The tragic death of an 18 year old while in the care of an NHS Trust in July 2013, has uncovered the Trust’s widespread failure to investigate the unexpected deaths of hundreds of patients with learning disabilities or mental health problems and led to a storm of criticism.

An inquest concluded that neglect by the Southern Health NHS Foundation Trust had contributed to Connor Sparrowhawk’s death by drowning after having an epileptic seizure in a bath at Slade House, a learning disability unit in Oxford.

The Mazars Report
NHS England commissioned Mazars, an independent audit firm, to examine the Trust’s practice and review all deaths of people receiving care from its Mental Health and Learning Disability services between April 2011 and March 2015, either at the time of their death or in the 12 months preceding their death.

The report, published in December, concludes there had been ‘a lack of leadership, focus and sufficient time spent on reporting and investigating unexpected deaths of mental health and learning disability service users at all levels of the Trust, including at the Trust Board.’

It went on to point to ‘facets of this poor leadership’ that included ignoring coroners’ warnings about the Trust’s need to improve its substandard investigations and reports, and the Board’s failures to challenge systems and processes concerning investigations, including how decisions are made on whether to investigate. The report’s authors also castigated the Trust for its ‘lack of transparency', its inadequate involvement of families and carers in investigations and failure to involve other service providers where appropriate.

Timeliness was a major concern and getting reports to closure panels was particularly weak, said the report. It could be months or in some cases years before deaths were reported to the Strategic Executive Information System (StEIS) while 90% of Serious Incidents Requiring Investigation (SIRIs) were not completed within the 45 days specified in guidance.

The report’s authors said: ‘We have little confidence that the Trust has fully recognised the need for it to improve its reporting and investigation of deaths of people with a Mental Health (in particular Older People) or Learning Disability need.’

The Trust provides Mental Health and Learning Disability services to about 45,000 people each year across Hampshire, Oxfordshire, Buckinghamshire, Berkshire, Wiltshire and Dorset and to about 650 social care users in TQtwentone, the Social Care arm of the Trust.

Most of the 10,306 patient deaths that occurred in the Trust’s Mental Health and Learning Disability services between April 2011 and March 2015 were expected. However, 1,454 of the deaths were reported to the Trust’s risk and incident management system and 722 of these were categorised as ‘unexpected’.

There was a striking difference in the decision whether or not to investigate these 722 unexpected deaths further: 60% (237 of 394 deaths) in Adult Mental Health services were reviewed; only 13% (30 of 235 deaths) in Older People Mental Health (OPMH) services were investigated; and just 4% (4 of 93 deaths) of people with a Learning Disability (LD) were followed up by an investigation.

Even where there were investigations, despite numerous warnings...
The Recommendations

The Mazars report makes 23 recommendations to the Trust that include:
• Calls for improvement of Board leadership and oversight to ensure that existing policies are followed and that processes of reporting and investigating unexpected deaths are transparent, timely, consistent and robust
• Calls to ensure the involvement of families in investigations
• Detailed recommendations on monitoring mortality and developing clear terms of reference for defining unexpected deaths in people with a learning disability or a mental health problem
• Production of a template for a thematic review that meets best practice standards and includes follow up, evaluation and demonstration of lessons learned and practice change
• Improved procedures for multi-agency working and information management

The report also includes nine recommendations for those who commission mental health and learning disability services from the Trust (including Clinical Commissioning Groups) and seven national recommendations for NHS England and its partners

Commissioners’ recommendations include:
• CCGs should take action to ensure that incidents are reported to the appropriate systems within an agreed timeframe
• All commissioners should agree a protocol for ensuring joint investigation between NHS providers, in particular for people with a learning disability

National recommendations include:
• 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

about the poor quality of the investigations and subsequent reports, executives gave constant reassurances that the problems were being addressed yet no effective action was taken to deal with these weaknesses, says the report.

... and some responses

Katrina Percy, chief executive of Southern Health NHS Foundation Trust since it was established in April 2011, said: ‘We fully accept that our processes for reporting and investigating deaths of people with learning disabilities and mental health needs were not always as good as they should have been.’

She apologised ‘unreservedly’ and said that while the Trust has substantially changed the way it records and investigates deaths it recognises the need to make further improvements.

Ms Percy added, however, that ‘in most cases referred to in the report, the Trust was not the main care provider’ and said the Trust believed its rate of investigations into deaths ‘is in line with that of similar NHS organisations’.

Monitor, as the regulator of foundation trusts, has announced that it will take regulatory action at the Trust and appoint an Improvement Director to provide expert support and ensure the Trust fixes its problems.

Claudia Griffith, regional director at Monitor, said: ‘It is clear that more work is needed across the NHS to identify and spread best practice for reporting and investigating deaths among people with a learning disability and/or mental illness.’

She added that Monitor will work closely with the Care Quality Commission (CQC) to assess how these deaths are investigated and what further action is needed by the Trust and across the NHS.

Mencap chief executive Jan Tregelles said the review showed the Trust had only investigated four of 93 unexpected deaths of people with a learning disability, which meant that opportunities were lost to learn from them.

She said: ‘Families are clear that those responsible for this failure must be held to account. Monitor’s announcement will not address this concern. It offers little in the way of accountability of Southern Health leadership and it is not clear how families will get answers about what happened to their loved ones.

Ms Tregelles added that Monitor and the CQC must set out a timetable for completing their examination of how deaths of people with a learning disability are investigated across the NHS and spell out what it will include, to address concerns that the issues exposed at Southern Health might also be present in other parts of the NHS.

Responding on behalf of the commissioners, Heather Hascall, chief officer for West Hampshire Clinical Commissioning Group, accepted all the Mazars recommendations and promised to work with the Trust, other commissioners, local authorities and NHS England to ensure the implementation of the recommended improvements to processes.

NHS Improvement, NHS England and the Care Quality Commission (CQC) issued a joint response2 to the report.

Alongside Monitor, the CCGs that commission services from Southern Health will scrutinise the Trust’s improvement actions and delivery, while NHS England South Region will hold them to account for overseeing that improvement, said the joint response.

The Mazars review reinforces the need for more work on care
co-ordination to ensure access to advocacy services and good healthcare services that are fully accessible to people with a learning disability, said the joint response. The national service model published in October 2015, by NHS England, the Local Government Association and other partners, gives clear guidance to health and social care commissioners on this.

NHS England has set up a three year comprehensive, national retrospective review of the deaths of people with learning disabilities to investigate why they typically die much earlier than average and to devise a strategy to reduce their premature deaths.

NHS England has commissioned Bristol University to undertake the first ever National Learning Disability Mortality Review Programme, to review the causes of death of people with a learning disability by March 2018 in a phased roll-out across England. There will be clear protocols in place to ensure that unexpected deaths are subject to a multidisciplinary review, covering the totality of the person’s care in order to assess causes of death and learn what actions might have been taken to prevent that death.

References
2. 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 formally comes into existence on 1 April 2016

POEMs

Acupuncture, Alexander technique better than medical care for chronic neck pain

Clinical question
In patients with chronic neck pain without an identifiable cause, is either acupuncture or Alexander technique lessons more effective in reducing pain and disability than usual care?

Bottom line
Acupuncture and Alexander technique lessons are options for patients with chronic neck pain, since both decrease pain and disability to a greater extent than usual care alone in those with neck pain lasting an average 6 years. Alexander technique is a process in which patients are taught by Alexander-trained practitioners to notice muscle tension and to train themselves (“intentional inhibition”) to avoid their maladaptive physical habits, usually bad posture and inefficient movements. (LOE = 1b–)

Reference

Study design: Randomized controlled trial (non-blinded) Funding source: Foundation Allocation: Unconcealed Setting: Outpatient (primary care)