Commissioners' response to Mazars report into Mental Health and Learning Disabilities deaths in Southern Health NHS Foundation Trust

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.