AT A MEETING of the HEALTH AND ADULT SOCIAL CARE SELECT (OVERVIEW AND SCRUTINY) COMMITTEE of the COUNTY COUNCIL held at The Castle, Winchester on Tuesday, 9 February 2016.

**PRESENT**

Chairman:
p Councillor Roger Huxstep

Vice-Chairman:
p Councillor Chris Carter

**Councillors:**

p Ann Briggs
a Graham Burgess
p Rita Burgess
p Charles Choudhary
p Ferris Cowper
p Alan Dowden
p Jacqui England
p David Harrison
p Marge Harvey
p Tony Hooke
p David Keast
p Martin Lyon
p Fiona Mather
p Andy Moore
a George Ringrow
p Frank Rust
p Bruce Tennent
p Martin Tod

**Substitute Members:**
n/a

**Co-opted Members:**
Councillors:
a Tonia Craig
p Alison Finlay
p Yvonne Weeks
p Dennis Wright

**In attendance at the invitation of the Chairman:**
Councillor Liz Fairhurst, Executive Member for Adult Social Care
Councillor Patricia Stallard, Executive Member for Health and Public Health

111. **BROADCASTING ANNOUNCEMENT**

The Chairman announced that the press and members of the public were permitted to film and broadcast the meeting. Those remaining at the meeting were consenting to being filmed and recorded, and to the possible use of those images and recording for broadcasting purposes.

112. **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Councillor Graham Burgess and co-opted member Councillor Tonia Craig. The Conservative standing deputy was not able to be in attendance.

113. **DECLARATIONS OF INTEREST**

Members were mindful that where they believed they had a Disclosable Pecuniary Interest in any matter considered at the meeting they must declare that interest at the time of the relevant debate and, having regard to the circumstances described in Part 3 Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter was discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore, Members were mindful that where they believed they had a Personal interest in a matter being considered at the meeting they considered whether such interest should be declared, and having regard to Part 5, Paragraph 4 of the Code, considered whether it was appropriate to leave the meeting whilst the matter was discussed, save for exercising any right to speak in accordance with the Code.

Councillor Jacqui England declared a personal interest in Item 6, as she is the Chairman of the Lymington Hospital 'League of Friends'.

Councillor Frank Rust declared a personal interest in Item 6, as he is a member of Southern Health NHS Foundation Trust.

Councillor Martin Tod declared a personal Interest in Item 6, as he is the Chief Executive of the Men's Health Forum, which receives funding from Public Health England and the Department of Health.

114. **MINUTES**

The Minutes of the meetings of the Health and Adult Social Care Select Committee (HASC) held on 24 November 2015 and 18 January 2016 were confirmed as correct records.

There was one matter arising in relation to the 18 January Minutes:

Minute 106: Public Health Revenue Budget

A new model of care for breastfeeding support services would be considered by the Executive Member for Health and Public Health on 30 March, and the Chairman had requested that the Committee scrutinise this topic at its meeting on 29 March.

115. **DEPUTATIONS**

The Committee received one deputation in relation to Item 6

on the agenda (Mazars report reviewing deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015):

Mr John Green and Mr Arthur Monks, who are both public governors on the Southern Health NHS Foundation Trust Council of Governors, but were speaking in a personal capacity, discussed and outlined a recent report titled 'Causes of Serious Failures of the Southern Health (NHS) Foundation Trust which led to the Mazars Report and the Failures Identified in the Mazars Report December 2015', which had been considered by the Trust's Council of Governors, and related issues.

116. **CHAIRMAN'S ANNOUNCEMENTS**

There were not any Chairman's Announcements on this occasion.

117. **MAZARS REPORT REVIEWING DEATHS OF PEOPLE WITH A LEARNING DISABILITY OR MENTAL HEALTH PROBLEM IN CONTACT WITH SOUTHERN HEALTH NHS FOUNDATION TRUST APRIL 2011 TO MARCH 2015**

A number of representatives from Southern Health NHS Foundation Trust, NHS England (Wessex) and NHS West Hampshire Clinical Commissioning Group attended before the Committee in order to speak to the Mazars report and associated reports and action plans received since its publication (see report and appendices, Item 6 in the Minute Book).

Before proceeding with the item, the Chairman highlighted the foreword to the Mazars report, which stated that the "report presents a lot of numbers. The team recognise that each number represents a loved one and would like to give their condolences to the families of every person referred to". The Chairman and the Committee echoed this sentiment.

The Chairman reminded the Committee of their remit in relation to the report and its scrutiny, specifically noting:

- The history and context to the Mazars report.
- That the role of the Committee would be to hold the NHS Bodies present to account for the findings in the report, and to make any recommendations to them.
- That specific actions were being taken in relation to the report by commissioners and regulatory bodies, and the need not to duplicate these processes.

Each NHS organisation present was given an opportunity to highlight any salient points from the report or their

subsequent papers, together with any additional information or comment that they wished to provide to the Committee.

Southern Health NHS Foundation Trust

The Chief Executive of the Trust began by apologising to the families and loved ones of those people referred to in the report, and was sorry if instances of poor quality reporting or investigations, or a lack of involvement in these, had led to an enhancement of bereavement or grief in already difficult circumstances.

The Trust fully accepted the recommendations in the Mazars report, where they fell within the Trust's statutory remit as a provider of NHS services. It also accepted that although improvements had been made to the internal processes of the Trust in relation to the investigation of deaths, there was still a lengthy journey to go. For example, the Trust agreed that an unacceptably low number of families had been involved in reviewing service user deaths, with an approximate involvement of 0% a decade ago, but since this time efforts had been made to change the culture of review from one that was overly paternalistic and precluding involvement due to the perceived grief of the families involved, to one today where 100% of families are given the opportunity to be involved in an individualised fashion, should they wish to be.

The Mazars report had highlighted that approximately 30% of reports were not sufficiently well written. This was an average taken across the four-year period, and the Trust stated that the figure was likely to have been higher in the earlier part of the review period, but that the quality of reports had improved during the latter part. Additionally, it was stated that the guideline of 60 days for the completion of mortality review reports was not being met, and this was still not the case, with approximately 50% exceeding this timescale.

The issue of multi-agency reviews was a salient one in the report, and there was an acceptance across the Hampshire region that organisations sharing care should work better together. Commissioners would be taking this work forward.

The Trust had taken a lot of action before and since the publication of the Mazars report to implement improvements. Examples included ensuring clinical representation on the Executive Board, centralising the review and investigation processes, investing in new reporting software, better capturing the results of inquests and making greater steps to involve families.

Southern Health would be contributing to national reviews and data sharing exercises to provide benchmarks for all Trusts, and to see if any learning could be achieved at this level.

The national news reporting on the Mazars report and its findings had confused matters and it was felt that the public were not fully aware of the difference between expected, unexpected and preventable deaths. It was important to remember that the report had not highlighted any trends in data which suggested that the Trust was an outlier in terms of the number of deaths of service users with a learning disability or mental health illness.

The Trust was now subject to a follow-up inspection from the Care Quality Commission, and action by the Foundation Trust regulator, Monitor. NHS England had also begun action through its 'risk summit' process to monitor the progress of recommendations pertinent to the national landscape, and commissioner assurance.

In summary, the Chief Executive repeated her earlier apology, and stated the Trust's deep felt sorrow should any of the issues outlined in the report have impacted negatively on the public it serves.

NHS England (Wessex)

The Director of Commissioning Operations for NHS England (Wessex) noted that, alongside his organisation, a new body, 'NHS Improvement' (comprising Monitor and the NHS Trust Development Authority), would be established as a single regulator of all NHS providers from April 2016 and would be working with other regulators, including the Care Quality Commission, to oversee improvement at Southern Health NHS FT.

There were a number of areas on which NHS England would lead a national response to recommendations in the Mazars report. Two that were especially relevant to the day's discussions were: first, to explore the capture and use of comparative data on mental health and learning disability services as a basis for performance improvement. The second would be to commission a programme of work to review all learning disability deaths and to learn any lessons from this. This review had already been commissioned from Bristol University and was expected to have completed its work in early 2018. The aim of both of these recommendations was to provide a clearer, more transparent understanding of the data and trends nationally in relation to learning

disability deaths.

Additionally, the Director emphasised the Chief Executive of Southern Health's earlier comments in respect of the families concerned.

NHS West Hampshire Clinical Commissioning Group

The Accountable Officer for West Hampshire Clinical Commissioning Group (CCG), who commission mental health and learning disability services on behalf of all Hampshire CCGs, noted to the Committee that the CCG were already aware of a number of issues raised in the Mazars report, and had been working closely with Southern Health to bring about improvements to processes.

The main issues raised to commissioners through the report were: the use of mortality data; the methodology used to determine if a death needed to be reported; and the timeliness and quality of these reports.

The CCG received a wide range of information about the Trust through a number of different mechanisms, including through contract and quality monitoring, reports from regulatory bodies, coroner inquests, independent investigations, complaints data and the views of its GP Body membership. These could all be triangulated to assimilate a picture of how the Trust is performing. Further work needed to be undertaken to ensure a richer stream of information could be sought from service users, their families and the public, as currently this engagement work took place mostly in relation to substantial changes of service.

In the next few months the CCG would seek to engage with a variety of other organisations in order to ensure that the multi-agency recommendations in the report could be taken forward. Additionally, work was ongoing to transform learning disability services, and the CCG would seek to ensure the Mazars report, its findings and the actions being taken forward would feed in to this.

The Chairman provided all NHS Bodies with the opportunity to clarify any details, to which they expressed their contentment with the information provided to the Committee.

The Chairman moved to question from the Committee.

Some Members raised specific cases relating to the care of service users in their constituencies, which the Chairman determined should be discussed outside of the meeting with

Southern Health NHS Foundation Trust, given that these cases did not specifically relate to the Mazars report being discussed by the Committee as part of this item.

In response to questions, Members heard:

- The Trust had held long conversations with the Council of Governors in relation to the Mazars report, and separate discussions on the extent of their powers as a Council of Governors on a Foundation Trust. The Non-Executive Directors of the Trust had reviewed whether action would be required against the Executive Directors on the Board, and had decided that it wouldn't be pursuing any action.
- It is part of the statutory framework governing NHS Foundation Trusts that the Chair of the Trust is also the Chair of the Council of Governors. The Council of Governors' role was a voluntary position which primarily aimed to listen to the views of the population, and provided this feedback to the Trust.
- The Trust felt it had taken steps to strengthen clinical leadership across the organisation; the addition of senior clinical leaders to the Board had already been highlighted, and additionally a new Chief Nurse was due to take up post soon. The Trust would seek to continue to invest heavily in in a diverse workforce, and develop strong local leadership. Examples of this in practice included highlighting areas of strong performance and management in the Trust, and applying this learning to those areas requiring improvement through the temporary transfer of strong leaders to the weaker areas of the organisation.
- Frontline staff to Executive Board interaction (and vice versa) was promoted in the Trust, in order to ensure messages from the ground level were heard by decision-makers. The Board and frontline staff also interacted through formal briefings, question and answer sessions, and an open door/email policy where individuals could approach senior leaders with concerns. The next staff learning session for staff leaders would be on the Mazars report and changes to mortality reporting.
- The Trust felt that the best culture was one which was open, without fear of blame or punishment if staff make a mistake, as all experiences were an opportunity to learn and progress as a care providing organisation.
- Southern Health had multiple methodologies available to allow open discussion of, or (if appropriate) whistleblowing on, any concerns from staff regarding the quality of services, or how these are being delivered. The Chief Executive was keen that all staff should feel empowered and confident to raise issues, report mistakes and highlight opportunities for learning.
- The Chief Executive was also passionate about

empowering staff to be able to make informed decisions without needing to defer to leaders to support the right choices, unless this was the most appropriate course of action. If individuals are enabled to take decisions, they are also able to be accountable to themselves and their colleagues for the actions they take.

- All staff are recruited based on their behaviours as well as their skills, and the method of appraisal used by the Trust reflected the need by staff to display appropriate behaviours, and be mindful of Trust culture and policy.
- The Trust believed it had hardworking and high quality clinical staff who were trying to do the right thing in sometimes difficult and highly pressurised environments. Not all staff had the same skillset and so it was important to highlight strengths and work on/with weaknesses through the Trust's appraisal system.
- All clinical leaders have access to the Trust's leadership programme, 'Going Viral'.
- From 2011 to 2015, the Trust was going through a journey of significant cultural change and standardisation of best and safest practice across specialities. This journey is still ongoing.
- The continued poor performance or attitude of staff wasn't tolerated, and the Trust had and would take disciplinary or professional standards actions against staff where informal leadership action had not resolved issues to the Trust's satisfaction.
- A complex skillset was required to be able to review and appropriately report on an unexpected or preventable death in an unbiased fashion. Previously, the Trust had trained over 100 staff to be able to undertake mortality reviews, but it had since been accepted that not all staff trained had the expertise or experience to be able to undertake reviews to the standard required. An additional issue in having a large pool of staff undertaking mortality reviews was that there was an inconsistency of approach, and skills learnt could not be kept up to a high level if staff were not involved in reviews regularly.
- Following the publication of the Mazars report, a greater amount of discussion was being held on the topic of leadership and culture at a national level, including the need to be more transparent on outcomes so that quality can be driven up through data being shared and learnt from.
- During the period of the report's review, Southern Health entered a new commissioning relationship to provide learning disability services in Oxfordshire and Buckinghamshire. With hindsight, the Trust had underestimated the challenge of providing services across such a wide geographic area. Additionally, the clinical leadership at the time in those areas was not strong enough, and a significant investment in staff was

required to increase staff diversity, skills and experience.

- Following the preventable death of Mr Connor Sparrowhawk, NHS England commissioned Mazars to undertake an independent report reviewing the way in which Southern Health reported and investigated deaths of people with mental health needs and learning disabilities who had one or more contacts with the Trust in the 12 months prior to their death.
- The Trust was deeply sorry and fully accepted that mistakes were made in the care of Mr Sparrowhawk that led to his preventable death in July 2013. A jury reached a narrative conclusion following an inquest into Mr Sparrowhawk's death held in October 2015, stating that he died by drowning following an epileptic seizure while in the bath, contributed to by neglect. Southern Health had apologised unreservedly to Mr Sparrowhawk's family and in the intervening two years had thoroughly reviewed this case, taken disciplinary action and commissioned an independent investigation into the circumstances surrounding the preventable death which resulted in a report by Verita. The Trust had made extensive changes to the way it provides services.
- The Trust agreed that it had clearly failed Mr Sparrowhawk's family, both in terms of his preventable death, and through the Trust not being able to involve his family in the review in a way that they felt was appropriate.
- A new mortality review process had now been introduced, with a centralised team - which had been in place for three months - now responsible for providing expert support across the organisation. In implementing this team and additional mechanisms to improve the quality of reviewing and reporting, the timeframes for completing the process had increased, but it had been agreed with commissioners that delayed reports were preferable to those that are rushed or inaccurate.
- A new IT system for recording and reporting mortality had also been implemented, with all deaths required to have a completed Initial Management Assessment within 48 hours, and then subsequently reviewed by a Trust Panel, in order to determine whether further investigation would be required.
- The new serious incident process, which was followed whenever it was determined that a death should be investigated, mandated family involvement (or their request not to be) in the review of a service user's death.
- All preventable deaths, of which eight were highlighted in this report, were reported nationally.
- All complaints made to the Trust are processed quickly in order to ensure that complainants have a named

contact within the Trust, and are given the opportunity to shape the process to suit their needs.

- Commissioners have open and honest dialogue with the Trust in relation to the quality of reports, and often provide constructive feedback on how to improve these. West Hampshire Clinical Commissioning Group (CCG) had returned a number of reports to the Trust where the quality of the reporting was not of the level expected. Additionally, this issue had previously been highlighted to Southern Health and commissioners through Coroner reporting.
- The commissioner view was that a significant improvement had been seen in the mortality review process since April 2015; all reports were now reviewed by a closure panel of the CCG, made up of multiple agencies, which reported their findings to a sub-committee of the CCG.
- Lord Crisp's recent report had reviewed the provision of acute inpatient psychiatric beds and alternatives to admission available for patients, including the use of 'out-of-area' beds. Within this report, it was highlighted that Southern Health was a leading provider in reducing 'out-of-area' placements; an achievement, given that several years ago Hampshire residents were regularly being sent out-of-County to receive inpatient care. This progression demonstrated the ability of the Trust to highlight issues and implement solutions to achieve improvement across the system.
- There are 57 beds across Hampshire for learning disability inpatients, including specialist forensic units.
- Hampshire has one of the lowest rates of inpatient beds for individuals with learning disabilities, with the Trust believing that institutionalising service users was not in their best interest.
- The suicide of individuals was always a tragedy, but it was important that the Trust struck a balance between taking appropriate actions in relation to an assessed suicide risk, and the need for the individual to continue to live as independent a life as possible, whilst having their needs met to recover.
- It would always be incumbent on the Trust to learn the lessons from any death from suicide, to understand if any action could have been taken to prevent that death from occurring. All suicides were treated as serious incidents and reported as such.
- It was also important to remember that the Trust were successful in treating mental health issues to allow people to recover, and preventing suicide.
- There had been discussions with all safeguarding boards in the areas covered by the Trust on the outcomes of the report. A specific recommendation had not been made in relation to safeguarding as it was not picked up in the report as an issue.

- The data for the time period April 2011 to March 2015 had been averaged out. If the data had been plotted out from year to year, improvements to processes would have been evidenced.
- All of those cases where a review should have been undertaken have now been subject to one, and learning has been taken from these.
- The data was also not broken down by geographic area in the report. The Trust and commissioners were happy to provide this to the Committee, if helpful.
- Commissioners had introduced greater measures to encourage open dialogue between the CCG and the Trust, with Board to Board meetings taking place, and the CCG engaging with the Trust's Council of Governors.
- The Trust was not an outlier in relation to the number of unexpected or preventable deaths recorded. Current data suggested it was better than the South East England average in relation to this.
- The Trust was concerned about the level of negative press attention the Mazars report's outcomes had received, and the impact this had had on public confidence, and the confidence of Southern Health's current and future service users. The implication from some of the media reporting was that services were not safe or an implication that more people died than the national average in the Trust's care. Both of these were not true. Especial concern had been reflected in discussions with Learning Disability service users and their representatives.
- The Trust would be taking a range of actions in relation to public confidence, including the commissioning of engagement exercises with the CCG to understand public confidence in Southern Health, and talking to all individuals who request this to reassure them on the Trust's services and the Mazars report and its outcomes.
- The Trust did seek feedback, whether positive or negative, from all service users and their families, and over 30,000 pieces of feedback were received in 2015.
- It was expected that Monitor would be placing an Improvement Director into the Trust for a day or so per week. There would be a role for them to review the skills and qualities of the Board, and to determine where the gaps were and how these could be bridged by the Trust.
- The Care Quality Commission last undertook a comprehensive inspection of the Trust in October 2014, with an overall outcome of 'requires improvement', with a number of actions to be completed by the Trust and its partners. The CQC were undertaking a follow-up inspection currently, with 20 inspectors visiting the Trust in January, and a further seven expected in February.

Hampshire specific data to be provided to the Trust.

Specifically, the CQC would be focusing on those actions previously recommended in relation to mental health and learning disability services. The outcomes from this inspection would be published 50 days after the inspectors had finished visiting the Trust. It was requested that this report be provided to the Committee, once published.

CQC report circulated once available.

*Councillor Cowper left at this point in proceedings.*

Following questions, the Chairman moved to debate. It was agreed that Members had given their views on the report whilst asking questions and therefore there was not a need to duplicate this discussion. Salient points raised included:

- The need to ensure that the culture and leadership of the Trust evolves to meet the challenges outlined in the Mazars report.
- The need to ensure that staff have the skills and tools needed to effect appropriate, high quality and timely reviews and reports, and that these processes include families in an inclusive manner.
- A priority to ensure that the Trust's service users and the wider public can be assured about the services provided, and that there was no evidence to suggest that the data on mortality for the Trust was unusual or an outlier compared to other providers.
- The need to continue to monitor the progress of the Trust and its recommendations, whilst not duplicating the roles and responsibilities of other agencies.
- A question on why the Trust's regulators had not previously raised the issue of mortality reviews, or why this issue, if known locally, hadn't been raised before the Committee in its scrutiny of Southern Health previously. The Chairman agreed to review this and report back.

Several Members throughout the meeting gave their view that the resignation of the Chief Executive of Southern Health would lead to a change in leadership and inspire greater confidence in the Trust. Discussion was heard in debate on this, with the Trust repeating that the Non-Executive Directors, who hold the Executive Board of the Trust to account, had already considered whether this was required, and had determined that it wasn't.

The Chairman moved to proceed to recommendations. Those recommendations already discussed and agreed throughout the meeting included requesting Hampshire-specific data referred to in the Mazars report, and receiving the CQC follow-up inspection report.

The Chief Executive of Southern Health also offered to the Committee the opportunity to visit any Trust-provided

services, in order to better understand the views of patients, their families and staff, and to help restore public confidence in the Trust's quality of care, which although unrelated to the Mazars report had been affected by news reporting. Additionally, an offer was made to all Members to observe panels, attend patient forums and to become Trust peer reviewers, in order to provide more direct feedback on the implementation of the report's recommendations. The Committee accepted this offer.

An additional recommendation was proposed by Councillor David Harrison and seconded by Councillor Bruce Tennent. A recorded vote was requested and agreed by a quorum of Members present. A vote took place on the recommendation as set out below:

*'That whom so ever it concerns in Southern Health NHS Foundation Trust are invited to reconsider whether the public interest and perception of the Trust would be better served by asking the Chief Executive to move on.'*

| | |
|---|---|
| For: | Cllr Jacqui England, Cllr David Harrison, Cllr Tony Hooke, Cllr Andy Moore, Cllr Bruce Tennent, Cllr Martin Tod (6) |
| Against: | Cllr Anne Briggs, Cllr Rita Burgess, Cllr Chris Carter, Cllr Charles Choudhary, Cllr Alison Finlay, Cllr Roger Huxstep, Cllr David Keast, Cllr Fiona Mather, Cllr Frank Rust, Cllr Yvonne Weeks (10) |
| Abstained: | Cllr Alan Dowden, Cllr Marge Harvey, Cllr Martin Lyon, Cllr Dennis Wright (4) |

The recommendation was not carried.

RESOLVED

That the Committee:

1. Adds this topic to its work programme, and requests a monitoring update on the progress made with actions taken to implement the report's recommendations in six months' time.
2. Requests a Hampshire-specific breakdown of the data referred to in the Mazars report.
3. Receives the Care Quality Commission report on the follow-up inspection of Southern Health NHS Foundation Trust, once available.
4. Accepts the offer from Southern Health NHS Foundation Trust to visit mental health and learning disability services, observe internal meetings and forums relating to the implementation of the report's findings, and volunteer as peer reviewers. That any Member who wishes to take up these offers does so

through the Committee’s scrutiny officer.

Chairman, 29 March 2016