Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

Trust Board meeting (Part 1)		Date:	25 May 2016
Agenda item	**Title**	**Executive Director lead and presenter**	**Report author**
BD/16/045	**AWP Response to the Mazars' Report**	**Director of Nursing and Quality**	**Head of Patient Safety Systems**

This report is for:	
Decision	
Discussion	
To Note	X

History
Quality and Standards Committee

The following impacts have been identified and assessed within this report	
Equality	X
Quality	X
Privacy	X

Executive summary of key issues

This report advises the Trust Board on the Mazars' investigation into Southern Health NHS Foundation Trust and provides an analysis of AWP's current position on the same issues. It identifies the prioritised recommendations that will be taken forward to ensure that AWP learns from Southern Health's experience and that its practice is in line with national expectations.

This report addresses these strategic priorities:	
We will deliver the best care	X
We will support and develop our staff	X
We will continually improve what we do	X
We will use our resources wisely	X
We will be future focussed	X

1 Introduction

The preventable death of Connor Sparrowhawk in July 2013 led to a number of investigations and enquiries into practice at Southern Health NHS Foundation Trust in whose care he died. One report, commissioned by NHS England, was undertaken by Mazars, an integrated international audit, tax and advisory firm, and was formally published in December 2015 after it had been leaked.

Mazars reviewed all deaths of people in receipt of care from Mental Health and Learning Disability services in Southern Health between April 2011 and March 2015 to establish the extent of unexpected deaths in Mental Health and Learning Disability services provided by the Trust and to identify any themes, patterns or issues that may need further investigation.

The findings of Mazars report has been considered by the Critical Incident Overview Group, at the request of the Chief Executive, to determine whether there is learning from their findings that can be applied to AWP to improve patient safety and governance.

2 Key Findings of the Mazars' Report

The key findings of the Mazars' Report were:

- A lack of Board challenge to the systems and processes around the investigation of deaths, including how investigation decisions were made, in the context of external criticism of reports being received.
- A lack of consistent corporate focus on death reflected in Board reports. Data reporting was variable and only centred on a small part of the overall available data.
- Insufficient strong enforcement or attention paid by a variety of commissioners in requiring improvement by accepting poor quality investigations and accepting considerable delays.
- Southern Health reported a very small and reducing number of deaths compared to the national 'average'.
- Very poor quality written investigation reports that lacked significant challenge or rigour, not aided by a decentralised approach to investigations.
- Delays in reporting serious untoward incidents externally and in completing investigations.
- An inability to demonstrate a comprehensive, systematic approach to learning from deaths, as evidenced by action plans, board review and follow up, thematic reviews and resultant service change.
- Inadequate investigation of deaths involving patients with a learning disability.
- Very limited involvement of families and carers in investigations of unexpected deaths.
- Deaths were not investigated across the local health economy where this would have been appropriate.
- A lack of system advocacy for service users, meaning a lack of compassionate enquiry, independent representation, investigation and transparency.
- A failure to use data effectively to understand mortality and issues relating to deaths of service users.

3 AWP Analysis

Wherever possible based on the information provided AWP compared its practice with that of Southern Health and found:

- AWP's stated purpose for conducting investigations was very similar to that recommended by Mazars and has been further strengthened to reference the need to establish and share learning for the wider NHS and its partners.
- AWP reporting of serious untoward incidents (SUIs) strictly aligns with the national Serious Incident Framework published by NHS England in 2015, and additionally it adopts the National Confidential Inquiry standards for the investigation of suicides.
- AWP's performance in reporting serious untoward incidents externally is consistently achieving national standards.
- Unlike Southern Health, AWP's data shows an increase in reporting of death incidents against a background of increased patient safety incident reporting.
- Unlike Southern Health, AWP does not report fewer deaths to STEIS (the national system for reporting serious untoward incidents) under unexpected death and suicide categories compared to other mental health trusts in its region.
- The timeliness of AWP's investigations was comparable to that of Southern Health, both in terms of the time taken for the Trust to complete an investigation and the time taken to complete the investigation on STEIS. Since 1 January 2016, however, AWP has completed all investigations within the agreed timescales.
- It is AWP's routine practice to endeavour to involve families in investigations and our Being Open processes have been refreshed to support this practice.
- AWP has established a central investigations team and has had feedback from its commissioners that this has led to an improvement in the quality of investigation reports received.
- AWP has revised the terms of reference of the Critical Incident Overview Group to encompass the responsibility for mortality review. It has received several mortality reports, however it is fair to stay that the Trust is at an embryonic stage of development in this area.

4 National Perspective

NHS England has indicated that they are seeking to establish a standardised methodology for reviewing deaths in hospitals with the aim of identifying themes for improvement both nationally and within organisations. This will be supported by a training programme in retrospective case review. This has been driven by research determining that about 4% of deaths in hospitals were potentially avoidable. A Mortality Governance Guide has additionally been developed by Monitor and the Trust Development Authority.

5 Future Work

The Quality and Standards Committee agreed the following broad actions to respond to learning from the Mazars' report:

- Complete and respond to a self-assessment of current practice against the Mortality Governance Guide.
- Include a quarterly report of all incidents of death in the Clinical Executive report to ensure regular Board oversight and challenge.
- Implement a process of continuous improvement in relation to the timeliness and quality of investigations undertaken by the Trust.

- Work with Commissioners to contribute to processes whereby deaths can be investigated across the local health economy.

An implementation plan has been developed to address these actions and progress is being tracked via the Quality Tracker, reported to the Quality and Standards Committee.

Additionally, the Trust has partnered with Solent NHS Trust to develop its mortality governance work and to share learned experiences.

6 Recommendations

The Trust Board is asked to **note** this report.