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DEBATE PACK

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Governance of Southern Health NHS Foundation Trust

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Contents

Summary

A Westminster Hall debate on the Governance of Southern Health NHS Foundation Trust has been scheduled for Wednesday 8 June 2016 at 2.30 pm. It will be led by Suella Fernandes.

This debate pack contains a Library summary of the issues, relevant reports, press and parliamentary coverage, and links to further reading.

1. Summary

Following the death of Connor Sparrowhawk in July 2013, NHS England commissioned an independent report into the deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust. The independent report (the Mazars report) highlighted the failure of the trust to investigate and learn from the deaths of patients; particularly those receiving care. This led to a CQC investigation in January 2016 and on 6 April 2016 the CQC issued a warning notice. The notice requires the trust to improve its governance arrangements to ensure robust investigation and learning from incidents and deaths, to reduce future risks to patients. The CQC inspectors were also checking on improvements, which had been required in some of the Trust's mental health and learning disability services following previous inspections.

CQC inspectors found that the trust had failed to mitigate against significant risks posed by some of the physical environments from which it delivered mental health and learning disability services and did not operate effective governance arrangements to ensure robust investigation of incidents, including deaths. It did not adequately ensure it learned from incidents to reduce future risks to patients. In addition, inspectors found that the trust did not effectively respond to concerns about safety raised by patients, their carers and staff, or respond to concerns raised by Trust staff about their ability to carry out their roles effectively.

On 12 April 2016 CQC announced it would be carrying out a review of how NHS trusts identify, report, investigate and learn from deaths of people using their services. This followed a request from the Secretary of State for Health, which was part of the Government's response to events at Southern Health NHS Foundation Trust. CQC's wider 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.

Following the CQC warning notice, in April NHS Improvement also announced its intention to take regulatory action at the trust. NHS Improvement intends to put an additional condition in the trust's licence to provide NHS services, which would allow it to make management changes at the trust if progress isn't made on fixing the concerns raised.

The trust has the opportunity to comment on NHS Improvement's proposals before a final decision is made on whether to put the additional condition in its licence.

Further information on policies to improve services for people with learning disabilities, and reviews into premature deaths (including the National Learning Disability Mortality Review Programme which was announced in June 2015) can be found in a separate Library briefing:

http://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN07058

2. Press articles

Health Service Journal (HSJ), 16 May 2016,

Daily Insight: Picking up the pieces at Southern Health

Health Service Journal (HSJ), 16 May 2016,

Problems at Southern Health 'not a one off

The Guardian, 4 May 2016

People with learning disabilities are still not recognised as fully human

Nursing Times, 29 April 2016

Southern Health leaders 'not proactive' in identifying risks to patients, says CQC

Health Service Journal (HSJ), 29 May 2016,

Regulators install Tim Smart as Southern Health chair

BBC News, 28 April 2016

Southern Health chairman resigns over new revelations

Nursing Times, 6 April 2016

CQC issues warning notice to Southern Health over safety

The Guardian, 22 February 2016

A learning disability commissioner? Views from the social care sector

Nursing Times, 13 January 2016

Regulator sends improvement directorto Southern Health

The Guardian, 21 December 2015

Revealed: NHS hospitals investigate one in seven deaths of vulnerable patients

The Guardian, 21 December 2015

Failure to investigate deaths of vulnerable patients

The Independent, 20 December 2015

NHS fails to investigate 85% of deaths of hospital patients with learning disabilities

Health Service Journal (HSJ), 17 December 2015

Southern Health leadership condemned in report on patient deaths

The Guardian, 17 December 2015

Jeremy Hunt criticises NHS trust over response to unexpected deaths

The Independent, 13 December 2015

There is a sickness at the heart of the NHS - and if we pretend not to see it, we'll condemn it to destruction

BBC News, 10 December 2015

NHS trust 'failed to investigate hundreds of deaths'

The Independent, 9 December 2015

NHS trust 'failed to investigate 1,000 unexpected deaths', report finds

The Telegraph, 9 December 2015

NHS 'failed to investigate 1000 deaths'

The Guardian, 9 December 2015

NHS trust 'failed to properly investigate deaths of more than 1,000 patients'

Nursing Times, 18 June 2015

Mental health trust has improved care, say regulators

Please contact the Library for help with access to these publications.

3. Press releases

Care Quality Commission (CQC)

12 April 2016

CQC review of how NHS trusts investigate and learn from deaths

CQC is carrying out a review of how NHS trusts identify, report, investigate and learn from deaths of people using their services.

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

CQC's 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.

Professor Sir Mike Richards, CQC's Chief Inspector of Hospitals, said:

"Very many people are under the care of secondary healthcare services at the time of their death.

"For most, the care provided has prolonged their life, eased their suffering and helped them to die with dignity. However, this is not the case for everybody. Every year thousands of people under the care of NHS trusts die prematurely because their treatment or care has not been as good as it could have been. Healthcare workers might have failed to identify an illness that could have been treated, not provided the advice that might have prevented an illness developing, not made a life-saving intervention with a person who is critically ill or made some other error that contributed to a premature death.

"It is essential that, when this happens, NHS services identify and investigate the circumstances of these deaths so that staff can learn from them and reduce the likelihood of a similar event happening in the future. It is also essential, that NHS providers are open and honest with the families and carers of people who die whilst under their care.

"CQC's review aims to find out to what extent NHS trusts are learning organisations when it comes to investigating the deaths of people under their care and how well they support and engage with the families of people who have died."

CQC will be writing to all acute, community and mental health trusts seeking information about the number of deaths in their services, how they decide which of these should be investigated and how they then carry out those investigations. Importantly we'll be asking how they involve families and how they use the learning from those investigations

to make improvements. The review aims to look for examples of good practice as well as identifying problems.

The work will be supported by an expert advisory group. As part of this, and wider work, CQC will involve families and organisations that represent them. Further information can be found by joining our online community for the public. CQC registered providers and health and social care professionals can find out more by joining our online community for professionals.

The findings will be published in a national report towards the end of the year.

CQC

CQC tells Southern Health NHS Foundation Trust to take urgent action to improve governance arrangements to ensure patient safety

6 April 2016

The Care Quality Commission (CQC) has told Southern Health NHS Foundation Trust that it must make significant improvements to protect patients who are at risk of harm while in the care of its mental health and learning disability services.

CQC has issued a warning notice requiring the Trust to improve its governance arrangements to ensure robust investigation and learning from incidents and deaths, to reduce future risks to patients.

CQC Inspectors visited the Trust as part of a focused inspection during January 2016. This inspection followed the publication of an independent report (the Mazars report) commissioned by NHS England that highlighted the failure of the Trust to investigate and learn from the deaths of patients; particularly those receiving care in its older people's, learning disability and mental health services.

The team of inspectors were also checking on improvements, which had been required in some of the Trust's mental health and learning disability services following previous inspections.

Inspectors found that the Trust had failed to mitigate against significant risks posed by some of the physical environments from which it delivered mental health and learning disability services and did not operate effective governance arrangements to ensure robust investigation of incidents, including deaths. It did not adequately ensure it learned from incidents to reduce future risks to patients. In addition, inspectors found that the trust did not effectively respond to concerns about safety raised by patients, their carers and staff, or respond to concerns raised by Trust staff about their ability to carry out their roles effectively.

Dr Paul Lelliott, CQC Deputy Chief Inspector of Hospitals and Lead for Mental Health said:

"We have made it clear that the safety of patients with mental ill health and or learning disabilities, provided by Southern Health NHS Foundation Trust requires significant improvement.

"We found longstanding risks to patients, arising from the physical environment, that had not been dealt with effectively. The Trust's internal governance arrangements to learn from serious incidents or investigations were not good enough, meaning that opportunities to minimise further risks to patients were lost.

"It is only now, following our latest inspection, and in response to the warning notice, that the Trust has taken action and has identified further action that it will take to improve safety at Kingsley ward, Melbury Lodge in Hampshire and Evenlode in Oxfordshire. The Trust must also continue to make improvements to its governance arrangements for reporting, monitoring, investigating and learning from incidents and deaths. CQC will be monitoring this Trust very closely and will return to check on improvements and progress in the near future."

CQC expects to publish a full report of its January 2016 inspection of Southern Health NHS Foundation Trust in late April.

Monitor and NHS Trust Development Authority

April 2016

NHS Improvement intends to take further action at Southern Health

NHS Improvement announces its intention to take further regulatory action at Southern Health NHS Foundation Trust

NHS Improvement has informed Southern Health NHS Foundation Trust that it intends to take further regulatory action at the trust to ensure urgent patient safety improvements are made, following a warning notice being issued by Care Quality Commission (CQC).

The trust was issued with a warning notice by the CQC which highlighted a number of improvements that needed to be made following an inspection. The CQC's announcement is available here.

NHS Improvement intends to put an additional condition in the trust's licence to provide NHS services, which would allow it to make management changes at the trust if progress isn't made on fixing the concerns raised. The warning notice issued by the CQC identifies issues with how the trust monitors and improves the safety of its services, and how it assesses and manages any risks to its patients.

The trust now has the opportunity to comment on NHS Improvement's proposals before a final decision is made on whether to put the additional condition in its licence.

Dr Kathy Mclean, Executive Medical Director at NHS Improvement, said:

"Patients and service users at Southern Health expect to get safe and good quality care, and it is worrying to see that the CQC have identified patient safety concerns which have still gone unaddressed at the trust.

"The trust needs to ensure that it fixes these issues quickly and that it can spot and quickly mitigate any future risks to patients and service users. If we don't see enough progress on this we will consider taking action on behalf of patients."

Claudia Griffith, Regional Director at NHS Improvement, said:

"These latest findings from the CQC are concerning and need addressing promptly and effectively. The trust has continued to breach its licence to provide NHS services, so we have informed it of our intention to put an additional condition in its licence to allow us to make management changes should it not take rapid action."

NHS Improvement has already taken action at the trust to support improvements to the way it reports and investigates deaths among people experiencing mental health illness and/or have learning disabilities.

Alan Yates, a chief executive with over 35 years' experience of management within the NHS, was also appointed to act as Improvement Director at the trust by NHS Improvement.

The Patients Association

13 January 2016

Monitor appoint expert to improve investigation into deaths at Southern Health NHS Foundation Trust

Katherine Murphy, Chief Executive of the Patients Association said:

"The story of Jo Deering epitomises the severity of Southern Health's failings to patients and families. The trust's attitude has shattered patient trust in the investigations process, and they have completely disregarded their responsibilities to patients and their families by failing to learn from their poor standard of care.

This must serve as a wakeup call, not just for this trust, but for the whole of the NHS. Care and understanding of mental health and learning disabilities must improve, and trusts have to ensure that the necessary protections are in place to look after the most vulnerable patients. The Patients Association would like to extend its full support to any families who have been affected by the failings of Southern Health NHS Foundation Trust.

For the sake of those who have died, there must be true accountability and full transparency to ensure that they get the answers they deserve. We call on Southern Health to show real and sustained commitment to changing their culture and putting their patients first. "

Monitor

12 January 2016

Southern Health to get expert help to improve investigations into deaths

Monitor is to take regulatory action at Southern Health NHS Foundation Trust.

Southern Health NHS Foundation Trust will receive expert support to improve the way it investigates and reports deaths at the trust, particularly among people with a learning disability and/or those who are experiencing mental illness.

After considering a report by Mazars on Southern Health, which was published in December 2015, the health regulator Monitor has stepped in to ensure the trust improves its reporting and investigations into deaths.

When investigating, the trust also failed to engage properly with families. This is particularly important when the individuals concerned had a learning disability and/or mental illness and may have been less able to speak up for themselves, because families are often closely involved with their care and may have important knowledge to support investigations.

Monitor has taken regulatory action and agreed a number of steps with the trust to ensure these issues are addressed as quickly as possible.

The trust has agreed to implement the recommendations of Mazars' report, and to get expert assurance on how well it plans and carries out those improvements. Monitor will appoint an Improvement Director for the trust, who will use their expertise to support and challenge the trust as it fixes its problems.

Claudia Griffith, Regional Director for Monitor, said:

"The NHS should take every opportunity to learn from any mistakes that happen when caring for people, to ensure that they are never repeated again.

"We have taken action to ensure that Southern Health improves the way it investigates deaths among people with a learning disability and/or those who are experiencing mental illness.

"However, it is also 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."

Monitor will work closely with the Care Quality Commission to assess how deaths among people with a learning disability and/or mental illness are investigated and what further action is needed across the NHS and by the trust.

NHS England

17 December 2015

NHS England publishes report into Southern Health

NHS England has today published an independent report into the deaths of people with a learning disability or mental health problem at Southern Health NHS Foundation Trust, and highlighted a system-wide response.

The report was commissioned by NHS England (South) following the death of Connor Sparrowhawk in July 2013 in a unit in Oxford run by Southern Health NHS Foundation Trust.

Both Southern Health NHS Foundation Trust and the clinical commissioning groups (CCGs) that commission services from them have accepted the recommendations.

NHS Improvement (Monitor, as the regulator of Foundation Trusts), NHS England and the Care Quality Commission have set out a joint response to the recommendations which relate to national policy. NHS England has now forwarded the report to Monitor, who will consider as a matter of urgency whether regulatory action is required.

The report will feed into the National Learning Disability Mortality Review Programme which was announced in June.

This three-year project is the first comprehensive, national review set up to get to the bottom of why people with learning disabilities typically die much earlier than average, and to inform a strategy to reduce this inequality.

Jane Cummings, Chief Nursing Officer, said: "Openness, transparency, learning, improving and working with families should be the core tenets of the NHS, especially where things don't go right.

"We commissioned this report following concerns expressed by Connor Sparrowhawk's family, and we are grateful for their contribution to this publication.

"The report now recommends further action from us and others, in particular that its findings should be shared across England to ensure that deaths are investigated properly. We have jointly committed to ensure that this and the other actions it sets out are taken."

Some of the report's main findings are:

- Many investigations were of poor quality and took too long to complete
- There was a lack of leadership, focus and sufficient time spent in the Trust on carefully reporting and investigating deaths
- There was a lack of family involvement in investigations after a death
- Opportunities for the Trust to learn and improve were missed.

Of the 1,454 deaths recorded at the Trust during this period, 722 were categorised as unexpected by the Trust. Of these 540 were reviewed and 272 unexpected deaths received a significant investigation. The report does not specify how many investigations there should have been, but draws attention to the limited number of deaths that were investigated in different categories.

NHS England has fully accepted the findings of the final report, following a period of review which included an independent verification of the methodology used.

Members of the public with queries or concerns about the report can call NHS England's Customer Contact Centre on 0300 311 22 33.

4. Parliamentary questions, statements and debate

4.1 Questions

Southern Health NHS Foundation Trust

03 May 2016

Luciana Berger

Urgent Question: To ask the Secretary of State to make a statement on the safety of care and services provided by Southern Health NHS Foundation Trust.

The Minister for Community and Social Care (Alistair Burt)

I thank the hon. Member for Liverpool, Wavertree (Luciana Berger) for her question. At the outset of my response, I want to express my deep concern and apologies to the patients and family members who will again have felt let down by the contents of last week's report from the Care Quality Commission. Our first duty to patients and their loved ones is to keep them safe. This applies to all of us with a role to play in the NHS, from the frontline to this House, and the Government are therefore clear that it is imperative to be open and transparent about what has gone wrong in order to minimise the risk of similar failings occurring throughout the NHS as a whole. We must ensure that the trust itself continues to be scrutinised and supported to make rapid improvements in care. If that means intervention from the regulators, they will not hesitate to take the necessary action, and we will not hesitate to back them.

Last week's CQC report followed a focused inspection announced and requested by my right hon. Friend the Secretary of State in December 2015. The report from the CQC set out a number of concerns, including: a lack of robust governance arrangements to investigate incidents; a lack of effective arrangements to identify, record or respond to concerns about patient safety; and a need for immediate action to address safety issues in the trust environment. The report also found that the senior management and board agendas were not driven by the need to address these issues. None of those matters is acceptable.

NHS Improvement has taken action in recent months to address the issues at the trust. It has been working closely with the CQC and the trust, and on 24 March, NHS Improvement appointed an improvement director to the trust. On 14 April, following a CQC warning notice on 6 April, NHS Improvement placed an additional condition on the trust's licence, asking it to make urgent patient safety improvements to address the issues found by the CQC. That condition gave NHS Improvement the power to make management changes at the trust if it did not make progress on fixing the concerns raised.

On 29 April, following the resignation of the trust chair Mike Petter, NHS Improvement announced its intention to appoint Tim Smart as the

chair of the trust. As chair, Mr Smart will have responsibility for looking at the adequacy of the trust's leadership. Given the centrality of issues of governance to the CQC's report, I welcome the action taken by NHS Improvement. The direct appointment of a new chair by a regulator is a relatively rare step, and it reflects the seriousness of the issues at the trust. NHS Improvement will continue to monitor the situation closely in the coming weeks and months.

I understand that the CQC is considering the trust's response to its warning notice, and the risks it highlighted, before deciding whether to take any further enforcement action, and none of its options is closed. The notice required significant improvements to be made by 27 April. Dr Paul Lelliott, the deputy chief inspector at the CQC, was directly responsible for the report, and I spoke to him this afternoon. He informs me that the delivery plan required by 27 April has been received and is in the process of being evaluated. NHS Improvement is working closely with the CQC and the trust, and the improvement director appointed by NHS Improvement is on site regularly, so there is constant independent oversight of the progress being made as well as the formal monthly progress meetings between NHS Improvement and the trust.

In addition to the action we are taking on Southern Health, it is vital that we learn the wider lessons for the NHS as a whole. First, I hope the whole House can agree that it is right that we have robust, expert-led inspection from an independent CQC that provides an objective view about issues of safety and leadership, and that this is backed with action from NHS Improvement where that is required. Secondly, it is vital that we take the issue of avoidable mortality as seriously for people with learning disabilities and mental health problems as we do for other members of our society. To that end, the learning disability mortality review programme has been put in place by NHS England to ensure that the causes of this inequality are understood, and with the aim of eliminating them. In addition, the CQC will be leading a review of how all deaths are investigated, including those of people with learning disabilities or mental health needs. There can be no question but that the CQC report makes for disturbing reading, and that it demands action at local and national levels. We owe our most vulnerable people care that is safe and secure, and I am determined that we will do all we can to ensure patient safety.

Luciana Berger

I thank the Minister for very brief advance sight of his response. Patients and parents have a right to be angry at the failure of Southern Health NHS Foundation Trust, and we in this House have a duty to be angry on their behalf. To read the litany of failure, missed warnings, reports and recommendations ignored, and secrecy over the last four years would make any reasonable person angry, too. Friday's CQC report shows that very little has been done since the House last discussed the matter in December.

The scandal at Southern Health has happened on this Government's watch, and Ministers must take responsibility for what has happened to

some of the most vulnerable people in our country. We should be angry that Connor Sparrowhawk was left to drown in a bath. We should be angry that Angela Smith took her own life. We should be angry that David West died in the care of this NHS trust—his father was repeatedly ignored when he raised his concerns. All of them were denied the care that they so desperately needed. Last week, the BBC reported that over the past five years, 12 patients who had been detained for the safety of themselves or others have jumped off the roof of a hospital run by this trust. Access to a roof was still permitted to people at risk of suicide. If all those tragic incidents were the only signs of systemic failure, we should be angry, but there is a much bigger story of neglect and malpractice, which aggregates into a major scandal.

When the Secretary of State responded to the urgent question on Southern Health in December, he rightly said:

"More than anything" people will "want to know that the NHS learns from" such tragedies".—[Official Report, 10 December 2015; Vol. 603, c. 1141.]

The CQC report published on Friday shows that that clearly has not happened. So I ask the Minister: first, what guarantees can the Minister give to the 45,000 patients currently in the care of Southern Health, and their families, that they are safe? Secondly, where is the accountability, the culpability and the responsibility? There seems to be very little. I heard what he said about the chair, but does he agree that the chief executive's position is now untenable, and that she should be sacked? Thirdly, will he listen to the heartfelt pleas of the victims' families, the campaigners, and all of us who are demanding a full public inquiry into Southern Health and broader issues, such as the abject failure adequately to investigate preventable deaths?

As the Secretary of State said in December, such issues are not confined to one trust. The Ofsted-style ratings that he previously mentioned will make a difference only if there is proper accountability and the ability to take action to make real improvements to patient care and patient safety. The families have behaved with such dignity and tenacity, and we owe them a debt of gratitude, but it should not be left to them alone to push for accountability.

I listened carefully to what the Minister told the House, but I remain unconvinced that enough has changed. Four months ago, we heard similar reassurances. Today, we are debating the Government's failure to act. The time for yet more warm words and hollow reassurances is over. We need action, and we need it now.

Alistair Burt

I thank the hon. Lady for her response. We are not actually debating the Government's failure to respond at all. The Secretary of State did exactly what he said he was going to do, and the CQC's inquiry and work that followed can be seen in the report that was produced last week. The report contains a number of further concerns—there is no doubt about that—and people are right to be angry, but there is a process to find out what is going on and to do something about it and that process is

in place. That is what NHS Improvement is doing and it is important that that is done.

There is an issue of urgency, which is really important. There are things that are discovered and things take time to get done. I am not content with that in any way, but the process is in place to do something about that. The CQC has been engaged and has ruled out no option for further action. Its options are quite extensive, including prosecution for things that it has found. The process started by the Secretary of State is not yet finished. That my right hon. Friend has demonstrated his commitment to patient safety from the moment he walked into that office cannot be denied by anyone, and this is a further part of that.

I asked the same question that the hon. Lady asked about safety directly to the CQC this afternoon, and I spoke to Dr Paul Lelliott who compiled the report. I asked whether people are safe at the foundation trust today. People are safe because, as we know, the CQC has powers to shut down places immediately if there is a risk to patients. It has not done so, but I am persuaded that if it had found such a risk it would have closed things down. There is therefore no risk to safety in the terms that the hon. Lady suggests.

On the chief executive's position, the power to deal with management change is held by NHS Improvement. I also offer a brief word of caution. There is a track record of Ministers speaking out, at great cost, about the removal of people in positions over which they have no authority. That is understandable in situations of great concern when an angry response seems right, but it is not an appropriate response. The chair has gone, and processes are available should any more management changes be necessary, which is important. Colleagues in the House can say whatever they like, but a Minister cannot and must say that appropriate processes can be followed, because that is right and proper.

I do not yet know about an inquiry, and I want to wait and see what comes out of the further work being done in the trust. I do not rule out some form of further inquiry, but an inquiry is physically being carried out now by the actions taking place on the ground. What needs to follow is urgent action to respond to what the CQC has said, and a long drawn-out public inquiry is not necessarily the right answer. More work might be necessary, but I need to consider that in relation to further work being done at the trust.

On preventable deaths, as I made clear in my statement, I am sure that not enough attention has been given to those cases that require further investigation across the system, often dating back many years and preceding this Government. We have turned our attention to that issue, and we will make changes because such inequality must end.

Dr Sarah Wollaston (Totnes) (Con)

The report into Southern Health makes disturbing reading, but we will never tackle unacceptable levels of health inequality and early deaths among those who live with learning disability and mental health issues unless we address safety and risk. Will the Minister go further on the mortality review and set out how we can see where differences exist

around the country? Will he reassure the House that duty of candour will in future be more than a tick in the box?

Alistair Burt

A tick in the box for duty of candour, which the report mentioned, was unacceptable—it must mean much more than that. The learning disability mortality review programme is important and will support local areas to review the deaths of people with learning disabilities, and use that information to help improve services. In time, it will also show at a national level whether things are improving for people with learning disabilities, and whether fewer people are dying from preventable causes. That review is already under way in a pilot in the north-east in Cumbria, which will help to inform us how the programme operates as it is rolled out. Plans are in place to roll out that review across all regions of England between now and 2018, with pilots commencing in other parts of the country between 2016 and 2017. That work has never been done before, and it is right that we are doing it now.

Dr Alan Whitehead (Southampton, Test) (Lab)

As the Minister and other hon. Members have said, Friday's report makes grim reading for the many families and patients in the care of Southern Health NHS Foundation Trust. The Minister said that those failings are not isolated to that trust, but are on a much wider scale. In light of that, is he seriously considering a public inquiry that will get to the heart of the underlying factors in those matters? Patients and families who use this trust—some of whom are my constituents—must be reassured that those underlying issues are being properly considered and not brushed under the carpet.

Alistair Burt

It is vital that they are not brushed under the carpet, and I will come to that in a second. It is important to put it on the record that there are some positive aspects of this report, some of which relate to Southampton. I am sure the hon. Gentleman will already have seen those, with the trust being commended for its work on the community pathway. On the substance of his question, I spoke honestly a moment ago when I said that I really do not know at this stage whether an inquiry is the right thing to do. I am well aware of the seriousness of this matter, of the questions the families have raised, and of the fact that this has been going on for some time. The important thing is both to effect change and to find out what has happened. The CQC report—the extensive work that has already been done—is in depth, public and transparent. That may well have the answers that are required, but if not, something further may be needed, which is why I have an open mind on this. The most important thing is to give the reassurance that certain things have happened, which the CQC report cannot yet do because that is where the work is needed and where the work is going on now.

Mrs Maria Miller (Basingstoke) (Con)

Our constituents, particularly those with learning disabilities, need to have confidence in the complex set of services provided by Southern Health. The failings that have been identified are completely unacceptable and disturbing, and I welcome the Minister's statement and the CQC's action with the warning notice it has issued. Will he join me in paying tribute to the dedicated staff at Southern Health facilities that are not implicated in these serious problems, including Parklands hospital in my constituency, which provides acute wards for adults needing intensive psychiatric care, in a much-needed facility that has very dedicated staff running it?

Alistair Burt

Absolutely. When I got the report over the weekend and turned to the summary of findings, I saw that the first positive summary finding was:

"Staff were kind, caring, and supportive and treated patients with respect and dignity. Patients reported that some staff went the 'extra mile'."

It is important to put that on the record; it does not minimise the things that are wrong, but in a trust that is so large, covering such a wide area and so many people, it is important that that good work is recognised, and that errors and faults of management and governance should not be laid at their door. I pay tribute to those staff, who work in incredibly difficult circumstances.

- Several hon. Members rose—

Mr Speaker

I just note in passing that four Members on the Opposition Benches are standing and none of them hails from the area covered by the trust. That does not preclude a question, but I should just make the point that the question must be about this trust and this set of circumstances, rather than, as is commonly deployed in this House, "and elsewhere". It is just about this matter, in this situation, covered by this trust—a matter that will be approached with great dexterity, I am sure, by Ann Clwyd.

Ann Clwyd (Cynon Valley) (Lab)

I will attempt that, Mr Speaker. I just want to ask the following: how long does it take to effect change? Some 45 years ago, the Ely hospital inquiry took place, under the chairmanship of Geoffrey Howe, and recommendations were made. I took part, writing a report on the condition of mental health facilities throughout Wales. We are talking about some 45 years here, and it seems to me that things are going at such a slow pace that we will be asking the same question again in 45 years' time.

Alistair Burt

The frustration in the NHS is that although what the right hon. Lady says is not true in some places, it is in others; the special measures process in effect at the moment has effected change and has done so more quickly. There are other places where that does not happen. I am concerned that for too long in mental health the sense of defensiveness

which we know has characterised parts of the NHS for too long has probably had too great a grip, and we have not always got things done more quickly or demanded that things are done with the degree of urgency that we would expect, on behalf of constituents. I am very determined that any difficulties in getting things done locally in trusts when they need to be done will not be aided or abetted by any lack of urgency in the Department or the upper reaches of the NHS with which we have contact. The concern to make sure that urgency is there is rightfully expressed by the House, and we have to see that that is delivered.

Dr Julian Lewis (New Forest East) (Con)

In 2011 and 2012, I was locked in a bitter confrontation with Southern Health Foundation Trust over the determination of its top management to close no fewer than 58 out of its 165 acute in-patient beds for people suffering from mental health illnesses and breakdowns. It is the only constituency issue over which I have ever suffered sleepless nights, and I failed to stop the trust closing the Windsor ward in the relatively new Woodhaven hospital in my constituency. Today, apart from this terrible issue about the deaths, the system remains overfull, the beds remain too few and I understand that at least 80% of the in-patients are people who have been sectioned, leaving people a very low chance of getting an elective bed from Southern Health unless they are prepared to wait a long time. Can the CQC look into this wider issue, given that it has so many other serious concerns about the trust?

Alistair Burt

The CQC's powers are extensive and I know that it will absolutely know what my hon. Friend says. The debate comparing the provision of beds for treatment with community treatment has been going on for some time in mental health, and different pathways are taken by different trusts. Some trusts put more people into beds, while others are doing more in the community. The general sense is that more should be available in the community, but that must not preclude the availability of emergency beds when they are needed. I will ensure that the CQC is aware of my hon. Friend's concerns about that particular trust.

Paula Sherriff (Dewsbury) (Lab)

Are the failures at Southern Health a symptom of the growing and unsustainable pressure being placed on the mental health and learning disability services? In the context of increased demand, significant pressure on beds, higher thresholds for care, staffing cuts and shortages, how can the Minister guarantee that mental health and learning disability trusts are able to do their jobs?

Alistair Burt

Let me point out that we have announced an increased resource for mental health of £11.7 billion. The extra £1 billion that the Mental Health Taskforce recommended being spent by 2020 will be spent, and it will be spent right across the board from perinatal mental health to crisis care. It will also improve baselines to ensure that the governance

and quality of foundation trusts are good enough, and we are watching what CQCs are spending. Yes, we recognise that there has been historic underfunding from Governments of all characters, but we are determined to improve it and the money is there.

Caroline Nokes (Romsey and Southampton North) (Con)

All too often it is our constituents with mental health problems and learning difficulties who find it hardest to get their voices heard. Those who are patients of Southern Health are not in a position to call for urgent change. I note that the Minister has said that the delivery plan is being evaluated, but can he reassure us that that is being done with the utmost speed so that we see improvements on the ground and not just more reports gathering dust?

Alistair Burt

Today, I met departmental officials and spoke to the regional director responsible for NHS improvement and, as I mentioned earlier, the deputy chief inspector of the CQC who is responsible for this report. I can assure my hon. Friend that, in so far as it is up to me or the Department, that change will be adequately delivered with a sense of urgency, because, as she rightly says, patients and families have, in some cases, waited much too long for this. If warm words are to mean anything, we must show that delivery follows.

Greg Mulholland (Leeds North West) (LD)

The failure of care for people with mental health issues, learning disabilities and autism has been shocking and the board should go. Equally shocking is that, 11 months before Connor Sparrowhawk's tragic and unnecessary death, failures had been identified but not acted on. What can the Minister do to ensure that, as part of a robust inspection regime, when failures are identified they are acted on and done so very quickly to prevent such failures again?

Alistair Burt

Over the past 12 months I have met a number of families who have been victims in similar circumstances—some had children who had been placed badly in an inappropriate place, and, in one or two cases, death had been the result. My colleagues and I are determined to do whatever we can to break down those situations where people feel that they have to fight for everything, and where they find closed doors against them when they want to challenge something. All too often in mental health, when people are challenged, they respond defensively. The whole transforming care process stems from Winterbourne View and the determination of the NHS and the board that monitors and oversees that process, including those who have mental health issues themselves and their advocates. The concerns that have been expressed in the past will not go completely, but I am sure the system is better placed now to deal with them and to listen to people more seriously than was the case, tragically, in the past.

Suella Fernandes (Fareham) (Con)

Does the Minister agree that the resignation of the chairman is a measure of the seriousness of the issue, and that after two damning reports, serious changes in the leadership are needed? What reassurance can he provide to my constituents in Fareham, such as the family of David West, that the regulatory bodies have the powers necessary if intervention is required?

Alistair Burt

I know that my hon. Friend has followed these matters closely for her constituents. Since last year there have been nine changes to the board, and the chair of the board left last weekend. NHS Improvement has the powers to alter governance, and I know from speaking to NHS Improvement that it takes that power and responsibility extremely seriously. The balance is between ensuring continuity and stability so that what the trust has promised is delivered, and wholesale change, which would provide an opportunity for further delay and prevent the work going on, but I know that NHS Improvement is very aware of its responsibilities in relation to governance, as I hope is the trust itself.

Debbie Abrahams (Oldham East and Saddleworth) (Lab)

It is right that this House legislated for parity of esteem for mental health care; I am proud that we did that. I recognise the Minister's commitment to quick resolution so that we can implement recommendations to address the failings of the trust. Will he consider an independent inquiry similar to the first independent inquiry into Mid Staffs that my right hon. Friend the Member for Leigh (Andy Burnham) initiated in 2010?

Alistair Burt

I can do nothing more than repeat what I said earlier. I am aware that there might be circumstances in which an inquiry would bring out more and would demonstrate the degree of concern that colleagues in the House might find appropriate and that the families and others would understand. My first duty is to make sure that everyone is safe in the trust and to ensure the completion of the work that needs to be done to deliver what the CQC has found. Even after this very thorough work by CQC, which is transparent—that is why we are talking about it today—if anything further is needed, I will give it genuine and serious consideration.

Kit Malthouse (North West Hampshire) (Con)

The Minister is right to call the report disturbing. It has caused alarm and uncertainty across my constituency, and it is with the uncertainty that I hope he can help. In common with other Members, I am keen to know whether he has a hard date by which the trust is to be reviewed again. If it were to fail that hurdle, what would the next action be—revocation of the licence or further improvements? He will understand that most of my constituents want to see a deadline for compliance and after that, significant change that might mean a new era at Southern Health.

Alistair Burt

The best way that I can convey it is to say that constant monitoring is being done. First, the improvement director, who was appointed not by the trust, but by NHS Improvement, is there. In due course he will have a constant presence, but the monitoring needs to be done on a very regular basis. Also, the CQC has made it clear that should there be any need for further unannounced inspections, it will carry them out, so the trust is under constant notice that there can be a further inspection at any time. Further powers of the CQC include issuing another warning notice, varying and removing conditions of registration, monetary penalty notice for prescribed offences, suspending registration, cancelling registration, and prosecution. I understand from speaking to Mr Paul Lelliott that none of these measures has been ruled out.

Marie Rimmer (St Helens South and Whiston) (Lab)

It is that very point I wish to talk about. The duty of candour was going to give us so much more strength, but it is not being applied as yet. It is a statutory duty, placed on people carrying out regulated activities. It can lead to prosecution by the CQC, including without a warning notice. Will the Minister assure me that he will watch carefully to make sure that the CQC uses those powers appropriately? If it does not, we are once again failing these very vulnerable people.

Alistair Burt

Absolutely. If we now have a system where there is, quite rightly, a degree of autonomy, and Ministers' responsibility is to make sure that the process and the system work well, Ministers cannot make all the decisions personally, but we do have to make sure that decisions that need to be taken are taken and, if not, that there is a good explanation why.

The CQC's powers have been strengthened. Just a few months ago, we had the first case of a care home owner being jailed because of the care given to people in their home. While I recognise that the work done in caring for vulnerable people is complex and difficult, and that prosecution will not be the right answer in every case, knowing that powers are there is really important. The hon. Lady's anger is appropriate, and I know the CQC takes these powers very seriously.

Bob Stewart (Beckenham) (Con)

Does the NHS improvement director now have the power to go into any Southern Health NHS Foundation Trust facility to assess and neutralise threats we have learned about that have resulted in people dying?

Alistair Burt

I hope my hon. Friend will forgive me, but I will not say things from the Dispatch Box that I do not know, and I do not know the precise powers of the improvement director, although I know the CQC has exactly the powers my hon. Friend suggests. However, the purpose of appointing the improvement director, and indeed of NHS Improvement's appointment of the new chair, Tim Smart—the former chief executive of King's College Hospital NHS Foundation Trust—is to put in place people who know what they are doing, know what they are looking for

and can authorise others to make sure that nothing is being covered up and that everything is transparent.

Chris Heaton-Harris (Daventry) (Con)

In this sorry saga, what assurances can the Minister give about current levels of care and safety to the families of patients with learning disabilities who are in the care of Southern Health?

Alistair Burt

I think the best thing, genuinely, is to refer to the CQC report. It highlights good practice and good work in relation to staff in a variety of places and community pathways and in relation to work being done for those with learning disabilities. This is a large trust, covering many areas and many different facilities, and it would be quite wrong to assume that the standard of care is uniform across the board in terms of the criticisms that have been made. The criticisms are very real and very strong, but the work done by individual members of staff caring for people is reported by the CQC to be good. Again, in terms of safety, I am reassured that the CQC has powers and that it has assured me that, if it needed to use those powers in relation to safety and risk to patients, it would do so.

Mr Speaker

I thank the Minister and other colleagues who have taken part in these exchanges. I content myself simply with the observation that they have been a very important treatment of a very important subject. Perhaps, on behalf of the House, I can express the hope that the *Hansard* text of these exchanges will be supplied to Southern Health NHS Foundation Trust. It needs to know that we have treated of it and what has been said—politely and with notable restraint, but with very real anxiety—in all parts of the House about the situation within its aegis. [Hon. Members: "Hear, hear!]

03 May 2016 | 609 cc38-48

Southern Health NHS Foundation Trust

Asked by: Luciana Berger

Commons

To ask the Secretary of State for Health, what communication his Department has had with Southern Health NHS Foundation Trust since the warning notice issued to that trust by the Care Quality Commission on 6 April 2016.

Answered by: Alistair Burt

There has been one piece of incoming correspondence from the Southern Health NHS Foundation Trust to the Department on 11 April 2016, which has not yet received a reply.

26 April 2016 | Written questions | 35090

Southern Health NHS Foundation Trust

Asked by: Norman Lamb

To ask the Secretary of State for Health, when NHS England will publish the findings of the Mazars review into the deaths of people with mental health problems and learning disabilities at Southern Health NHS Foundation Trust.

Answered by: Alistair Burt

I refer the Rt. Hon. Member to the Written Ministerial Statement of 17 December 2015, HCWS421. NHS England published the Mazars report on Southern Health NHS Foundation Trust on 17 December 2015. The report is available on the NHS England website.

21 Dec 2015 | Written questions | 20267

Southern Health NHS Foundation Trust

Asked by: Heidi Alexander

To ask the Secretary of State for Health, when (a) his Department, (b) NHS England and (c) Southern Health NHS Foundation Trust first received a copy of the Mazers report on Southern Health NHS Foundation Trust.

Answered by: Alistair Burt

A search of the Department's Ministerial correspondence database has identified 40 items of correspondence expressing concerns about Southern Health NHS Foundation Trust. This figure represents correspondence received by the Department's Ministerial correspondence unit only.

In 2014, NHS England initiated action including an investigation of the deaths of all patients of the trust who had been in receipt of mental health or learning disability services since 2011.

We are advised by NHS England that a first draft of the Mazars report was shared with it and Southern Health Foundation Trust in September 2015. The Department has not received a copy of the report and the report is still to be finalised before publication.

15 Dec 2015 | Written questions | 19687

Southern Health NHS Foundation Trust

10 Dec 2015

Heidi Alexander (Lewisham East) (Lab) *(Urgent Question)*: To ask the Secretary of State for Health if he will make a statement on the report of the investigation into deaths at Southern Health NHS Foundation Trust.

The Secretary of State for Health (Mr Jeremy Hunt): The whole House will be profoundly shocked by this morning's allegations of a failure by Southern Health NHS Foundation Trust to investigate over 1,000 unexpected deaths. Following the tragic death of 18-year-old Connor Sparrowhawk at Southern's short-term assessment and treatment unit in Oxfordshire in July 2013, NHS England commissioned a report from audit providers Mazars on unexpected deaths between April 2011 and March 2015.

The draft report, submitted to NHS England in September, found 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. Of 1,454 deaths reported, only 272 were investigated as critical incidents, and only 195 of those were reported as serious incidents requiring investigation. The report found that there had been no effective, systematic management and oversight of the reporting of deaths and the investigations that follow.

Prior to publication, or indeed showing the report to me, NHS England rightly asked the trust for its comments. It accepted failures in its reporting and investigations into unexpected deaths, but challenged the methodology, in particular pointing out that a number of the deaths were of out-patients for whom it was not the primary care provider. However, NHS England has assured me this morning that the report will be published before Christmas, and it is our intention to accept the vast majority, if not all, of the recommendations it makes.

Our hearts go out to the families of those affected. More than anything, they want to know that the NHS learns from tragedies such as what happened to Connor Sparrowhawk, and that is something we patently fail to do on too many occasions at the moment. Nor should we pretend that this is a result of the wrong culture at just one NHS trust. There is an urgent need to improve the investigation of, and learning from, the estimated 200 avoidable deaths we have every week across the system.

I will give the House more details about the report and recommendations when I have had a chance to read the final version and understand its recommendations, but I can tell the House about three important steps that will help to create the change in culture that we need. First, it is totally and utterly unacceptable that, according to the leaked report, only 1% of the unexpected deaths of patients with learning disabilities were investigated, so from next June, we will publish independently assured, Ofsted-style ratings of the quality of care offered to people with learning disabilities for all 209 clinical commissioning group areas. That will ensure that we shine a spotlight on the variations in care, allowing rapid action to be taken when standards fall short.

Secondly, NHS England has commissioned the University of Bristol to do an independent study of the mortality rates of people with learning disabilities in

NHS care. This is a very important moment at which to step back and consider the way in which we look after that particular highly vulnerable group.

Thirdly, I have previously given the House a commitment to publishing the number of avoidable deaths, broken down by NHS trust, next year. Professor Sir Bruce Keogh has worked hard to develop a methodology to do this. He will write to medical directors at all trusts in the next week explaining how it works, and asking them to supply estimated figures that can be published in the spring. Central to that will be establishing a no-blame reporting culture across the NHS, with people

being rewarded, not penalised, for speaking openly and transparently about mistakes.

Finally, I pay tribute to Connor's mother, Sarah Ryan, who has campaigned tirelessly to get to the bottom of these issues. Her determination to make sure the right lessons are learned from Connor's unexpected and wholly preventable, tragic death is an inspiration to us all. Today, I would like to offer her and all other families affected by similar tragedies a heartfelt apology on behalf of the Government and the NHS.

Heidi Alexander: These are truly shocking revelations that, if proven, reveal deep failures at Southern Health NHS Foundation Trust. The BBC has reported that the investigation found that more than 10,000 people died between April 2011 and March 2015. Of those 10,000 deaths, 1,454 were not expected. Only 195 of those unexpected deaths—just 13%—were treated by the trust as a serious incident requiring investigation. Perhaps most worryingly, it appears that the likelihood of an unexpected death being investigated depended hugely on the patient: for those with a learning disability, just 1% of unexpected deaths were investigated, and for older people with a mental health problem, just 0.3%.

We obviously await a full response from the Government when the report of the investigation is published, but a number of immediate questions need answers today. First, does the Health Secretary judge services at the trust to be safe? A recent Care Quality Commission report found that

"inadequate staffing levels in community health services was impacting on the delivery of safe care."

What advice can he give patients, and the families of patients, currently in the care of Southern Health?

Secondly, the Health Secretary confirmed in his reply that NHS England received the report in September, but can he explain why it still has not been published, and can he provide a specific date on which the final report will be made publicly available?

Thirdly, when was the Health Secretary first made aware of concerns about Southern Health, and what action did he take at that time? What does he have to say to the relatives and friends of people who have unexpectedly died in the care of the trust and who, today, will be reliving their grief with a new anxiety?

The issue raises broader questions about the care of people with learning disabilities or mental health problems. Just because some individuals have less ability to communicate concerns about their care, that must never mean that any less attention is paid to their treatment or their death. That would be the ultimate abrogation of responsibility, and one which should shame us all.

The priority now must be to understand how this was allowed to happen, and to ensure this is put right so it can never happen again.

Mr Hunt: I agree with what the shadow Health Secretary says. She is absolutely right in both the tone of what she says, and in the seriousness with which she points to what has happened. It is important to say that this is only a draft report. To put the hon. Lady's mind at rest, I am completely satisfied that NHS England took this extremely seriously from the moment we understood that there was an issue about the tragic death of Connor Sparrowhawk. David Nicholson, the then chief executive of NHS England, and Jane Cummings, the chief nurse, met the family and ordered the independent investigation. It is a very thorough investigation.

As the hon. Lady will understand, when there is an investigation about something as serious as avoidable mortality, we have to give the trust the chance to correct any factual inaccuracies and challenge the methodologies. It has taken from September until now to get to the point in the process where the report is ready to be published. I have been assured by Jane Cummings this morning that it will be published before Christmas. We will not allow any further arguments about methodologies to stand in the way of the report being published before Christmas, as was always planned.

On the hon. Lady's very important question about whether services are safe at Southern Health, we have the expert view on that, because we set up a new chief inspector of hospitals and a new inspection regime. There was an inspection of Southern Health, and it got a "requires improvement". The inspectors were not saying that its services were as safe as they should be, but that its services, along with those of many other trusts in the NHS, needed to become safer. She was right to draw attention to some of the failings alluded to in the report.

The hon. Lady can draw comfort from the fact that this matter has been taken seriously. NHS England commissioned a report, which is, by all accounts, hard-hitting. I have been following the situation since we first understood the issues around Connor Sparrowhawk's tragic death, and so has NHS England. That is why we have a report that I think will lead to important changes.

The fundamental question on which we all need to reflect is why we do not have the right reporting culture in the NHS when it comes to unexpected deaths. We have to step back, be honest and say that there are reasons, good and bad, for that. People are extremely busy, and there is a huge amount of pressure on the frontline. People have an understandable desire to spend clinical time dealing with the patients who are standing in front of them, rather than going over medical notes and trying to understand something that went wrong. Sometimes, there will be prejudice and discrimination. The whole House will unite in saying that we must stamp that out. Sometimes, people do not speak out because they are worried that they will be fired or penalised. We have to move away from a blame culture in the NHS to a culture in which doctors and nurses are supported if they speak out, which too often is not the case.

The whole House will want to unite in supporting the leaders of the NHS who want to change that culture. It is unfinished business from Mid Staffordshire NHS Foundation Trust; it is important to get it right, and I know that the NHS is determined to do just that.

Dr Sarah Wollaston (Totnes) (Con): The allegations in the draft report about Southern Health are deeply disturbing, and I welcome the steps that the Secretary of State has announced. In particular, I am pleased that he will not treat this as an isolated incident. The key findings of the draft report show that in nearly two thirds of the investigations, there was no family involvement. Will he immediately send the message out to all trusts that it is vital to involve family members, particularly when we are talking about those who cannot speak for themselves?

Mr Hunt: I will do that, and I am very grateful to my hon. Friend for giving me the opportunity to do so. We see this situation all too often. There was a story in the Sunday newspapers about a family being shut out of a very important decision about the unexpected death of a baby. It is incredibly important to involve families, even more so in the case of people with mental health problems or learning disabilities. The family may be the best possible advocates for someone's needs.

We need to change the assumption that things will become more difficult if we involve families. More often than not, something like litigation will melt away if the family is involved properly from the outset of a problem. It is when families feel that the door is being slammed in their face that they think they have to resort to the courts, which is in no one's interests.

Dr Philippa Whitford (Central Ayrshire) (SNP): I echo what the Secretary of State said about family involvement, which should be routine in investigating an adverse event. It definitely takes the heat out of the situation.

There are two issues here. One is the shocking difference between 30% of adult deaths being investigated, and just 1% of deaths of people with learning disabilities, and Connor represents the human face of that, which is frightening. The second issue is about individual trusts being left to decide what and how much they investigate, and what they produce, because a much more systematic consideration of the data is required. NHS England publishes annual mortality figures. Strikingly, 16 trusts that were identified with higher than expected mortality levels also had higher than expected mortality the year before, yet it appears that no action was taken. The benchmark appears to be "average", but if we have poor performance, that average is lower. We should set our aspirations higher than that.

Mr Hunt: The hon. Lady is absolutely right. The 30% figure was for people with mental health conditions, not for all adults, but I question why we are investigating only 30%—the highest figure at Southern Health NHS Trust—of unexpected deaths. These were not just deaths; they were unexpected deaths, and it is the duty of medical directors in every trust to satisfy themselves that they have thought about every unexpected death. We must reflect on these serious matters.

The hon. Lady is right about the need to systematise processes when there is an unexpected death, so that we do not have a big variation between trusts. The exercise that Sir Bruce Keogh is doing, going around all the trusts, is about trying to establish a standardised way of understanding when a death is or is not preventable. The hon. Lady has been a practising clinician, so I am sure she will understand that at the heart of this issue is the need to get the culture right. Clinicians should not feel that a trust will take the easy route and blame it all on them, rather than trying to understand the system-wide problems that may have caused a clinician to make a mistake in an individual instance, and that is what we must think about.

Jeremy Lefroy (Stafford) (Con): Behind each statistic is a person and a family, and the Secretary of State is right to say that finger-pointing should not be directed at clinicians alone; it is more important to consider the whole system and the culture in a trust. Will he encourage all trusts, and all medical and nursing schools, to make the Francis report on Mid Staffordshire compulsory reading? There is so much in there that could prevent such occurrences in future.

Mr Hunt: No one knows more about the Francis report than my hon. Friend, because of the direct impact that it had on his local hospital, and he is right to talk about that culture change. There is an interesting comparison with the airline industry: when it investigate accidents, the vast majority of times, those investigations point to systemic failure. When the NHS investigates clinical accidents, the vast majority of times we point to individual failure. It is therefore not surprising that clinicians feel somewhat intimidated about speaking out. People become a doctor or nurse because they want to do the right thing for patients, and we must support them in making that possible.

Norman Lamb (North Norfolk) (LD): The coalition Government rightly established a public inquiry to look into the appalling care at Stafford hospital, and the Secretary of State has pointed to the challenge to the culture that the Francis report engendered following that scandal. Is this the moment to consider something similar for people with learning disabilities, or those with severe and enduring mental ill health, who too often continue to be treated as second-class citizens in our NHS? Sara Ryan, Connor Sparrowhawk's mother, has called for a public inquiry. Will the Secretary of State consider that? It seems that it is time to shine a light on what is going on.

Mr Hunt: I am happy to consider that. The right hon. Gentleman and I are completely on the same page on these issues. My only hesitation is that a public inquiry will take two, three or four years, and I want to ensure that we take action now. I hope I can reassure him and the House that by, for example, publishing Ofsted-style ratings for the quality of care for people with learning disabilities across every clinical commissioning group, we will shine a spotlight on poor care in the way that the Francis report tells us that we must. I do not see the treatment of people with learning difficulties as distinct from the broader lessons in the Francis report, but if we fail to make progress, I know that the right hon. Gentleman will come back to me, and rightly so.

Caroline Nokes (Romsey and Southampton North) (Con): Many of my constituents are service users of Southern Health, or the family members of service users. They are looking for reassurance from the Secretary of State that there will not simply be an immediate

intense spotlight but an ongoing one, so that they can have confidence that the scrutiny and oversight, particularly for young people with learning difficulties, will be ongoing.

Mr Hunt: I can absolutely give that assurance to my hon. Friend's constituents. I hope they will consider the tone of my w and realise that we are not looking at this simply as an issue for Southern Health. Clearly, important changes must happen there and must happen quickly, and we will do everything we can to make sure that they happen. I also think, however, that there is a systemic issue in relation to the low reporting of avoidable and preventable deaths and harm, and the failure to develop a true learning culture in the NHS, which in the end is what doctors, nurses and patients all want and need.

Mr Ben Bradshaw (Exeter) (Lab): I thank the Secretary of State for his statement and congratulate NHS England on what sounds like a very thorough report. I remind him that challenging the methodology was exactly the same first line of defence used by the now disgraced management at Mid Staffs hospital. Will he answer the specific question my hon. Friend the Member for Lewisham East (Heidi Alexander) asked as to when Ministers first knew about problems in the trust, which we hear go back to 2011, and what action they took as a result?

Mr Hunt: I thank the right hon. Gentleman for his comments. I hope I did address that by saying that the first time was when we realised there were issues around the tragic death of Connor Sparrowhawk. That is what started the process and led to the independent investigation. Because NHS England wanted it to be very thorough, that investigation went right back to 2011 and up to 2015. It looked at all unexpected deaths in that period, and at the reporting culture and lessons that had or had not been learned as a result. A lot of action has been taken. I can also reassure the right hon. Gentleman that during that period we have been implementing the recommendations of the Francis report, which has meant that throughout the NHS there is much greater focus on and transparency in patient safety.

It is important to give the NHS credit. During the past three years, we have actually seen a 25% increase in the number of reported incidents. I think people are treating this much more seriously than in the past, but there is much more to do.

Mrs Cheryl Gillan (Chesham and Amersham) (Con): I, too, welcome my right hon. Friend's statement and the news that he plans to accept the recommendations of this very sobering report. Will he reassure the House that anyone found to have been deliberately contributing to patient neglect or failing to investigate avoidable deaths will be held to account both by the professional regulators and the full weight of the law?

Mr Hunt: I can of course give my right hon. Friend that assurance, but there is a note of hesitation in my response. That is partly because professional standards, as my right hon. Friend knows, are not a matter for politicians—they have to be set independently by the General Medical Council and the Nursing and Midwifery Council—and partly because if we are going to improve the reporting culture, which in the end is what the report is about, we have to change the fear that many doctors and nurses have that if they are open and transparent about mistakes they have made or seen, they will get dumped on. That is a real worry for many people. Part of this is about creating a supportive culture, so that when people take the brave decision to be open about something that has gone wrong they get the support that they deserve.

Mark Durkan (Foyle) (SDLP): As well as asking the Secretary of State how the learning on this very important issue will be shared with the devolved Administrations, may I ask whether all other trusts are being advised that they will now probably receive approaches from families — no doubt Members may be contacted in this regard, too—who have questions about their own experiences? Will he ensure that they will be sensitive to such approaches about possible historical cases?

Mr Hunt: I can give the hon. Gentleman that reassurance. Trusts understand that that is already happening and has been happening. All trusts will have families that have been in touch with them with concerns about potentially avoidable or preventable deaths. I hope that this will be a reminder to all trusts that they need to take those concerns very seriously indeed.

Dr Andrew Murrison (South West Wiltshire) (Con): The disparity in excess deaths between vulnerable groups at Southern Health is truly shocking, but of course responsibility for looking after the people in question spans health and social care. Is my right hon. Friend content that we have in place the informatics that will allow outliers to be identified, and therefore rectification to be under way? One assumes that that could easily be done by NHS England, but at the moment the informatics seem to be problematic in this respect.

Mr Hunt: My hon. Friend is absolutely right. That is why Professor Sir Bruce Keogh is developing a methodology to help us understand the number of avoidable deaths and the reporting culture on a trust level. We have a good methodology for understanding the number of avoidable deaths on a national level. The Hogan and Black analysis says that about 3.6% of deaths have a 50% or more chance of being avoidable. However, we will not get real local action until we localise it, and that is the next step.

Diana Johnson (Kingston upon Hull North) (Lab): Is the Secretary of State satisfied that families seeking truth and justice for their loved ones are having to rely on pro bono lawyers for advice and representation, and on crowdsourcing to get legal advice?

Mr Hunt: I am afraid that that probably does happen. We all, in all parts of the House, passionately believe in and support the NHS. It should never come down to lawyers. When there is a problem, we need

a culture where the NHS is totally open and as keen as the families are themselves to understand what happened, whether it could be avoided, and what lessons can be learned. If nothing else, that is the big lesson that we need to make sure we act on as a result of today's leaked report.

Bob Blackman (Harrow East) (Con): It is clear from my right hon. Friend's statement that there is a cultural problem in Southern Health and across the NHS. Does he agree that far too often NHS management and clinicians are far too defensive and end up arguing about the data rather than addressing the underlying causes, which would fix the problem in the first place?

Mr Hunt: My hon. Friend is right. It is quite heartbreaking that when these things happen we seem to end up having an argument about methodology and statistics, and whether it is this many thousand or that many thousand, rather than looking at the underlying causes. We have to ask ourselves why people feel that they need to be defensive in these situations. We have to recognise that everyone is human, but, uniquely, doctors are in a profession where when they make mistakes, as we all do in our own worlds, people sometimes die. The result of that should not automatically be to say that the doctor was clinically negligent. Ninety-nine times out of 100, we should deduce from the mistake what can be learned to avoid it happening in future. Of course, where there is gross negligence, due process should take its course, but that is only on a minority of occasions. That is where things have gone wrong.

Mr Barry Sheerman (Huddersfield) (Lab/Co-op): Not many people are as grateful to the NHS as I am, having just returned to full health thanks to the intervention of the wonderful team at Guy's hospital, so any criticism I make of the NHS is in the generality. Many of us have known for a long time that there is a problem with access to full NHS treatment for people with learning difficulties. In particular, speaking as a member of the newly formed Autism Commission I can say that many people on the autism spectrum have poor communication skills and finish up with inadequate access to the health service. I do not particularly want a public inquiry; I want fast action to change the culture now. The Secretary of State is absolutely right about that.

Mr Hunt: I am delighted that the hon. Gentleman was looked after by Guy's and St Thomas's, where my mother was a nurse and where I was born, so I have connections to that trust as well. He is right about making sure that we get the culture right. It is about creating a more supportive environment for people who do a very, very tough job every day of the week. When we have a conversation along those lines with patients and with our constituents, they understand that as well. More than anything else, they want to know that lessons are going to be learned and acted on.

Mr Andrew Turner (Isle of Wight) (Con): Was it necessary to delay the report's publication for two or three months—a week or two I could

understand—and will it now be published not in a fortnight's time, before Christmas, but next week, when we will be here?

Mr Hunt: I hope it will be published next week. The commitment I have from NHS England is that it will be published before Christmas. I am confident that, whenever it is published, it will generate huge media interest, rightly so and partly thanks to the shadow Health Secretary's urgent question. When the draft report was sent to the trust, it came back with 300 individual items of concern, and it was right for NHS England, in the interests of accuracy and justice, to consider fully all those concerns. It has given me an assurance, however, that, whether or not it can reach an agreement with the trust about its contents, the report will be published before Christmas.

Mr Jim Cunningham (Coventry South) (Lab): What will the Secretary of State do about whistleblowers? As most Members know, we have had problems over the years with whistleblowing and people being victimised by the NHS after raising concerns.

Mr Hunt: Sir Robert Francis's report "Freedom To Speak Up", which I received and presented to Parliament just before the election, looked specifically at this issue and the difficult problems people face when they speak out about a problem in their trust. Sadly, on occasions, not only are they hounded out of that trust but they find it difficult to find a job anywhere else in the NHS, because word gets round on the old boys' network. I think, however, that if we need whistleblowing at all, we have failed. We need a culture where, when people raise concerns, they are confident they will be listened to. That is a big statement to make, but other industries have managed it, including the airline, nuclear and oil industries. I do not think any health care service in any other country has managed to get this right. Individual hospitals—Salford Royal in this country, Virginia Mason in Seattle—have fantastic learning cultures, but I want the NHS to be the first whole health economy to get that culture right.

Rehman Chishti (Gillingham and Rainham) (Con): I welcome the Secretary of State's answer to the urgent question. I speak as a Member with a hospital in special measures that had the seventh-highest mortality rate in the country in 2005-06. Does he agree that to address this problem we need tough CQC inspections, good local leadership—Medway hospital now has an excellent chief executive—and the right support from the Government?

Mr Hunt: My hon. Friend is absolutely right. It seems wrong to draw any crumbs of comfort from the awful things in the draft report, but we can draw some comfort from the fact that the NHS itself is commissioning hard-hitting reports that do not pull any punches—the new CQC inspection regime does exactly that. I commend all the staff at Medway hospital who have worked so hard to raise the standard of care over the last few years. I know it has not been easy for them.

Liz McInnes (Heywood and Middleton) (Lab): The Secretary of State has not yet mentioned the role of the medical examiner. Does this latest tragedy not illustrate that the introduction of a national system of

medical examiners, as recommended by the Shipman, Mid Staffs and Morecambe Bay public inquiries and supported by the Royal College of Pathologists, is now long overdue?

Mr Hunt: I agree with the hon. Lady. It was also a recommendation of the Francis report that the coalition Government committed to implementing. We will tell the House shortly what our plans are on this front.

Mr David Nuttall (Bury North) (Con): People will be both saddened and dismayed that after Mid Staffs and the new CQC inspection regime such problems can still arise. Does the Secretary of State agree that, although there is no simple solution, the solution certainly does not lie in trusts adopting and relying on a tick-box approach to safety?

Mr Hunt: My hon. Friend is absolutely right. It is worth saying that the tragedy that sparked this report happened before the new CQC inspection regime had got under way. The old CQC regime was rather a tick-box approach, partly because the people doing the inspections were often not doctors who could make peer-review judgments about the quality of services. If someone is not a doctor, there is a tendency to want to tick yes or no in reply to a question rather than to deal with the underlying issues. Having judgment in our inspections will be a very important step forward.

Ruth Cadbury (Brentford and Isleworth) (Lab): This investigation would not have happened if it had not been for the tenacity and work of Sara Ryan, Connor Sparrowhawk's mother. Is it right that the family's legal representation was funded by crowdsourcing?

Mr Hunt: I think it is tragic when anyone has to resort to the courts to get justice. Sara Ryan is one of many who have had to go to huge out-of-pocket expenses to get justice and the truth with respect to their loved ones. Last week, I went to the launch of James Titcombe's book. He campaigned for years and years to get justice and the truth about the death of his son, Joshua. That is exactly what we have to change.

Mrs Flick Drummond (Portsmouth South) (Con): Will the Secretary of State confirm that the draft report also covers the Southern Health Foundation community-based mental health services for adults? That received a "good" in the CQC report published in February 2015. Is my right hon. Friend satisfied that the CQC report was rigorous enough?

Mr Hunt: I believe it does cover the mental health services for adults, but I will check and write to my hon. Friend. When the CQC does its inspections, it is important for it to inspect individual elements of what a trust does, and it gives different ratings to different parts. We need to recognise that even within one trust it is possible to have big variations in the quality of care. As I say, I will look further into this and write to my hon. Friend.

Peter Kyle (Hove) (Lab): The Secretary of State rightly mentions the fact that the culture needs to change so that people can be more uninhibited about talking about the problems they face within trusts and hospitals. May I remind him that the culture is set from the top? I

therefore invite him to come to the Dispatch Box again and inform the families and the House when Ministers first knew that there were problems in this trust.

Mr Hunt: I think this is now the third time I have said it, but the answer is that Connor Sparrowhawk's tragic death happened in July 2013. Sara Ryan then campaigned bravely. As always on these occasions, it started with a local process where concerns were raised with the trust. The matter was escalated to NHS England in early 2014 when David Nicholson, the chief executive, and Jane Cummings, the chief nurse, got involved. Ministers were kept informed throughout, and that was the point at which Mazars—*[Interruption.]* I have just said that Ministers were kept informed of what NHS England was doing throughout, but that was the point at which the report by Mazars was commissioned. It is a very thorough report, and we will see it when it is published before Christmas.

10 Dec 2015 | 603 cc1140-1150

4.2 Written Statement

Southern Health NHS Foundation Trust

NHS England will today publish the Mazars report on Southern Health NHS Foundation Trust. It will be available on the NHS England website later today at https://www.england.nhs.uk/south/our-work/ind-invest-reports/. I want to update the House on the action that the NHS will be taking in response.

The report describes, as I set out to the House on 10th December (HC Deb, Col 1141-2), 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. The report found that there had been no effective, systematic management and oversight of the reporting of deaths and the investigations that follow.

I am determined that we learn the lessons of this report, and use it to help build a culture in which failings in care form the basis for learning for organisations and for the system as a whole.

As a first step, I am announcing a number of measures today to address both the local issues at Southern Health NHS Foundation Trust and the systemic issues raised in the report:

- The Care Quality Commission will undertake a focused inspection of Southern Healthcare early in the new year, looking in particular at the Trust's approach to the investigation of deaths. As part of this inspection, the CQC will assess the Trust's progress in implementing the action plan required by Monitor and in making the improvements required during their last inspection, published in February of this year.

- Avoidable mortality – understanding, action and improvement. The report reinforces the point that we need to do more across providers to understand and tackle the problem of avoidable mortality. Bruce Keogh and Mike Durkin are therefore writing to Medical Directors to describe the offer of help to providers (the mortality audit tool, case-note review

methodology and reiterating the government's commitment to delivering medical examiners) setting out how to use the audit tool to supply data to support understanding and improvement.

- Learning Disability and mortality. The Learning Disability mortality review will support improvement by acting as a repository for anonymised reports pertaining to people with learning disabilities from a variety of sources, in particular anonymised copies of Serious Case Reviews and Ombudsman Reports. This project will start in January 2016.

- The Care Quality Commission will also be undertaking a wider review into the investigation of deaths in a sample of all types of NHS trust (acute, mental health and community trusts) in different parts of the country. As part of this review, we will assess whether opportunities for prevention of death have been missed, for example by late diagnosis of physical health problems.

I will continue to update the House on progress in each of these areas. I will place a copy of the report in the Library of both Houses once it has been published by NHS England.

This statement has also been made in the House of Lords: HLWS425

17 Dec 2015 | HCWS421

Associated deposited paper: Deposited Paper DEP2016-0017NHS England will today publish the Mazars report on Southern Health NHS Foundation Trust. It will be available on the NHS England website later today at https://www.england.nhs.uk/south/our-work/ind-invest-reports/. I want to update the House on the action that the NHS will be taking in response.

4.3 Debates

Southern Health NHS Foundation Trust
03 May 2016 | House of Lords 771 | cc1371-6

NHS: Learning from Mistakes
09 Mar 2016 | 607 cc295-310

Southern Health NHS Foundation Trust
10 Dec 2015 | House of Lords | cc1681-5

Associated Deposited Paper: Deposited Paper DEP2015-0993

5. Further reading

NHS England/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 (December 2015)

CQC inspection reports for Southern Health NHS Foundation Trust (February 2015)

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