Southern Health NHS
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. Southern Health apologises unreservedly for this and accepts the recommendations made in the report.

**1.2** 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.

**1.3** Since the 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.

- Latest figures show that under this new system, 100 per cent of the 289 deaths reported onto the new system between 1 December 2015 and 29 February 2016 have been 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.

**1.4** 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.

**1.5** The health sector regulator Monitor 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

**1.6** Last month Monitor announced that Alan Yates had been appointed as Improvement
Director to work with Southern Health, and he started this role on 30th March 2016. Alan is providing expert support and challenging the Trust as we continue to build on improvements already made. We are committed to working with Alan to make all necessary changes. Alan's extensive 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 our patients.

**1.7** We are keen to have robust and independent assurance of our plans in place as quickly as possible. We have undertaken a thorough and detailed procurement process, in partnership with Monitor, to appoint a company to provide independent assurance regarding Southern Health. As of the end of March 2016, this process is ongoing and we hope to have this support in place imminently.

**1.8** 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, 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. As of the end of March 2016, the inspection report is yet to be published, but is expected to be published during April.

**1.9** Southern Health fully accepts the need to continue to make changes. We will continue to work closely with 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**