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		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

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.

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.

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.

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.

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 17th 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: • 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 12th 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 17th 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 18th 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	
Capital/Revenue	
13.	None.
Property/Other	
14.	None.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
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.
Other Legal Implications:	
16.	None
POLICY FRAMEWORK IMPLICATIONS	
17.	None
KEY DECISION	No
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report
SUPPORTING DOCUMENTATION	
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	