SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 1 FEBRUARY 2016

Present: Councillors Bogle (Chair), Furnell, Houghton, Noon, Painton, Tucker and White (Vice-Chair)

Also in Attendance: Rob Kurn, Healthwatch Southampton

28. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

It was noted that following receipt of the temporary resignation of Councillor Parnell from the Panel, the Head of Legal and Democratic Services acting under delegated powers, had appointed Councillor Painton to replace them for the purposes of this meeting.

29. **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**

The Panel considered the report of the Chair of the Health Overview and Scrutiny Panel reviewing the recently published Mazars report commissioned by NHS England to investigate unexpected deaths of service users of Southern Health NHS Foundation Trust Mental Health or Learning Disability services from April 2011 to March 2015. The report highlighted a number of actions for the Trust, commissioners and regulators.

The Chair of the HOSP introduced the key findings and issues arising from the Mazars report:

(i) that there was 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.

(ii) That despite the Board being informed on a number of occasions, including representation from Coroners, that the quality of the Serious Incidents Requiring Investigation reporting processes and standard of investigation was inadequate; no effective action was taken to improve investigations during the review period.

(iii) That 30% of all deaths in Adult Mental Health services were investigated as Critical Incident Reviews or Serious Incidents Requiring Investigation, less than 1% of deaths in Learning Disability services were investigated as Critical Incident Reviews or Serious Incident Requiring Investigation and 0.3% of all deaths of Older People in Mental Health services were investigated as Serious Incident Requiring Investigation.

(iv) In terms of deaths 'categorised as unexpected' within Adult Mental Health services, 60% of all unexpected deaths were investigated as Critical Incident Reviews or Serious Incidents Requiring Investigation; in Learning Disability only 4% of all unexpected deaths were investigated as Critical Incident Reviews or Serious Incidents Requiring Investigation and in Older Peoples' Mental Health services, 13% were investigated as a Serious Incidents Requiring Investigation.

(v) From the review of the evidence, too few deaths were investigated in Learning Disability and Older People Mental Health services. When an investigation did

occur, the report identified the overall poor quality of these investigations and of the subsequent reports.

(vi) That there was no effective systematic management and oversight of the reporting of deaths and the investigations that followed.

(vii) Timeliness of investigations was a major concern – taking on average of nearly 10 months from an incident to 'closing' a Serious Incident Requiring Investigation (SIRI) relating to deaths.

(viii) The Trust could not demonstrate a comprehensive, systematic approach to learning from deaths.

(ix) The involvement of families and carers had been limited - 64% of investigations did not involve the family.

(x) Initial management assessments and investigations did not involve other service providers where this would have been appropriate.

(xi) Despite the Trust having comprehensive data relating to deaths of its service users, it had failed to use it effectively to understand mortality and issues relating to deaths of its Mental Health or Learning Disability service users.

(xii) Commissioners had a role in demanding better information relating to deaths and using it to seek improvement.

It was stated that the Hampshire Health and Adult Social Care Scrutiny Committee were to discuss the report at their meeting on 9th February and reiterated that Southampton represented a small part of the Southern Health Services area which covered six counties.

The Panel noted that there had been an omission from the information in Appendix 3 – Southern Health's Mortality and SIRI Improvement Action Plan. It was agreed that this information be supplied to Panel members at the earliest opportunity.

Representatives from Southern Health NHS Foundation Trust, NHS Southampton City Clinical Commissioning Group (SCCCG) and NHS England (Wessex) provided the Panel with an update on developments since the publication of the meeting papers and addressed questions from the Panel and other interested parties present at the meeting. It was emphasised that the report criticised the Trust's investigation and reporting of deaths rather than the standard of the care provided.

The Panel raised various issues with the representatives present from Southern Health NHS Foundation Trust – including the following points:

- Concerns about Southern Health as an organisation - its leadership, governance and culture.
- The reasons for numerous warnings having been ignored - including concerns from Coroners, commissioners?
- Why opportunities were not taken to inform the Panel of the ongoing inquiry – specifically at the meeting on 26th November as part of the update on CQC Action Plan and the April 2015 Quality Accounts?
- What progress had been made on improvements by Southern Health and any re-assurance that could be offered to Southampton residents?
- Feedback from CQC and Monitor on action plans.
- Whether the report raised issues about the size of the Trust and the area it covered?

Issues raised by the Panel regarding Southampton CCG as commissioners of Services from Southern Health:

- The report referred to commissioners repeatedly raising issues with the Trust about the quality and timings of reports - what more could commissioners have done to challenge Southern Health performance?
- How commissioners would ensure that there was no recurrence and that Trusts follow policies and procedure?
- How CCGs would work collectively to identify issues within service providers and ensure consistent improvements?
- The impact the development of a new service model for mental health services in Southampton would have?
- Whether the SCCCG had confidence in Southern Health as a provider of health services in Southampton?
- The role NHS England (Wessex) played in overseeing improvements?

The Panel also recognised the general issue around the parity of esteem between physical and mental health including those with learning disabilities and other vulnerable people.

RESOLVED

(i) that the full version of Appendix 3, Southern Health's Action Plan for Mortality Serious Incident Requiring Investigation Improvement, be circulated to the Panel and the agenda for the meeting on the Council's website be updated accordingly;
(ii) that the Panel be provided with a Southampton specific breakdown of the key statistics highlighted within the Mazars report;
(iii) that an update on the 'Mental Health Matters' initiative be provided to the Panel at the meeting on 24 March 2016;
(iv) that an update be provided at a future meeting of the HOSP by Southern Health NHS Foundation Trust on progress made implementing the improvement plan and feedback from regulators; and
(v) that the Panel be provided with an update on progress made with regards to the involvement of families and carers in investigations.