Southern Health NHS
NHS Foundation Trust

Update on progress made since publication of the independent review of deaths of People with Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015

1.1 This report aims to update Southampton Health Overview and Scrutiny Panel members regarding progress made against Southern Health's improvement plans following publication of the Mazars report in December 2015.

1.2 The independent review found that the Trust's processes for reporting and investigating deaths of people with learning disabilities and mental health needs could have been better. We fully accept this and apologise unreservedly that families were not always involved as much as they could have been. We accept the report's recommendations.

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 on contact with Southern Health at least once in the previous year, over a four-year period from April 2011 to March 2015. The report did not consider the quality of care provided by the Trust to the people we serve.

1.4 Since the independent report was published four months ago we have made extensive changes to the way we record and investigate deaths of any patient who uses services provided by Southern Health. On 1 December 2015, a new Trust-wide system for reporting and investigating deaths came into force to increase monitoring and scrutiny, share learning with staff and improve the quality of reports and investigations. This system is continuously being reviewed by the Board and significant progress has been made in a number of areas:

- The Mazars report highlighted concerns over the quality of investigations and reports into patient's deaths. Reports made by Southern Health are now reviewed by a clinically-led panel, including an Executive member, to ensure full oversight by the Board of all deaths. This new process is monitored daily by the Trust's Quality and Governance Team and the panel specifically considers the quality of reports to make sure they are thorough, clearly written and understandable.
- Since December 2015 we no longer define deaths as "expected" or "unexpected" as this is not helpful in determining whether an investigation is required. Instead all deaths of patients outlined in the new procedure must be recorded, this includes all deaths of people known to the learning disability service within 12 months of their last contact with the service. This is to ensure that every death is scrutinised by the clinically-led panel and investigated further if required.

- Under this new system, 100 per cent of the 316 deaths reported under the new system between 1 December 2015 and 4 April 2016 have bene reviewed by the clinically-led panel. Panel members have carefully considered on a case-by-case basis, whether a further investigation into a patient's death is needed. Where required, a full investigation into a patient's death has been launched.
- Every family has been offered the opportunity to be involved in an investigation into the death of their loved one wherever possible.
- All clinical staff have been informed of the requirement for them to adhere to the new system for reporting patient deaths. Compliance with the new system is closely monitored and scrutinised by a member of the Executive team.

1.5 This is in addition to steps already taken, which include:

- 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 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.

1.6 The health sector regulator NHS Improvement announced in January 2016 that it had 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 reports and investigates 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
- Get assurance from independent experts on the action plan
- Work with an Improvement Director appointed Monitor

1.7 Earlier this month, independent experts were appointed to provide assurance on improvements being made by Southern Health following publication of the Mazars report. Specialist health and social care consulting firm Niche has now been appointed to provide expert external assurance on the Trust's action plan. A thorough and detailed procurement process was undertaken in partnership with NHS Improvement prior to Niche being appointed.

1.8 The appointment of Niche comes after NHS Improvement announced last month that Alan Yates would work with Southern Health as Improvement Director. Alan started his role on 30 March 2016. He is providing expert

support and challenging the Trust as we continue to build on improvements already made. Alan's experience as a Chief Executive is extremely valuable in supporting us as we continue to learn, and make improvements to the way we deliver care to everyone who relies on the services we provide. We are committed to working with Alan to ensure we make all necessary changes required as quickly as possible.

1.9 The Care Quality Commission (CQC) undertook 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, units for people with learning disabilities, crisis/community mental health teams and child and adolescent inpatient and secure services. The inspection also focused on how the Trust is progressing with our action plan in place following the Mazars review, and progress on improving how we investigate and respond to patient deaths. At the time of submitting this update, the inspection report is yet to be published, but is expected to be published near the end of April.

1.10 However the CQC published a warning notice on 6 April 2016 which highlights further improvements that need to be made to our governance arrangements in respect of findings from the 2014 inspection. We have been very clear and open that we have a lot of work to do to fully address recent concerns raised about the Trust.

1.11 Good progress has been made, however we accept that the CQC feels that in some areas we have not acted swiftly enough. We take the CQC's concerns very seriously and have taken a number of further actions. The full CQC inspection report will allow us to consider their findings in full.

1.12 In addition, NHS Improvement has announced that it intends to take action to allow it to make management changes if progress isn't made on fixing the concerns raised.

1.13 Southern Health fully accepts the need to continue to make changes. We will continue to work closely with the Improvement Director, our regulators and commissioners to make the improvements required. The Trust's focus continues to be on ensuring that everyone who relies on the services we provide receives the best possible care.

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