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.