

## **Mazars report into mental health and learning disabilities deaths in Southern Health NHS Foundation Trust – a joint response from NHS Improvement, NHS England and the Care Quality Commission**

This report was commissioned by NHS England following the death of Connor Sparrowhawk in July 2013 in a unit in Oxford run by Southern Health NHS Foundation Trust.

The review looked at the deaths of people with a learning disability or mental health problem at Southern Health NHS Foundation Trust, including investigations. It highlights the need for a system-wide response.

Connor's family have been engaged in this report via an expert reference group which provided oversight and quality assurance.

The review team reviewed deaths of people who had died in the period between April 2011 and March 2015 and 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.

The report is critical of the trust's internal governance and assurance processes. It describes "...a lack of leadership, focus and sufficient time spent in the trust on carefully reporting and investigating unexpected deaths of mental health and learning disability service users".

The report also makes critical comment about the trust's 'lack of transparency' and the lack of involvement of families in investigations into the deaths of service users.

The report makes a number of recommendations to improve the systematic management and oversight of deaths and investigations, including best practice when working with families and carers, the processes by which lessons are learned, and that any resultant service change can be evidenced.

Southern Health NHS Foundation Trust has accepted the report's recommendations to strengthen its ways of working in these areas, and will be setting out separately how it intends to do so. Monitor, as the regulator of foundation trusts, is urgently considering regulatory action to address failings in governance, highlighted by the report, and to ensure the trust delivers the necessary improvements.

Before this publication, the trust had already begun a programme of work to review and improve its systems, processes and practice. As a provider of specialist mental health and learning disabilities services it is essential that systems, practice, and governance of ensuring the need to investigate deaths of current and past service users is systematically considered, and that local mortality reviews and Serious Incident investigations are of the highest quality.

Clinical commissioning groups (CCGs) that commission services from Southern Health, alongside Monitor, will scrutinise the trust's improvement actions and delivery. NHS England South Region will hold the CCGs to account for overseeing that improvement.

The results of the review into deaths at this trust also raise questions about premature mortality in people with a learning disability, which require further evaluation.

The review again demonstrates that there is more work to do across the health and social care system to ensure everybody has access to good healthcare. The national service model published by NHS England, the Local Government Association and other partners in October 2015 – as part of wider reforms to services for people with learning disabilities– gives clear guidance to health and social care commissioners about the role of care co-ordination, ensuring access to advocacy services, and ensuring that services are accessible to people with a learning disability.

NHS England also commissioned a national premature mortality review for people with learning disabilities in June, which follows the confidential inquiry report that also highlighted similar issues. This is a three-year programme that began in 2015/16 and will be rolled out across England during 2016/17. The review will use the information from this report to develop its work, in particular to support the development of more local premature mortality review functions.

## **Response to national recommendations**

The final Mazars report makes 23 recommendations for Southern Health NHS Foundation Trust, nine for commissioners, and seven for national bodies.

NHS Improvement (which includes Monitor as the regulator of Foundation Trusts), NHS England and the Care Quality Commission have set out below the actions they will take in response to the recommendations which pertain to national policy.

The response of Southern Health Foundation Trust can be found here: [link](#)

The response of the CCGs which commission services from Southern Health Foundation Trust can be found here: [link](#)

- 1. NHS England and its partners should facilitate the use of comparative mortality information relating to mental health and learning disability service users amongst mental health providers. This should include making use of the Mental Health Minimum Data Set (MHMDS) experimental data linkage and the information contained in the new Mental Health and Learning Disabilities Data Set (MHLDMDS).**

We entirely agree with the spirit of this recommendation. However, using complicated statistics to look at the ratio of 'expected' to 'observed' deaths in acute hospitals has proved complex. Emphasis is now moving towards the greater value of case notes review.

NHS England will therefore commission data experts to explore how to feasibly develop statistics for mental health and learning disability services which can provide meaningful and helpful information.

**2. NHS England should ensure that learning from this review of deaths into people with a learning disability informs the national learning disability mortality programme.**

We accept this recommendation. NHS England has already had the necessary conversations with the team leading the NHS England-commissioned National Learning Disabilities Mortality Review Programme.

This three-year project is the first comprehensive, national review set up to get to the bottom of why people with learning disabilities typically die much earlier than average, and to inform a strategy to reduce this inequality.

It will seek to improve the quality of health and social care delivery for people with learning disabilities through a retrospective review of their deaths. The case reviews will support health and social care professionals, and others, to identify, and take action on, the avoidable contributory factors leading to premature deaths in this population.

**3. NHS England should highlight learning from this review for other NHS trusts including the apparent low level of reporting and investigation of learning disability deaths and ensure improvement.**

We accept this recommendation.

NHS Improvement will work with trusts and partners to emphasise that relevant incidents should be reported through all required channels in line with the revised Serious Incident Framework published in 2015. NHS England and NHS Improvement will work with partners like the Care Quality Commission (CQC) where this recommendation relates to requirements for reporting deaths to them.

Alongside this, NHS England has commissioned the first ever National Learning Disability Mortality Review Programme. The programme, which has been commissioned from the University of Bristol, will put in place a system to review the causes of death of people with a learning disability by March 2018 through a process of phased roll-out across England. Clearly most deaths will be expected, but there will be clear protocols put in place to ensure that any unexpected deaths are subject to a multidisciplinary review, covering the totality of the person's care, to assess the

causes of death and any actions which could have been taken to prevent that death.

The Disability Mortality Review Programme is designed to ensure that there is a continual cycle of learning about the causes of premature mortality in people with a learning disability and how to avoid deaths, with national oversight to support and scrutinise local processes.

In line with NHS Improvement's new role in relation to patient safety, Monitor has already led and been involved in national work on mortality. On 26 November, Monitor hosted a national mortality event covering the acute sector, and it had already begun planning for a national mortality event on mental health, community and learning disability which is expected to be the first stage in a programme of work.

**4. The Strategic Executive Information System (StEIS) should be reviewed to enable comparative information and easier analysis to be more readily able to identify where mental health and learning disability service users are involved including the identification of cases in detention.**

We accept this recommendation. In May 2015, NHS England amended StEIS to ensure clear identification of people detained under the MHA. While the deaths of people reported from learning disability and mental healthcare sectors can already be identified on StEIS, StEIS does not allow easy identification of people with learning disabilities whose death has been subject to a serious incident investigation in other care sectors, such as acute hospital trusts.

Ownership of the StEIS reporting system will transfer to NHS Improvement in April 2016 as part of the patient safety function, and will continue to be supported by the Department of Health. This recommendation will be considered by NHS Improvement for incorporating into future redevelopment of a proposed combined NRLS and StEIS as the Patient Safety Incident Management System (PSIMS).

It should be noted that StEIS is a management system that supports the reporting, analysis and learning from serious incidents between commissioners and providers, and is not a suitable database for generating comparative data or to facilitate analysis of themes and trends

**5. Develop guidance on an assurance framework for mental health and learning disability mortality and deaths for NHS trusts and require relevant trusts to include this in their board assurance arrangements**

We accept this recommendation. Responsibility for formal board assurance frameworks currently rests with the NHS Trust Development Agency; the well-led framework rests with Monitor. NHS England and CCGs need to be assured that services are investigating and learning from deaths and will make use of the learning

from this report in their current development of a CCG assurance framework. CQC also seeks assurance about this issue. All agencies will work together to take forward this recommendation.

**6. Regional data and national data should be interrogated to establish a better understanding of what might be expected as the ratio of deaths to investigations for older people mental health services.**

While we agree with the spirit of this recommendation we want a robust system that allows commissioners and regulators and others to be able to detect where organisations are not appropriately investigating and responding to unexpected or unnecessary deaths. However, there is not, and cannot be, a crude expected ratio of deaths to investigations in any healthcare service, as there are too many interdependencies that dictate when an investigation is or is not warranted.

We would therefore suggest, and will explore further together and with local commissioners and other stakeholders, whether there is an approach that will allow them to routinely seek assurances that deaths are being appropriately reviewed and, where necessary, investigated. This should also reflect the importance of an assessment of the quality of care.

**7. NHS England and its partners should provide further guidance for mental health trusts on what should be reported to CQC under Regulation 16 and to the National Reporting and Learning System (NRLS) given both use the same system and have different purposes.**

We accept this recommendation. Guidance does already exist on what should be reported to NRLS for learning purposes, and guidance has been issued by CQC on its requirements when healthcare providers are using the NRLS as a route to provide notifications to CQC.

However, NHS England and NHS Improvement will now work with CQC to ensure CQC's requirements are fully understood by all organisations that use NRLS as their route for reporting to CQC, including reissuing or updating existing guidance.

NRLS will move to NHS Improvement in April 2016. The teams developing the proposed new Patient Safety Incident Management System that will replace NRLS will work closely with CQC to explore the implications of using a learning system as a route for notifying regulators of incidents, and will provide further guidance as appropriate.

**17 December 2015**

NHS Improvement brings together Monitor, the NHS Trust Development Authority, the Patient Safety and Advancing Change teams from NHS England, two Intensive Support Teams from NHS Interim Management and Support and the National Reporting and Learning System. It will formally come into existence on 1 April 2016.