course was strengthened in 2015 and now covers 5 days in total.	Nil	Nil	Yes and this is to be considered as a core competency in relation to job roles	12.1, 12.2, 12.3
Thematic reviews	The Trust should undertake thematic reviews of the issues raised in the review, including: a. Medical input and senior medical oversight b. The role of the care co-ordinator c. The need for pharmacy colleagues to be more explicitly involved in cases involving drug toxicity and polypharmacy.	Although a retrospective review into these areas has not been undertaken reviews have taken place as part of service and process redesign work.	Whilst these issues have been reviewed in relation to service and process redesign, this has not been formally documented as a thematic review.	Nil	In part. A) and b) are particularly broad and rather than carry out a thematic review, the Trust will present its current position in relation to these two areas as papers to Board sub-committees. C. will be implemented in full and pharmacy colleagues will be involved in either the investigation itself or the corporate panel in cases involving drug toxicity or polypharmacy.	9.3

Thematic reviews	A regular review of all sudden deaths of OPMH inpatients should be carried out. This should include a review of whether care treatment decisions are taken quickly enough, whether cooperation and liaison with acute medical staff is adequate and whether staff feel confident in managing and identifying sudden physical deterioration including CPR.	All deaths within OPMH inpatient settings are now reported on the Ulysses system and are managed in line with the new death reporting procedure.	SHFT will need to implement a 6 monthly thematic review of all OPMH inpatient deaths.	Nil	Yes	91, 9.2
Reporting and Identifying Deaths	The Trust should review the way that deaths are categorised under the incident reporting policy so that: a. All relevant deaths are re-graded accurately before and after investigations have taken place. b. All relevant deaths are reported on regardless of impact grading to ensure that deaths have greater prominence in the Trust's reporting systems. c. Accurate information is provided for future Trust Mortality Reviews. d. That immediate work with the NRLS team is undertaken to ensure the changes to the local risk management system map as expected to NRLS and on to CQC.	The Trust policy includes guidance on categorisation of incidents; a. Deaths are graded by the reporter and quality assured by the manager, overseen and sign off by the senior clinician for the Division b. Impact grading is checked at the corporate panel before upload to the NRLS d. NRLS reporting takes place as per NHS requirement as interpreted by the Trust. CQC reporting of deaths is in place as a requirement of registration for deaths which meet the criteria e.g. those patients detained under a section of the Mental Health Act.	Written confirmation from NRLS as to the Trust's interpretation of its guidance	There is a lack of consistent national application of the NRLS guidance. As a Trust we have been assured that we are following the correct procedure.	Yes	4.1, 4.2, 4.5, 7.6, 10.1, 10.2, 4.5,
Quality of Investigation Reporting	The Serious Incident investigation process needs a major overhaul in the Trust. Improvements are needed in: a. Separation of people responsible for quality assurance and those undertaking investigations. This would enable training in review processes and quality assurance to be targeted at senior staff and in investigation techniques at a dedicated group of investigators. b. Quality assurance processes including independent review and sign off c. Achieving high professional standards in written presentation	Central investigation team, divisional and corporate panels are now all in place to ensure quality assurance and scrutiny. Independent review is achieved through CCG closure panels scrutiny. Investigator training has been undertaken which covers aspects of report writing and an electronic incident report template has been designed and is embedded in the Ulysses Safeguard system.	Development of ongoing assurance programme	Nil	Yes	1.3, 2.1, 2.3, 2.4, 2.5, 2.7, 3.3, 4.3, 5.1, 5.6, 10.1
Timeliness of Investigations	Reporting to StEIS should be undertaken within the 2 working days of notification as required by the national guidance.	The Trust is presently 47% compliant to this requirement. There is ongoing monitoring of this key performance indicator supported by the central investigation team.	Ensuring that 48 hr death and serious incident review panels occur with senior clinician attendance to make the decision that StEIS reporting is required.	Nil	Yes	1.1, 1.2, 1.7, 1.8

Timeliness of Investigations	There should be more explicit action to commence investigations promptly even when a coroner conclusion is not immediately available unless there is a specific reason to delay; any delay should have senior sign off.	The death reporting and incident procedure is specific that delays do not occur in reporting or commencing an investigation unless there is a specific and recorded reason for doing so.	Documentation of rationale for delaying commencement of a detailed investigation is not kept on Ulysses in a standardised format.	Nil	Yes	1.1, 1.2, 1.3, 1.7
Involvement of Families	The involvement of families in investigations requires improvement. In particular, improvements are needed in: a. developing clear guidelines for staff, including expected timescales and core standards, which recognise the need for iterative engagement when the family is ready b. ensuring that the investigation process is clearly defined and separate from the support and assistance offered by local treatment teams c. the Trust should ensure that investigators talk to families as early as possible in the process to identify any concerns and take these into account in the ensuing investigation d. provide reports to coroners in time for inquests e. explicitly demonstrating why families are not involved f. identifying next of kin details for all service users as part of a core assessment including where consent to share has not been provided to enable investigators to find relatives more easily. g. working with primary care to identify family members h. where the Trust delays the commencement of an investigation due to inquests or other investigations this should be made explicit to families and the reasons explained. i. the performance of divisions in involving families and securing feedback	The Trust is now 100% compliant in relation to this recommendation with the exception of f. and g. Corporate panels with Executive chair ensure that the duty of candour has taken place correctly for every incident. Incident investigator training includes a session on the duty of candour and involving families in investigations There is a centralised investigation team in post to provide expert help and support to investigators to fulfil the duty of candour and involve families.	recommendations f. and g.	f. cannot be implemented as it the patients choice as to whether next of kin details are provided at initial contact. g. next of kin details cannot is be sourced from primary care without the patients consent, this approach will only be taken in event of their death when details will be obtained either from primary care or the coroner.	Yes apart from f. g. will be dependent on information available to primary care partners and the coroner and is therefore not entirely within the Trust's control	5.1, 5.2, 5.3, 5.4, 5.5, 5.6 , 5.7, 5.8
Multi-agency working	The Trust Board should seek co-operation with other providers and commissioners to agree a framework for investigations in preparation for future incidents regarding escalation. Divisions should then apply this framework where the incident report suggests another organisation should review or investigate the circumstances of a death.		Consistent framework not in place for multi-agency investigations. A framework must be agreed with commissioners	Nil	Local commissioners have agreed that it is their responsibility to lead on multi-agency reviews and to share concerns with third party organisations. The Trust will work with commissioners to agree a framework for escalation of concerns about third parties.	11.1, 11.2, 11.3

Deaths in detention and inpatient deaths	The Trust should retain a contemporaneous list of all inpatient deaths mapped to Mental Health Act status to enable Trust-wide oversight of all inpatient deaths and deaths in detention	All inpatient deaths of individuals subject to detention under the Mental Health Act are reported and also reported to the CQC.	A 'flag' will be applied to the Ulysses System to ensure that this is recorded as part of the death reporting process.	Nil	Yes	1.9
Deaths in detention and inpatient deaths	All deaths of service users in detention should be investigated, whether expected or not. These investigations should occur regardless of inquest conclusions. This will give assurance that the 24/7 nature of the care required has been of the highest standard. Specific issues addressed in the Terms of Reference for these investigations should include: a. to ensure that physical health care symptoms are not dismissed where challenging behaviour presents; b. that delays in seeking physical health care are not apparent; c. that service users are fully aware of decisions regarding whether to treat or investigate chronic or acute symptoms and that these are made in an informed manner; d. that access to full care and treatment is not restricted in any way; e. that staff are adequately supported to provide physical health care and trained to do so.	It is SHFT policy to investigate all inpatient deaths of individuals subject to Mental Health Act detention.	Where patients under detention have died in expected circumstances or through natural causes, these have not been automatically investigated as a SIRI.	Nil	Yes	1.1, 1.2, 1.3, 1.4, 1.5
Information management	The Trust should develop an agreed RiO extract and Ulysses reporting protocol to capture all deaths of Adult Mental Health, Older People Mental Health and Learning Disability service users including community and inpatient locations to form the basis of future mortality review.	Mortality reports have been developed and are accessed through the Trust business intelligence system Tableau.	Report content/ design of data presentation will be reviewed by the mortality review group. Whilst the new process includes the requirement to report all deaths of LD patients within 12 months of contact and all deaths of MH service users who are inpatients or within 12 months of contact for suicides, it is not practicable to capture the thousands of community OPMH deaths on Ulysses unless a number of specific criteria are met as defined in the Trust's new Procedure for Reporting and Investigating deaths.	Nil	In part - OPMH community deaths are captured only in specific numbers due to the impracticability of recording the high numbers of OPMH community deaths in circumstances which are not untoward.	7.6, 8.1

Information management	The spreadsheet arrangement currently in place in TQ21 is insufficient to monitor deaths at corporate level as part of the whole Learning Disability service provision. TQ21 service users should be incorporated into Trust administration systems in a way which ensures their deaths are captured for reporting and investigation purposes.	The new death reporting process has been implemented within TQ21. The same system is in place across the Trust.	Nil	Nil	Yes	1.6, 2.4
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Commissioners' response to Mazars report into Mental Health and Learning Disabilities deaths in Southern Health NHS Foundation Trust

Appendix 5

Prepared by:	Heather Hauschild Chief Officer West Hampshire Clinical Commissioning Group Andrea O'Connell Director of Quality & Nursing West Hampshire Clinical Commissioning Group
Email:	Heather.hauschild@westhampshireccg.nhs.uk

Background

The Mazars report was commissioned by NHS England following the death of Connor Sparrowhawk in July 2013 in the Short Term Assessment and Treatment Team ('STATT') unit in Oxford run by Southern Health NHS Foundation Trust ('Southern Health'). The report was commissioned to identify any common themes and trends, any lessons to be learned for providers, commissioners and/or regulators, and any common contributory factors. The team reviewed deaths that occurred in the period between April 2011 and March 2015 of patients who had been in receipt of the Trust's mental health and/or learning disabilities services, either at the time of their death or within the twelve months preceding their death.

Response

We would like to offer our sincere condolences to any families that may have lost loved ones and are affected by this issue.

The Mazars report highlights a number of recommendations for commissioners, which we accept. It also highlights wider learning for the NHS and social care.

There are a number of commissioners across Hampshire, Southampton, Oxfordshire and Buckinghamshire that commission mental health and learning disability services from Southern Health NHS Foundation Trust including Clinical Commissioning Groups (CCGs), NHS England and local authorities (Oxford and Buckinghamshire CCGs commission only learning disability services). These commissioners work jointly and separately with the provider and the relevant local authority based on the needs of the population they are working with.

Commissioners have worked closely with Southern Health to understand the complexities inherent in the data presented in the report, looking specifically at the numbers of expected and unexpected deaths. It is clear that, where patients are receiving services from multiple agencies, the attribution of expected, unexpected and avoidable deaths is problematic and therefore it is important that we avoid unnecessary confusion and alarm. Mazars notes that a number of service and statistical issues are highlighted within the report which means that such 'headline findings' need very careful interpretation. Variation in death rates, for example, will be determined by a range of factors and are not necessarily a consequence of any particular aspect of the Trust's approach.

The needs of patients are taken very seriously by commissioners. By working extensively with partners, joint strategies have been developed to ensure that support for patients with learning disabilities and mental health issues are in place. Commissioners will continue to work together to make improvements for these areas.

The Mazars report highlights three key issues:

- The quality and timeliness of investigations
- Mortality rates for mental health and learning disability patients
- Reporting mechanisms in place

The quality and timeliness of reports

Southern Health have accepted that processes for investigating and reporting a patient death required improvement and have over the past two years introduced a number of changes to improve the quality of reporting and timeliness. Improvements include the launch of new reporting and investigations of deaths processes, a specialised investigation team and increased Executive oversight of the reporting processes. Commissioners have seen an improvement since April 2015 in the reports presented at serious incident panels.

Local contracting and monitoring arrangements that oversee the incident reporting process have been strengthened with the establishment of a strategic oversight group including all commissioners of Southern Health services.

Mortality rates for mental health and learning disability patients

Commissioners regularly review national and local data on mental health. There is only national data available for learning disabilities, the Confidential Inquiry into Premature Deaths (CIPOLD).

For Hampshire the rate of deaths by suicide between 2012 and 2014 by a proportion of our population is slightly lower than the national average (8.2 deaths per 100,000 in Hampshire compared to 8.9 deaths per 100,000 for England). Ref: Suicide Prevention Plan Hampshire County Council, June 2015:

http://www3.hants.gov.uk/councilmeetings/advsearchmeetings/meetingsitemsummary.htm?sta=&pref=Y&item_ID=6762&tab=1&co=&confidential=

The premature mortality rate for adults under 75 with serious mental health issues (2012/13) for Hampshire remains better than the South East average. Overall Hampshire has comparable levels of avoidable mortality than other parts of England. Ref: Public Health Outcomes Framework (2012/13):

<http://www.phoutcomes.info/public-health-outcomes-framework#page/3/gid/1000044/pat/6/par/E12000008/ati/102/are/E10000014/iid/91096/age/181/sex/4>

Specifically for learning disability patients, a learning disability partnership board has been established with the local authority in Hampshire who have co-developed and launched a learning disability plan that responds to the needs of service users.

Buckinghamshire CCGs (Aylesbury Vale CCG and Chiltern CCG) and Buckinghamshire County Council have established a similar partnership board and an integrated learning disability programme board to drive the transformation of learning disability provision in the county.

NHS England has commissioned a national premature mortality review for people with learning disabilities following a confidential inquiry report that also highlighted similar issues. The review will use the information from this report to undertake its work, in particular to support the development of more local premature mortality review functions that will be adopted by local commissioners.

Reporting mechanisms in place

The recommendations also highlight a need to improve the systematic management and oversight of deaths and ensure key focus is placed on working with families and carers.

As a provider of specialist mental health and learning disabilities services, it is essential that robust governance arrangements are in place to ensure that deaths are investigated for current and past service users. The Trust has recently introduced a new procedure on reporting and investigating deaths and in future commissioners will be independent contributors to the process. CCGs that commission services from Southern Health, alongside Monitor and NHS England, will scrutinise the Trust's improvement actions and delivery. NHS England will hold the CCGs to account for overseeing that improvement.

All commissioners will continue to work with Southern Health to ensure these processes deliver real assurance to patients, including those with mental health and learning disabilities, and we will strive to secure sustained improvement.

There are nine specific recommendations for CCGs, although we recognise that as commissioners we are integral to the implementation of the other recommendations. The recommendations for CCGs are:

Response to commissioner's recommendations

1. **The CCGs should take action to ensure:**
 - a. **Incidents are reported to the Strategic Executive information System (StEIS) within two working days as required**
 - b. **That reports are provided to closure panels within 60 days as required**
 - c. **That the quality of initial management assessments, critical incident reviews and serious investigations improves radically**
 - d. **That Serious Incident investigations are completed within an agreed timeframe**
 - e. **That the data provided to them relating to deaths is accurate**

Commissioners accept the recommendation and recognise this is an area for improvement. For complex and multiagency serious incidents, meeting the current timescales is challenging; however, we will work together across our health and social care systems to develop appropriate protocols to ensure high quality and timely reports that can be shared across partners. This may include reviewing serious incident reports prior to the coroner reaching a verdict.

The Hampshire CCGs recognised that the quality of serious incidents reports (SIRI) at Southern Health needed improving and we asked an independent expert to undertake a review of their investigation processes and used the findings from this report in conjunction with training to drive up the quality of reporting. Since April 2015 there has been a significant improvement in the quality of learning disability and mental health SIRI reporting.

- 2. Commissioners should ensure that all unexpected deaths of people with a learning disability, inpatients on older people's mental health wards and in cases of suicides of people in the period between referral and treatment are properly considered before a decision is taken not to report as a serious incident or report under CQC regulation 16.**

We accept this recommendation.

Commissioners will:

- Ensure that there is a clear incident management protocol for investigation of all learning disability deaths
- Fully participate in the national learning disability mortality review

A suicide prevention plan was developed in Hampshire by a wide range of partners including Southern Health, CCG's, police, transport organisations and the voluntary sector. It was actively supported and agreed by the Hampshire Health and Wellbeing Board in June 2015 and an action plan has been taken forward. The action plan is being implemented and progress against the plan is being monitored through the suicide prevention implementation group.

The plan covers six themes that:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring

A link to the plan can be found here:

http://www3.hants.gov.uk/councilmeetings/advsearchmeetings/meetingsitemsummary.htm?pref=Y&tab=1&item_ID=6762&cancel=n

Similarly, Buckinghamshire and Oxfordshire have recently published a joint suicide prevention plan. This is a multiagency plan led by Public Health and is closely aligned with the county's mental health strategy and the mental health crisis concordat action plan which is overseen by the Health and Wellbeing Boards. A link to the plan can be found here:

http://www.oxfordmhf.org.uk/SPIN_annualreport2014-15FINALAug2015.pdf

Southampton is currently developing its suicide prevention plan in conjunction with key stakeholders; this will be completed following the completion of the 2015 public health audit of suicide and presented to the Health and Wellbeing Board for approval before publishing.

Commissioners as statutory partners on their respective Safeguarding Adults Board will be involved in any serious case review investigating the death of a patient.

For learning disabilities the current focus is on proactive care through delivery to the Transforming Care agenda. It sets out a clear programme of work with other national partners to improve services for people with learning disabilities including those with a mental health condition.

<https://www.england.nhs.uk/wp-content/uploads/2015/01/transform-care-nxt-stps.pdf>

3. The CCGs with the CQC should ensure that the Trust reports and investigates all deaths in detention to ensure that full learning is derived from this group of deaths.

We accept the recommendation.

We will ensure that agreed recommendations are taken forward with an emphasis on reporting relevant incidents through all required channels in line with the revised Serious Incident Framework we published in 2015, and including sharing learning with all other Trusts, and working with partners like Care Quality Commission (CQC) where this recommendation relates to requirements for reporting deaths.

4. The CCGs, with NHS England, should review whether GPs should be involved in initial management assessments of people with a learning disability and the extent to which GPs are sufficiently informed to talk with the coroner if needed.

We accept this recommendation.

As registered doctors, GPs are able to sign a death certificate in circumstances where a death is deemed to be of natural causes. If a GP is uncertain or there are specific circumstances for example where there is sanction such as a deprivation of liberty, the certification is deferred to the coroner.

It is a matter for national consideration to make amendments to the certification process; however commissioners will undertake a training needs analysis for GPs in their areas.

For learning disability patients there is a national focus on GPs identifying patients with a learning disability and undertaking an annual health check. CCGs have adopted different schemes to ensure that we are implementing this best practise. We do recognise that there is further work required in primary care to ensure that all patients with a learning disability have a yearly check.

5. Commissioners should provide support to the mortality reviews in the Trust including agreeing appropriate independent representation and if possible co-ordinate between them to identify a GP member.

We accept this recommendation.

Commissioners will work with Southern Health to ensure that appropriate arrangements are made for independent representation which will also include a GP where appropriate.

To further support oversight of the mortality reviews, commissioners have established formal processes to assess the outcome of these reviews including any learning identified and actions to be taken. Commissioners will monitor all actions.

Advocacy is commissioned across health and social care to support families/carers where required.

- 6. All commissioners should monitor and co-ordinate between them, the progress of the Trust in its improved use of mortality data and contract negotiations should reflect the changes required from this review.**

We accept the recommendation.

The commissioners recognise that Southern Health has established a new mortality review group which will provide greater oversight and scrutiny on mortality within the trust. As commissioners, we will ensure we have representation at those meetings as well as strengthening our quality indicators within the contract. Learning will inform future commissioning of services. Oversight of changes required from this review will form part of the contracted arrangements going forward.

Contract Quality Review meetings (CQRM) currently scrutinise and challenge the information within the trusts bi-annual mortality reports. If the trust is identified in any element of the report as being higher than the national average, the trust would be requested to provide an improvement plan which would be monitored at CQRM.

- 7. The CCGs should discuss the implications of this review with acute care providers in the area and agree a protocol for ensuring joint investigation between NHS providers, in particular, for people with a learning disability.**

We accept the recommendation.

The first draft of a protocol for ensuring joint investigation between NHS providers has been written by Hampshire CCGs and will be included within the coming months for all providers.

As described previously, all commissioners are part of the national learning disability mortality review programme that ensures all learning disability deaths in whatever setting will receive an independent review.

- 8. The CCGs with local authorities should develop a detailed needs assessment of people with a mental health or learning disability in their area.**

We accept the recommendation.

Commissioners have worked with local authority partners to develop joint strategies for mental health and learning disabilities including strong representation from service users and carers in developing these strategies. Current workstreams supporting the delivery of the strategies include an early intervention and prevention programme focussing on people in at risk groups in local areas.

Public Health support and advise commissioners with a detailed analysis of the health and wellbeing of their communities. There are Joint Strategic Needs Assessments in place which include the detailed needs assessment of people with a mental health or learning disability. This information supports the planning and commissioning of local services.

Buckinghamshire are developing a new learning disability strategy (social care and health) and this will be aligned with the 'building the right support' paper and the transforming care agenda. The main health workstreams are already in place and will be strengthened to take into account the recommendations.

- 9. Commissioners should use the intelligence provided in this review to secure access to data on Mental Health and Learning Disability services to:**
- a) Develop investigation protocols that look across pathways more systematically including in primary care**
 - b) Inform service developments**
 - c) Ensure that general 'community physical care services' need to be accessible to all groups of patients**

We accept this recommendation.

As set out in response to recommendation one, we will work together across our health and social care systems to develop appropriate protocols to ensure high quality and timely reports are delivered that can be shared across partners.

Commissioners will continue to work in a joined up way to ensure that the issues raised in the Mazars report are considered and acted on.

In planning services commissioners will maintain their focus on using robust evidence bases to ensure they are accessible and meet the needs of our community.

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Mazars report into mental health and learning disabilities deaths in Southern Health NHS Foundation Trust – a joint response from NHS Improvement, NHS England and the Care Quality Commission

This report was commissioned by NHS England following the death of Connor Sparrowhawk in July 2013 in a unit in Oxford run by Southern Health NHS Foundation Trust.

The review looked at the deaths of people with a learning disability or mental health problem at Southern Health NHS Foundation Trust, including investigations. It highlights the need for a system-wide response.

Connor's family have been engaged in this report via an expert reference group which provided oversight and quality assurance.

The review team reviewed deaths of people who had died in the period between April 2011 and March 2015 and who had been in receipt of the trust's mental health and/or learning disabilities services, either at the time of their death or within the twelve months preceding their death.

The report is critical of the trust's internal governance and assurance processes. It describes "...a lack of leadership, focus and sufficient time spent in the trust on carefully reporting and investigating unexpected deaths of mental health and learning disability service users".

The report also makes critical comment about the trust's 'lack of transparency' and the lack of involvement of families in investigations into the deaths of service users.

The report makes a number of recommendations to improve the systematic management and oversight of deaths and investigations, including best practice when working with families and carers, the processes by which lessons are learned, and that any resultant service change can be evidenced.

Southern Health NHS Foundation Trust has accepted the report's recommendations to strengthen its ways of working in these areas, and will be setting out separately how it intends to do so. Monitor, as the regulator of foundation trusts, is urgently considering regulatory action to address failings in governance, highlighted by the report, and to ensure the trust delivers the necessary improvements.

Before this publication, the trust had already begun a programme of work to review and improve its systems, processes and practice. As a provider of specialist mental health and learning disabilities services it is essential that systems, practice, and governance of ensuring the need to investigate deaths of current and past service users is systematically considered, and that local mortality reviews and Serious Incident investigations are of the highest quality.

Clinical commissioning groups (CCGs) that commission services from Southern Health, alongside Monitor, will scrutinise the trust's improvement actions and delivery. NHS England South Region will hold the CCGs to account for overseeing that improvement.

The results of the review into deaths at this trust also raise questions about premature mortality in people with a learning disability, which require further evaluation.

The review again demonstrates that there is more work to do across the health and social care system to ensure everybody has access to good healthcare. The national service model published by NHS England, the Local Government Association and other partners in October 2015 – as part of wider reforms to services for people with learning disabilities– gives clear guidance to health and social care commissioners about the role of care co-ordination, ensuring access to advocacy services, and ensuring that services are accessible to people with a learning disability.

NHS England also commissioned a national premature mortality review for people with learning disabilities in June, which follows the confidential inquiry report that also highlighted similar issues. This is a three-year programme that began in 2015/16 and will be rolled out across England during 2016/17. The review will use the information from this report to develop its work, in particular to support the development of more local premature mortality review functions.

Response to national recommendations

The final Mazars report makes 23 recommendations for Southern Health NHS Foundation Trust, nine for commissioners, and seven for national bodies.

NHS Improvement (which includes Monitor as the regulator of Foundation Trusts), NHS England and the Care Quality Commission have set out below the actions they will take in response to the recommendations which pertain to national policy.

The response of Southern Health Foundation Trust can be found here: [link](#)

The response of the CCGs which commission services from Southern Health Foundation Trust can be found here: [link](#)

- 1. NHS England and its partners should facilitate the use of comparative mortality information relating to mental health and learning disability service users amongst mental health providers. This should include making use of the Mental Health Minimum Data Set (MHMDS) experimental data linkage and the information contained in the new Mental Health and Learning Disabilities Data Set (MHLDMDS).**

We entirely agree with the spirit of this recommendation. However, using complicated statistics to look at the ratio of 'expected' to 'observed' deaths in acute hospitals has proved complex. Emphasis is now moving towards the greater value of case notes review.

NHS England will therefore commission data experts to explore how to feasibly develop statistics for mental health and learning disability services which can provide meaningful and helpful information.

2. NHS England should ensure that learning from this review of deaths into people with a learning disability informs the national learning disability mortality programme.

We accept this recommendation. NHS England has already had the necessary conversations with the team leading the NHS England-commissioned National Learning Disabilities Mortality Review Programme.

This three-year project is the first comprehensive, national review set up to get to the bottom of why people with learning disabilities typically die much earlier than average, and to inform a strategy to reduce this inequality.

It will seek to improve the quality of health and social care delivery for people with learning disabilities through a retrospective review of their deaths. The case reviews will support health and social care professionals, and others, to identify, and take action on, the avoidable contributory factors leading to premature deaths in this population.

3. NHS England should highlight learning from this review for other NHS trusts including the apparent low level of reporting and investigation of learning disability deaths and ensure improvement.

We accept this recommendation.

NHS Improvement will work with trusts and partners to emphasise that relevant incidents should be reported through all required channels in line with the revised Serious Incident Framework published in 2015. NHS England and NHS Improvement will work with partners like the Care Quality Commission (CQC) where this recommendation relates to requirements for reporting deaths to them.

Alongside this, NHS England has commissioned the first ever National Learning Disability Mortality Review Programme. The programme, which has been commissioned from the University of Bristol, will put in place a system to review the causes of death of people with a learning disability by March 2018 through a process of phased roll-out across England. Clearly most deaths will be expected, but there will be clear protocols put in place to ensure that any unexpected deaths are subject to a multidisciplinary review, covering the totality of the person's care, to assess the

causes of death and any actions which could have been taken to prevent that death.

The Disability Mortality Review Programme is designed to ensure that there is a continual cycle of learning about the causes of premature mortality in people with a learning disability and how to avoid deaths, with national oversight to support and scrutinise local processes.

In line with NHS Improvement's new role in relation to patient safety, Monitor has already led and been involved in national work on mortality. On 26 November, Monitor hosted a national mortality event covering the acute sector, and it had already begun planning for a national mortality event on mental health, community and learning disability which is expected to be the first stage in a programme of work.

4. The Strategic Executive Information System (StEIS) should be reviewed to enable comparative information and easier analysis to be more readily able to identify where mental health and learning disability service users are involved including the identification of cases in detention.

We accept this recommendation. In May 2015, NHS England amended StEIS to ensure clear identification of people detained under the MHA. While the deaths of people reported from learning disability and mental healthcare sectors can already be identified on StEIS, StEIS does not allow easy identification of people with learning disabilities whose death has been subject to a serious incident investigation in other care sectors, such as acute hospital trusts.

Ownership of the StEIS reporting system will transfer to NHS Improvement in April 2016 as part of the patient safety function, and will continue to be supported by the Department of Health. This recommendation will be considered by NHS Improvement for incorporating into future redevelopment of a proposed combined NRLS and StEIS as the Patient Safety Incident Management System (PSIMS).

It should be noted that StEIS is a management system that supports the reporting, analysis and learning from serious incidents between commissioners and providers, and is not a suitable database for generating comparative data or to facilitate analysis of themes and trends

5. Develop guidance on an assurance framework for mental health and learning disability mortality and deaths for NHS trusts and require relevant trusts to include this in their board assurance arrangements

We accept this recommendation. Responsibility for formal board assurance frameworks currently rests with the NHS Trust Development Agency; the well-led framework rests with Monitor. NHS England and CCGs need to be assured that services are investigating and learning from deaths and will make use of the learning

from this report in their current development of a CCG assurance framework. CQC also seeks assurance about this issue. All agencies will work together to take forward this recommendation.

6. Regional data and national data should be interrogated to establish a better understanding of what might be expected as the ratio of deaths to investigations for older people mental health services.

While we agree with the spirit of this recommendation we want a robust system that allows commissioners and regulators and others to be able to detect where organisations are not appropriately investigating and responding to unexpected or unnecessary deaths. However, there is not, and cannot be, a crude expected ratio of deaths to investigations in any healthcare service, as there are too many interdependencies that dictate when an investigation is or is not warranted.

We would therefore suggest, and will explore further together and with local commissioners and other stakeholders, whether there is an approach that will allow them to routinely seek assurances that deaths are being appropriately reviewed and, where necessary, investigated. This should also reflect the importance of an assessment of the quality of care.

7. NHS England and its partners should provide further guidance for mental health trusts on what should be reported to CQC under Regulation 16 and to the National Reporting and Learning System (NRLS) given both use the same system and have different purposes.

We accept this recommendation. Guidance does already exist on what should be reported to NRLS for learning purposes, and guidance has been issued by CQC on its requirements when healthcare providers are using the NRLS as a route to provide notifications to CQC.

However, NHS England and NHS Improvement will now work with CQC to ensure CQC's requirements are fully understood by all organisations that use NRLS as their route for reporting to CQC, including reissuing or updating existing guidance.

NRLS will move to NHS Improvement in April 2016. The teams developing the proposed new Patient Safety Incident Management System that will replace NRLS will work closely with CQC to explore the implications of using a learning system as a route for notifying regulators of incidents, and will provide further guidance as appropriate.

17 December 2015

NHS Improvement brings together Monitor, the NHS Trust Development Authority, the Patient Safety and Advancing Change teams from NHS England, two Intensive Support Teams from NHS Interim Management and Support and the National Reporting and Learning System. It will formally come into existence on 1 April 2016.