17.12.15

Southern Health NHS
NHS Foundation Trust

Briefing Note – Mazars Report

- The Southern Health Board has fully accepted that the quality of processes for investigating and reporting a patient death, whilst improving, needed to be better. In the past, investigations have not always been up to the high standards our patients, their families and carers deserve, with Mazars finding that 70% met the required standard.

- We already have made substantial improvements in this area over a sustained period, including:
    - In July 2014 a new clinical executive structure was put in place which significantly strengthens Executive oversight of the quality of investigations, and ensures appropriate actions are in place to address any issues identified, and that all learning is disseminated and implemented.
    - In 2015 we invested in establishing a new central investigation team which is working with all clinical services to improve the quality, and consistency of investigations and the learning derived from them.
    - In consultation and in partnership with our commissioners we have launched a new system for reporting and investigating deaths to increase the monitoring, scrutiny and learning from these incidents.
    - New arrangements have been implemented to capture the conclusions of inquests more effectively to identify and act swiftly on areas for improvement.
    - Over the four year period, there was a steady increase in the involvement of families in investigations. 100% of families are now involved in investigations relating to the death of a loved one where they want to be.

- The Trust is, however, seeking to clarify the suggestion that it failed to investigate numerous deaths of patients in its care or that it is an outlier in either its mortality data or investigation practices as this is not borne out by the evidence.

- The following are some key facts which the Trust can provide evidence to support. This evidence was provided as part of the factual accuracy process which was still ongoing when the report was leaked:

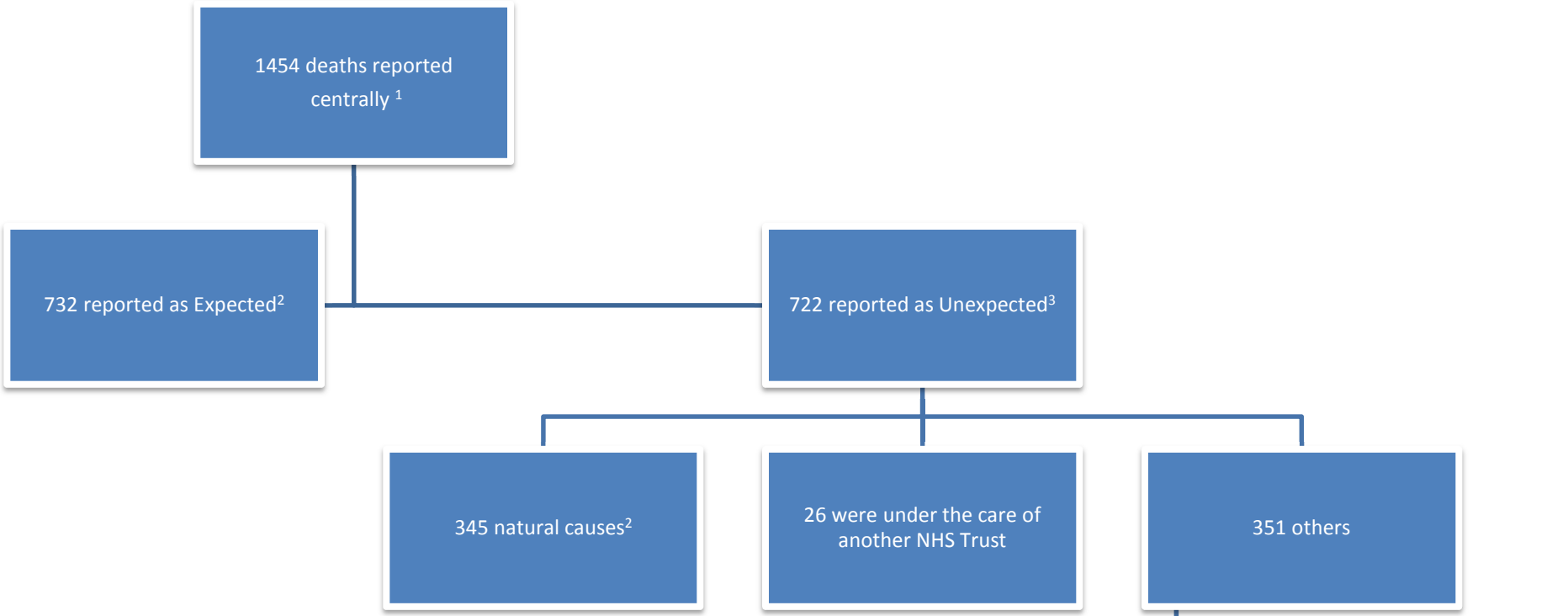
    - **Statistical analysis shows that Southern Health is not an outlier in respect of any mortality indicators.**

    - **91 patients over the four years died on an in-patient unit belonging to the Trust. Southern Health investigated all the deaths that were unexpected and not due to natural causes.**

- **143 deaths were recorded as suicide or suspected suicide – again the Trust is not a statistical outlier in this regard. Mazars note that 6 suicides did not have a full CIR. These were cases where the patient was under another provider or had not yet received services from the Trust.**

- **The remaining deaths were of people whose clinical care was the primary responsibility of their GP or the acute sector at the time they died and the Trust was providing services in a supportive role in the community. Under current guidance, Southern Health is not required to investigate these deaths as it was not the primary provider of care. The Trust did in fact review or fully investigate a number of these to identify opportunities for learning. There remains a debate to be had nationally about how deaths in the community (where the patient is primarily under the care of the GP but with multiple care providers involved) are investigated and learnt from.**

- The diagram below is designed to illustrate the way in which the 1454 deaths that were recorded on the Trust's system were managed. We have identified 9 patients who died where a simple case review might have identified some further learning but in all these cases Southern Health were not the primary care giver and death certification was handled by another Trust or the Patients GP.



1. In accordance with Trust policy at the time (note these patients were not all on the Trust's active case load and in several instances had not required SHFT intervention for weeks or months)
2. The Trust was only responsible for certifying the deaths of the 91 inpatients. All the others were certified by non-SHFT staff
3. Unexpected does not mean clinically avoidable. For eg. a heart attack or relatively rapid decline in a patient with advanced dementia may be unexpected but not untoward or avoidable
4. These are all community patients and will include cases were the Trust was not made aware of a formal cause of death. The majority of these patients died in local acute hospitals or Nursing homes
5. This was established through individual clinical case reviews

IMA – initial management assessment
CIR – critical incident review