NHS
Improvement

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12 May 2016

By email

Dear

Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of **11 April 2016** in which you requested information under the FOI Act from Monitor/NHS Improvement. Since 1 April 2016, Monitor and the NHS Trust Development Authority are operating as an integrated organisation known as NHS Improvement. For the purposes of this decision, NHS Improvement means Monitor.

Your request

You made the following request:

"*Can you provide a copy of all correspondence, including letters, emails and email chains between the following Monitor/NHS Improvement employees – Jim Mackey, Anne Eden, Bob Alexander, Stephen Hay and Paul Streat (prior to his departure) – and Southern Health NHS Foundation Trust since 1 November 2015 relating to the Mazars review of people with mental health and learning disabilities.*

Can you also provide copies of all correspondence, letters, emails and email chains between the same employees and the CQC relating to the issues identified in the Mazars report."

Decision

I have identified your request as relating to the Mazars "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" that was commissioned by NHS England and published in December 2015.

NHS Improvement does hold the information that you have requested and has decided to withhold some of the information that it holds on the basis of the applicability of the exemptions in sections 31 and 40 of the FOI Act as explained in detail below.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

The attached Annex sets out the details of the relevant information that we hold and whether that information is to be disclosed (in whole or in part) or withheld from disclosure. Where information is being withheld, I have identified in the Annex those exemptions which I consider to be relevant.

Section 31 – law enforcement

Section 31(2)(c) of the FOI Act exempts from disclosure information that would or would be likely to prejudice the exercise by NHS Improvement of its functions for the purposes of determining whether regulatory action is justified. I consider that this exemption is engaged.

NHS Improvement is responsible for monitoring compliance by NHS foundation trusts with the provider licence issued under Part 3 of the Health and Social Care Act 2012 ("the 2012 Act"), and for considering the exercise of enforcement powers where it is satisfied (or has reasonable grounds to suspect) that such a trust has provided, or is providing, NHS services in breach of the conditions of its licence, and for monitoring compliance with any enforcement action that may be taken.

In order to perform these functions NHS Improvement relies on information from a variety of sources, including information provided voluntarily by trusts. It also relies on having open and frank discussions with sector stakeholders about the appropriate regulatory response.
Disclosure of the withheld correspondence would have a considerable impact on the willingness of trusts and other third parties to provide such information to NHS Improvement on an open basis and on NHS Improvement's willingness to engage in discussions with third parties about its regulatory approach, which is likely to lead to less information being shared.

NHS Improvement has the power to require NHS foundation trusts to provide information but we believe we are better able to exercise our functions when information is provided voluntarily as part of an open relationship between the regulator and the regulated bodies.

In the present case, Southern Health NHS Foundation Trust (the "Trust") is subject to enforcement action under sections 106 and 111 of the 2012 Act for breaches of its licence relating to governance. In addition to the general concerns about the prejudice to our relationship with trusts, to disclose the withheld information would also be likely to prejudice NHS Improvement's ongoing review of the progress the Trust is making towards addressing the breaches of its provider licence.

Public interest test

I have considered whether, in all the circumstances of the case, the public interest in maintaining the exemption from disclosure outweighs the public interest in disclosing information, and decided that it does.

I have considered the public interest in disclosing this information on the grounds of accountability and transparency. There is a general public interest in disclosing information that fosters transparency, and enables the public to hold NHS foundation trusts and NHS Improvement and other health sector stakeholders to account. This has been weighed against the detrimental impact that would result if the information was disclosed. In

considering the public interest, I have taken into account that NHS Improvement routinely and proactively publishes details of any regulatory action it has taken. Details of the regulatory action taken against the Trust are available in the foundation trust directory on our website.

As stated above, the Trust is being closely monitored by way of formal regulatory action. It is vital that in such cases NHS Improvement is able to freely exchange information with the Trust and with relevant third parties (such as the CQC), The information is necessary for NHS Improvement to consider the Trust's compliance with its enforcement action and monitor its progress in addressing the breaches of its licence. Any disclosure would cause the Trust to reconsider exchanging potentially sensitive information relevant to NHS Improvement's performance of its enforcement functions, which would be detrimental to the process of regulation.

On balance, I consider that the need to avoid adversely affecting NHS Improvement's continued monitoring and assessment of this and other trusts, and the need to ensure that trusts and third parties are able to share information without concern that such information will enter the public domain, outweighs the public interest in disclosure of the information being withheld.

Section 40 – personal information

I consider that, where indicated in the Annex, some information is exempt from disclosure under sections 40(2) and 40(3)(a) of the FOI Act on the grounds that it contains personal data and that the first condition under section 40(3)(a) is satisfied, namely that disclosure would amount to a breach of the first data protection principle (personal data shall be processed fairly and lawfully). This is an absolute exemption and consideration of the public interest test is not required.

The documents being released contain minor redactions to omit the names and contact details of junior members of staff at the CQC, and personal contact details of senior staff, who would have a reasonable expectation that their names and/or details would be withheld.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within NHS Improvement of the issue or the decision. A senior member of NHS Improvement's staff, who has not previously been involved with your request, will undertake that review.

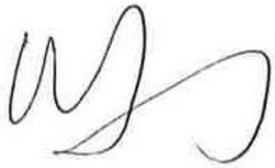
If you are dissatisfied with the outcome of any internal review, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, NHS Improvement, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to nhsi.foi@nhs.net.

Publication

Please note that this letter and the attached information will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,



Victoria Keilthy
Deputy Regional Director

Annex

Document	Disclosed/withheld	Exemption applied
Correspondence with the trust		
All emails	Partially withheld	Section 40
All emails	Withheld	Section 31
Correspondence with the CQC		
All emails	Partially withheld	Section 40
Email 12 December: Mike Richards to David Behan and Paul Lelliott	Partially withheld	Section 31

From: Paul Streat
Sent: 09 December 2015 12:47
To: Bennett-Wilson, Karen; [redacted]; [redacted]
Cc: Fowler Jan (NHS ENGLAND)
Subject: Re: Urgent Mazars Report

Hello Jan

I am travelling most of today which makes this difficult for me. However, my Deputy [redacted] leads on Southern and I am sure that our PA [redacted] can arrange a time where [redacted] can discuss.

Regards

Paul

On 9 Dec 2015, at 10:33, Bennett-Wilson, Karen <[redacted]@cqc.org.uk> wrote:

Hi Jan

I can be available anytime this afternoon – I can move things around to fit it.

Kind regards

Karen

Karen Bennett-Wilson
Head of Inspection (MH, LD, SM)
Hospitals Directorate
Care Quality Commission

Tel: [redacted]

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From: Lelliott, Paul <Paul.Lelliott@cqc.org.uk>
Sent: 13 December 2015 09:29
To: Richards, Mike; Behan, David
Cc: Bennett-Wilson, Karen; Stephen Hay; Hugo Mascie-Taylor; [redacted]
Subject: RE: Southern Health - possible regulatory action

Dear Mike and David

With respect to comparisons with CIPOLD, I came to the same conclusion as you, Mike. I don't think that we can conclude that Southern is an outlier in age of death of people with LD on the basis of the data that are presented in the Mazars' report. For all deaths, the trust is average for England when the cohort is standardised for age.

I agree that the main concerns are the poor quality of and delay in investigating deaths and the trust's decisions about which deaths it does investigate; especially the fact that it investigates very few deaths of people with learning disabilities (I go into this in some detail below).

When we inspected Southern last October, we commented on the back-log of investigations and on the poor quality of investigations. However, we expressed some optimism that the trust managers were starting to get a grip.

I could join you at 09.30 tomorrow. Could [redacted] please send the joining instructions.

Investigation of deaths of people in contact with LD services
The trust undertook a critical incident review or investigated as a SIRI 31% of all deaths in adult mental health services, 1% of all deaths in LD services and 0.4% of all deaths in old age mental health service. The differences between LD and adult mental health are less to do with what staff reported and much more to do with the decisions that the trust made about which incidents to investigate. The relevant facts relating to the rate of investigation of deaths of people with learning disabilities are that:

1. Trust staff reported 47% of deaths of people in contact with their learning disabilities services as incidents on their own incident reporting system. This is lower than the 60% of deaths of people in contact with their working age adult services that staff reported but much higher than the 9% of deaths of people in contact with their old age mental health services. I cannot find data on the age of the LD cohort. It is quite likely that is an 'ageless' service. We cannot therefore exclude the possibility that the gap between the rate of 'local' reporting of deaths of people in contact with LD services compared with working age adult mental health services might narrow if age was controlled for.

2. The trust conducted an initial management assessment (IMA) of 41% of deaths in LD that were reported locally (an IMA is not an investigation; its purpose is to determine whether investigation is required). The comparable figures for working age adult and old age mental health are 44% and 7% respectively.

3. The trust conducted an IMA on the deaths of 64 people who had been in contact with LD services. Following the IMA, the trust undertook a critical incident review (a local investigation) of two of these death. For deaths of people in contact with adult mental health, the trust undertook a critical incident review (CIR) of 76 of the 202 deaths where it had conducted an IMA. The comparable figure for old age mental health is three CIRs of 56 deaths on which an IMA was conducted.

4. A further two deaths of people in contact with the LD services were treated as serious incidents requiring investigation (SIRI) compared with 161 in adult mental health and 30 in old age mental health. It should be noted that 60% of the deaths in adult mental health that were subject to a SIRI were suicides – there are more likely to be many more deaths by suicide in adult mental health services than in LD services.

5. The net result is summarised in the table on page 59 of the report which shows that 51% of reported deaths in adult mental health were investigated compared 2.5% of deaths in LD and 4.5% in old age mental health.

Paul

Dr Paul Lelliott
Deputy Chief Inspector (Lead for Mental Health)
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PA

By post to:
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Gallowsgate
Newcastle upon Tyne
NE1 4PA

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From: Richards, Mike
Sent: 12 December 2015 15:13
To: Behan, David; Lelliott, Paul
Cc: Bennett-Wilson, Karen; Stephen Hay; Hugo Mascie-Taylor
Subject: Southern Health - possible regulatory action

David, Paul

Paul and Karen have looked in more detail both at the Mazars report and at the report of the CQC inspection in October 2014. I have read the 37 page summary of Mazars carefully. I have also looked back at the CIPOLD report in some detail.

The CIPOLD report is based on 247 deaths of people with over a two year period (2010-2012) registered

with a GP in 5 PCTs in the South West. They were notified of deaths through a range of sources, on average 2 days after the death. Interestingly they received considerably more notifications than they had been expecting , based on death certification data. 92% were recorded on a GP register as having LD. They note that there was a potential excess of people with LD in the locality, as there had been several institutions locally. After these had closed people may well have settled locally.

The Mazars report attempts to compare the severity of LD in Southern and that in CIPOLD and acknowledges that there was a higher proportion of people with mild LD in CIPOLD. The patients in the Southern cohort had all had contact with MH or 24/7 social care in the previous year. We do not have an equivalent figure for CIPOLD.

I personally think it is risky to make too much of the apparent difference in median/mean age at death between the two cohorts. Do others agree?

This still leaves the issue about governance. Should we (CQC) be taking action and if so should we do so jointly with Monitor?

Karen/Paul - you will have views on whether Southern is an outlier in this regard or whether this is a much more widespread problem.

I have agreed to speak to Stephen again on Monday morning at 9.30, as it is almost my only gap that day.

Mike

Sent with Good (www.good.com)

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From: Behan, David <David.Behan@cqc.org.uk>
Sent: 13 December 2015 11:17
To: Richards, Mike; Lelliott, Paul
Cc: Bennett-Wilson, Karen; Stephen Hay; Hugo Mascie-Taylor
Subject: RE: Southern Health - possible regulatory action

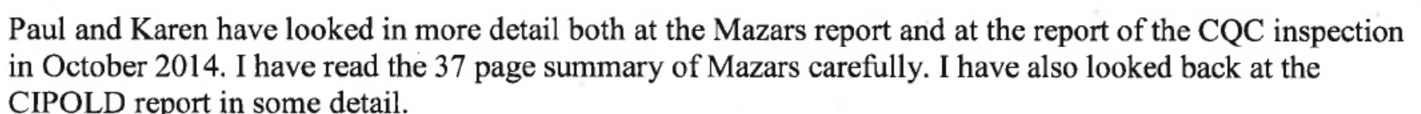
Mike ,
Very helpful and is Paul L's later e mail .
Some thoughts ……
In respect of regulatory action : we should consider this and in so doing we need to be clear about

- when was the field work for the Manzars report undertaken ?
- Is it possible that anything has changed since the field work ?
- If we are to take action under the regulations which is the regulation that was breached and when was it breached ?

I suspect it will be necessary for CQC and Monitor to visit Southern to test the Manzar findings, answer the above questions and then we could take action. Unless we do some field work we will be acting on the report only .We should test the report against our own field work .
The other issue to be clear on is what is it that NHSE are going to do as the commissioners and recipients of the report ? I think any action they take and any action CQC/Monitor take should be coordinated and be consistent .
Hope this helps
David

From: Richards, Mike
Sent: 12 December 2015 15:13
To: Behan, David; Lelliott, Paul
Cc: Bennett-Wilson, Karen; Stephen Hay; Hugo Mascie-Taylor
Subject: Southern Health - possible regulatory action

David, Paul



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From: Richards, Mike <Mike.Richards@cqc.org.uk>
Sent: 14 December 2015 10:40
To: Stephen Hay; Hugo Mascie-Taylor; Lelliott, Paul
Cc: Behan, David; Bennett-Wilson, Karen; [redacted]
Subject: Southern Health - follow up to T/C

All

Thanks very much for the T/C this morning. The actions I noted from this were as follows:

1. Victoria will circulate the documents that she has received from Southern Health on their procedures and action plan.

2. Monitor will require Southern Health to develop an action plan in response to the Mazars report as and when it is published.

3. CQC will plan an early focused reinspection of Southern Health to assess progress on their reporting, investigation and learning from unexpected deaths (probably with a major focus on deaths of people with learning disabilities. We anticipate that this will be a planned inspection early in the new year.

4. We agreed that the evidence that patients are dying at younger age with learning disabilities in Southern Health was 'unproven', however this should be investigated further in partnership with NHS England and probably with the Learning Disabilities Public Health Observatory. Hugo and I will pick this up at the Care meeting this afternoon.

Best wishes
Mike

Professor Sir Mike Richards
Chief Inspector of Hospitals, Care Quality Commission
mike.richards@cqc.org.uk

Exec PA: [redacted]
[redacted]@cqc.org.uk
Tel: (Ext) [redacted] (Int) [redacted]

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From: Richards, Mike <Mike.Richards@cqc.org.uk>
Sent: 15 January 2016 18:34
To: Hugo Mascie-Taylor; janecummings@[redacted]
Cc: Ruth May; Stanley Silverman; Stephen Hay
Subject: RE: Mazars

Hugo

Paul Lelliott and other members of my team met with Mary-Ann Bruce earlier in the week. I am sure this will have helped us to plan our 'short notice' inspection. We decided that this could not be unannounced as we needed to acquire information from the trust and to ensure that key people would be available for interview.

Mike

Professor Sir Mike Richards
Chief Inspector of Hospitals, Care Quality Commission mike.richards@cqc.org.uk

Executive PA: [redacted]
[redacted]@cqc.org.uk
Tel: (Ext)[redacted](Int) [redacted]

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-----Original Message-----
From: Hugo Mascie-Taylor [mailto:Hugo.Mascie-Taylor@Monitor.gov.uk]
Sent: 15 January 2016 18:14
To: janecummings@[redacted]
Cc: Ruth May; Stanley Silverman; Stephen Hay; Richards, Mike
Subject: Re: Mazars

Jane
Thanks - that's very helpful and an excellent source of information potentially.
We need to discuss with Stephen Hay and then Stephen and I will talk with Mike Richards about who makes the approach - we are meeting next week Best Wishes Hugo

Sent from my iPad
Hugo Mascie-Taylor

From:	Bleazard, Victoria <Victoria.Bleazard@cqc.org.uk>
Sent:	05 February 2016 13:49
To:	Hugo Mascie-Taylor; Stephen Hay; Ruth May; Stanley Silverman; Alex Lewis; [redacted] [redacted]
Cc:	Richards, Mike; Lelliott, Paul; Kim Forrester
Subject:	CQC & Monitor: Reviewing the investigation of deaths in NHS trusts

Dear all,

Thank you for joining us yesterday. We found our conversation very helpful, particularly in shaping our review of NHS Trusts' investigations into deaths of patients in their care.

Below I hope I have captured the key points agreed – please do amend or add:

- CQC, Monitor and NHS England are working closely together to respond to the Mazars review. We are undertaking a number of projects around mortality, including the review (requested by the Health Secretary) to investigate deaths in a sample of NHS trusts (acute, mental health and community) in different parts of the country. As part of this review, CQC will assess whether opportunities for the preventing deaths have been missed, for example by late diagnosis of physical health problems.
- Initial scoping suggests that many trusts are very unclear about how they should investigate deaths, so alongside this review we want to take an improvement approach and coproduce tools / a framework with trusts, commissioners and families, and share examples of best practice.
- The Review's focus is therefore focused on responding to this question: *"How can we ensure that NHS trusts have robust mechanisms in place to appropriately investigate the deaths of patients/service users (with learning quickly embedded to improve care) so that a co-produced framework and tools are in place by Autumn 2016 and system levers are agreed to ensure implementation from April 2017?'* (tbc)
- This needs to be owned by Trusts so we are looking to work with a range of providers – those struggling / those with best practice to share. CQC to present at Monitor's CAF on 4th March, and both organisations to consider further channels for engagement.
- Through this being supported by system levers, effective implementation is much more likely. From the outset we will be exploring what these might be (e.g. CQC / NHS Improvement can embed this into our investigations / programmes; NHSE may incorporate it in CQUINS, Health Education England into its training etc.)
- Effectively, and sensitively, involving families is key. [redacted] has kindly agreed to support this strand to ensure we proactively engage individuals, families and bodies such as INQUEST.
- There is considerable public cynicism around this. CQC's media team is keen to communicate our plans publicly via HSJ. We will keep you updated on this and try and ensure we all agree to key messages in advance.
- We agreed that the approach we create needs to be affordable (and realistic in terms of staff's expertise and capacity). Monitor kindly agreed to provide support via their economists for this work – for them to be involved throughout the programme to model different approaches.
- We agreed that Stan and Alex will be the leads from Monitor for this Review. Thank you both in advance for your support.
- CQC will be creating an External Reference Group (and more developed plans) over the days ahead and would value Monitor's suggestions around who should be part of this.
- CQC will update NHS England on this conversation and next steps.

We're very pleased to be working in partnership with you all on this, and firmly believe that this Review offers us a much-needed opportunity to support trusts in their investigations of deaths to ensure that learning is shared and quickly acted upon for the benefit of patients.

Kind regards,

Victoria

Victoria Bleazard
Head of Mental Health Policy
Care Quality Commission
151 Buckingham Palace Road
London, SW1W 9SZ

Telephone: [redacted]

Queries on mental health policy issues should be addressed to the team via MHPolicy@cqc.org.uk

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From: [redacted] <[redacted]@cqc.org.uk>
Sent: 12 April 2016 16:34
To: [redacted]
Subject: CQC review of how NHS trusts investigate and learn from deaths

Dear colleague,

We wanted to inform you that the CQC has today announced that we are carrying out a review of how NHS trusts identify, report, investigate and learn from deaths of people using their services. It is called *"A review of how NHS trusts investigate and learn from deaths"*.

This follows a request from the Secretary of State for Health, which was part of the Government's response to a report, published by Mazars in December 2015, into the deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust.

Our review will consider the quality of practice in relation to identifying, reporting and investigating the death of any person in contact with a health service managed by an NHS trust; whether the person is in hospital, receiving care in a community setting or living in their own home.

The review will pay particular attention to how NHS trusts investigate and learn from deaths of people with a learning disability or mental health problem. Further information about the review can be found here at www.cqc.org.uk/content/cqc-review-how-nhs-trusts-investigate-and-learn-deaths. We hope to publish the review by the end of the year. Colleagues from your organisation will be assisting with the review by taking part in our Expert Advisory Group.

If you have any questions or would like a discussion about this review, please do not hesitate to get in touch.

Best wishes,

[redacted]

[redacted]
Senior Parliamentary and Stakeholder Engagement Officer
Care Quality Commission
Tel: [redacted]
Mobile: [redacted]
Email: [redacted]@cqc.org.uk

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