Southern Health NHS
NHS Foundation Trust

**Update on progress made by Southern Health NHS Foundation Trust since publication of the Mazars report, and the Care Quality Commission inspection report**

**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, and the subsequent Care Quality Commission inspection report in April 2016.

**1.2** The independent Mazars 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 in 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 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:

- Deaths are reported under specific categories, reviewed by a senior manager (initial management assessment) and decision made at a 48 hour panel as to whether an investigation is required and at what level; no investigation, local investigation (internal reporting) or serious incident investigation (external reporting). Since the introduction of the new mortality reporting process in December 2015 (and as of 3 June 2016) there have been 442 deaths, with the 48 hour panel and Initial Management Assessment completed in 100% of cases.
- 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** 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.

**1.6** 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.

**1.7** The full CQC inspection report was published at the end of April 2016, which highlighted some areas of good practice and improvement, but a number of areas of serious concern.

**1.8** We take the CQC's concerns very seriously and have been very clear and open that we have a lot of work to do to fully address the concerns raised. Good progress has been made, and we are pleased that the CQC report pointed to a significant amount of progress made in a number of our units. However, we accept that the CQC feels that in some areas we have not acted swiftly enough. We acknowledge that there is more work to be done to improve services and are moving at pace to achieve this.

**1.9** Some of the action taken in response to the CQC report has included the following:

- The Trust is reviewing the current Risk Management Strategy, and is developing a Quality Improvement Strategy. This will ensure that actions taken in response to concerns raised by patients, families, staff, or external reviews and reports are fully embedded across the organisation.
- A Ligature Project Manager has been appointed, each ward has Ligature Plan which shows where any remaining ligature points are and how to risk assess them, and the Trust's ligature policy and procedure has been revised.
- A series of environmental improvements have been made to a number of sites including Antelope House, Melbury Lodge, Evenlode and The Ridgeway Centre.
- Improvements in the way staff supervision is carried out, recorded and monitored across Adult Mental Health teams, improving the support and leadership available.

**1.10** 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. NHS Improvement is providing expert support to improve the way the Trust reports and investigates deaths. Southern Health has agreed with NHS Improvement 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 by NHS Improvement.

**1.11** In addition to the above, on 3 May 2016 Julie Dawes joined Southern Health as Director of Nursing and Quality. Julie's role has a focus on quality; reviewing and strengthening existing quality structures and arrangements, as well as providing strong professional leadership for nursing and Allied Health Professionals. Julie is also leading on delivery of the improvements following the CQC inspection, and working closely with staff to maintain high levels of patient care.

**1.12** On 5 May 2016 NHS Improvement appointed Tim Smart as Interim Chair of Southern Health. As Chair, Tim is working closely with Alan Yates (who was appointed as Improvement Director earlier this year) and our Board to support us in continuing to make the improvements needed to address the CQC's concerns.

**1.13** Tim is currently undertaking a review of the work carried out across the Trust in response to the Mazars and CQC reports, and of the current governance arrangements. At the end of June he intends to be able to deliver a plan for any further action based on his review findings.

**1.14** 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.

**ENDS**