MILLS & REEVE

briefing

February 2016

Mazars' report: the importance of good quality investigations

December 2015 saw the publication of *Mazars' independent review* into 10,296 deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust. It is a damning and hard hitting report.

Although focussed on a mental health/LD provider there are lessons in the report for everyone in the health sector – providers of any size and shape and commissioners.

We recommend that the report is reviewed by Boards and Governing Bodies across the country.

www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

The Executive Summary can be found at pages 14 – 36 of what is a report running to over 250 pages.
We set out below some of their key findings and learning points.

The report starts by setting out Mazars' thinking about the purpose of reviewing the circumstances of or investigating a death which included:

- To establish if there is any learning for the Trust, the wider NHS and its partners around the circumstances of the death and the care provided leading up to a death.
- To learn from any care and delivery problems or system failures that need to be addressed to prevent future deaths and improve services.
- To identify if there is any untoward concern in the circumstances leading up to a death.
- To be in a position to provide information to the Coroner, if requested.
- To be able to work with families to understand the full circumstances and answer questions.
- To have the full detail of events available for any subsequent complaint or legal investigation.

Against that backdrop we learn the following:

key findings

- There was a lack of leadership, focus and sufficient time spent in the Trust on carefully reporting and investigating unexpected deaths.
- Despite the Board being informed / warned on a number of occasions, including by Coroners and CCGs, that the quality of SI reporting processes and standard of investigation was inadequate, no effective action was taken to improve investigations.
- The only national non statutory guidance in place for SI Reporting allows Trusts to exercise considerable discretion.
- There was no effective systematic management and oversight of the reporting of deaths and the investigations that follow.
- Timeliness of investigations was a major concern. On average it took nearly 10 months from an incident to closing a SIRI. They state categorically that “this needs to change”.
- The Trust could not demonstrate a comprehensive, systemic approach to learning from deaths as evidenced by action plans, board review and follow up, high quality thematic reviews and resultant service change.
- The involvement of families and carers was limited.
- Despite the Trust having comprehensive data relating to deaths it failed to use it effectively to understand mortality and issues relating to deaths.
- Commissioners have a role in demanding better information relating to deaths and using it to seek improvement.
- There was a high level of “attrition” from the level of deaths initially recorded to those subsequently reported and investigated. There were missed opportunities for learning as a result.
- When an investigation did occur the investigations and reports were of a poor quality. Again, this mitigated against learning.

Leadership and Board oversight

- The failure to bring about sustained improvement in the identification of unexpected death and in the quality and timeliness of reports into those deaths is a failure of leadership and governance.
- The lack of leadership, focus and sufficient time spent on reporting and investigating unexpected deaths was at all levels of the Trust, including the Trust Board.
- Due to a lack of strategic focus relating to mortality and the relatively small number of deaths in comparison to total reported safety incidents this resulted in deaths having little prominence at Board level.
- There were several facets to this which included:
    - Failure to consistently improve the quality of investigations and subsequent reports.

- Lack of board challenge to the systems and processes around investigation of deaths.
- Lack of consistent corporate focus on death reflected in board reports.
- Ad hoc and inadequate approach to involving families and carers.
- Limited information presented at board and subcommittee level.
- Lack of attention to key performance indicators indicating considerable delays in completing death investigations.

Management and oversight of death investigations

- There was a limited amount of corporate oversight at all stages of reporting and investigating deaths.
- There was lack of corporate challenge about whether the right level of scrutiny was applied.
- They had little confidence that the Trust recognised the need for it to improve its reporting and investigations.

The role of commissioners

- There had been insufficiently strong enforcement or attention paid by a variety of commissioners in requiring improvement and accepting poor quality investigations and the considerable delays in receiving reports.

Report quality and timeliness

- There was very poor quality of written investigations at all stages. At least 30% of reports were of a poor standard; some would have caused further distress to families due to the carelessness with which they have been written and some had to be returned by commissioners.
- There was little evidence that there was any effective effort to improve the quality of the reporting.
- The reports were not reviewed with any significant challenge or rigour.
- Timeliness was a major concern. Timeliness of reporting to StEIS and getting reports to closure panels was particularly weak. 90% of SIRIs were not completed within 45 days.

Learning from deaths

- The Trust could not demonstrate a comprehensive, systemic approach to learning from deaths as evidenced by action plans, board review and follow up, thematic reviews and resultant service change.
- Action plans in SIRIs could not always be linked to the evidence in the SIRI reports and the recommendations being made.

- Actions were not logged corporately and similar actions recurred throughout reports suggesting that lessons were not being learnt.
- High quality, timely investigations are crucial for learning, for families, for service improvement, for commissioners and to provide inquests with accurate information. These were not being produced.

Family and carer involvement

- 64% of investigations did not involve the family. When contacted, only 4% of families declined involvement.
- There was a lack of separation between the clinical team supporting families clinically with bereavement and the lead professional undertaking the investigation.
- When there was involvement, very few cases involved face to face meetings and concerns set out by families were not addressed.
- Reports were often careless, lacking in attention to detail with grammar, spelling and date errors that demonstrate a lack of quality review. There was also a lack of courtesy in naming the deceased.
- Radically more effort needs to be made to develop the right culture across the Trust to engage with families when deaths occur. The Trust must continue to ensure systems to monitor Duty of Candour increase meaningful involvement, in particular, when unexpected deaths occur.

recommendations

23 recommendations were directed at the Trust themselves and 9 at commissioners. There were also 7 national recommendations made.

These include:

Trust

- Ensure staff at all levels recognise the need for timely, high quality investigation and how to include families and to ensure learning is demonstrated.
- The board or its sub committees should receive regular reports of all incidents of deaths.
- The board should ensure that national and trust policy/ guidance are being followed.
- A template for a thematic review should be produced.
- Separation of people responsible for quality assurance and those undertaking investigations are needed.
- Quality assurance processes should include independent review and sign off.
- High professional standards should be achieved in written presentation.
- There should be explicit action to commence investigations promptly even when a coroner's conclusion is not immediately available unless there is a specific reason to delay.
- All deaths of service users in detention should be investigated, whether expected or not.

Commissioners

- CCGs should discuss the implications of this review with acute care providers and agree a protocol for ensuring joint investigation between NHS providers, particularly for people with LD.
- The CCG should take action to ensure that reports are provided to closure panels within 60 days as required.
- The CCG should take action to ensure that the quality of investigations improves radically.

National

- NHS England should highlight learning from this review for other NHS Trusts.
- NHS England's patient safety team should ensure that Mental Health and Learning Disability providers and Trusts are provided with focussed MH / LD case examples or a specific framework to inform their own clear and transparent local policies for deciding what deaths to report and investigate.
- NHS England should provide further guidance for Mental Health Trusts on what should be reported to CQC under Regulation 16 and to NRLS.

what next?

Readers might want to start by comparing their own organisation with the flow charts and RAG ratings on pages 88-102 of the report. These cover decisions to investigate, the investigation process and timescales. There is also a proposed framework for Board Assurance on mortality and unexpected deaths at page 107.

How would you assess the quality of your SIRI reports? Here Mazars reviewed 191 reports and only assessed 19 of those as being good or excellent!

We are working with clients on risk identification, ownership and management and on how to conduct RCA's following a serious incident. Please do not hesitate to contact us to discuss your particular requirements and needs.

The focus on the quality and timeliness of investigations is growing. The Independent Patient Safety Investigation Service (IPSIS) goes live on 1 April 2016 so we can expect the focus to intensify throughout 2016.

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