Urgent Question on the Southern Health NHS Foundation Trust (House of Commons – 10/12/2015)

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
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.