Stage 2 Investigation - Southern Health NHS Foundation Trust Review

Terms of Reference

Introduction

This paper sets out the scope and terms of reference for stage 2 of the independent review into the quality of investigations and implementation of the resulting recommendations relating to the deaths of various patients who were in receipt of care provided by Southern Health NHS Foundation Trust ("the Trust") and as recommended for further investigation by the stage 1 report, authored by Nigel Pascoe QC.

Details on the format and procedure for stage 2 will be set out by the Panel in a separate paper.

Stage 2 Terms of Reference

Stage 2 will comprise two distinct investigations:

1. Subject to the consent of Edward Hartley's family and the agreement of the Panel, the factual circumstances of the death of Edward Hartley will be investigated in line with the Terms of Reference for stage 1. If the investigation is so agreed, it will be subject to separate Terms of Reference, which will themselves be agreed with the family and the Panel;

2. A limited public investigation that is specific and focused in nature, addressing some of the thematic issues identified in the stage 1 report, which could not be determined fully on paper. Following discussion with the families and agreement from the Chair and the Chief Nursing Officer for England, it is agreed that the key concerns from those identified in the report are in relation to:

    a. The implementation of a robust, efficient and effective complaints handling procedure at the Trust
    b. The structures and procedures now in place at the Trust for communication and liaison with patients' families, both during a patient's life and afterwards
    c. The establishment of a totally independent, robust investigative structure and process to conduct transparent and fair investigations into serious accidents, deaths and complaints at the Trust
    d. The supervision structure that has been in place since 2011 by the Clinical Commissioning Group (who shall provide the relevant evidence) and how it has been exercised towards the Trust in relation to complaints and investigations, and of any planned changes in the light of public concerns
    e. How the outcome of sub-paragraphs (a) and (d) above might be extrapolated across the NHS in England, and
    f. The extent to which recommendations from previous investigations referred to in the Stage 1 report have been developed, implemented and monitored by the Trust (including in its Action Plans and by providing illustrations of effective Action Plans in the recent past) and whether areas for further improvement have been identified and actioned.

Purpose and aims of the Stage 2 investigation

The Stage 2 investigation is subject to the purpose and aims as set out in the Terms of Reference for the Review (see Annex 1).

These are as follows:

> The participating families have unresolved questions and concerns relating to the care provided, as well as the circumstances leading up to their death and how these have been investigated to date by the parties concerned.
>
> Specifically, the families' aims are to achieve to their satisfaction the following:
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> - acknowledgement by the parties concerned of the evidenced facts;
> - acknowledgement by the parties concerned of clear failings, be they failings of the systems and procedures or be they failings in the application of those systems and procedures by individual staff members;
> - acknowledgment of the wider consequences of the failing to both the patient's family and involved members of staff;
> - to determine accountability and responsibility at an individual level for identified failings in systems, processes and people;
> - to make recommendations for remedial action and to assign accountability for their completion; and
> - to provide demonstrable proof through appropriate outcome measures that the actions completed have successfully addressed the identified failing.
>
> The Trust and NHS Improvement aim to ensure that lessons from any identified failing are learned by both the Trust and the wider NHS.

Stage 2 Investigation process and scope

The Stage 1 report recommended a limited public investigation that is specific and focused in nature.

The Stage 2 investigation will therefore investigate and address those issues identified in the report as set out in paragraphs 2a-f above in order to evaluate and comment on the Trust's progress to date and to conclude and recommend lessons for learning, but it will not further investigate specific facts of any of the cases considered in stage 1 (unless a separate investigation into the death of Edward Hartley is agreed by his family in line with paragraph 1 above) or consider new cases. The investigation will not name or hold individuals personally responsible for any failings but it will identify where there have been any failings, as appropriate, by the Trust or by another relevant organisation and the investigation will recommend where accountability for its recommendations should lie at an individual organisational level.

The Stage 2 investigation will be focused and result in clear recommendations. The investigation will:

- Consider relevant evidence submitted during stage 1 which touches directly on the specific policy issues identified in paragraph 2a-f above, which have been selected for public investigative examination

- Invite evidence from the family members who participated in stage 1 specifically on the thematic issues to give effect to their wishes to promote constructive and effective reform of the Trust's processes

- Invite evidence from existing staff at the Trust and the CCG who can provide in-depth knowledge of the topics identified and set out also the extent to which the Trust has implemented previous recommendations or put new policies / practices in place to address previous failures and concerns

- Consider evidence on existing and proposed NHS complaints handling and investigatory practices from the relevant regulators (NHS Improvement/England, the CQC) which may further the Panel's understanding of the concerns identified in the Stage 1 report and to explain national proposals to address those concerns

- Invite evidence from service users of the Trust on their experience of complaints handling and investigations. The investigation will not investigate individual cases but it may consider evidence of experiences from services users and suggestion on how they might improve. The Panel will share this evidence with the Trust and invite the Trust to respond, where relevant

- Invite evidence from others (such as specialist experts), as deemed by the Panel to be necessary and proportionate, to provide insight into how the complaints and investigation systems may be improved

- Evaluate and draw conclusions on the steps taken by the Trust to date and on its plans for improvement

- Make reasonable, proportionate, achievable and targeted recommendations for the Trust on lessons to be learned in relation to the areas identified

- Include the findings within the stage 2 report to the family, Trust, CCG and NHS Improvement/England

The investigation Panel and the key principles of the investigation

The investigation will be carried out by a Panel, which shall be appointed by NHS Improvement in agreement with the Chair. Panel Members shall be suitably independent and qualified to fulfil their roles. NHS Improvement will conduct due diligence on any panel member candidates to ensure that they meet these criteria and that there are no conflicts of interest which would put their position on the Panel at risk.

The investigation will consist of a public hearing (in virtual form, given the social distancing restrictions which are in place during the Covid-19 pandemic). The hearing will be a fact-finding process and will not be adversarial or accusatorial.

The hearing will be conducted by the Panel Chair in a fair, independent, impartial and objective manner.

The hearing will take place in public as a virtual hearing unless there is sufficient cause for evidence to be given in private.

The Panel will not have powers to compel persons to participate. Those who do participate will be expected to attest to the truth of what they say and to co-operate with the reasonable requests of the Hearing Panel.

The Panel's findings will be based only on evidence submitted to it in advance of the relevant hearing date or during the hearing on that topic.

Required output of the investigation

The Panel will prepare a comprehensive and concise written report covering the areas identified above, making clear recommendations for the trust and, where relevant, the wider NHS. This will conclude the overall review.

The report will be made public. Whilst the key audiences for the report are the family members and the trust, it is accepted that the report may have wider public relevance, including any recommendations which may inspire change across the wider NHS, and will contribute to the development of national changes in the approach to NHS complaints handlings and investigations.

The report will be published by NHS Improvement/England and will also be shared with local CCGs and any other relevant organisation.

The written report is the responsibility of the Panel. Before publication of the report, where the Panel considers it necessary, the Panel will conduct a factual accuracy checking exercise. It will be entirely in the discretion of the Panel how to conduct the exercise and any amendments to the report will remain solely within the discretion of the Panel based on the evidence submitted to it.

The Panel will agree with participants where their information is considered for publication and where the Panel form the view that any significant criticism should be notified to any relevant participant before publication, they will inform the organisation or person concerned who will be given an opportunity to respond within 14 days. The investigation will not name or hold individuals personally responsible for any failings.

The timing and arrangements for release of the report and its publication will be agreed between the Chair and NHS Improvement.

Access to documents

All relevant NHS organisations and any relevant regulators are expected to co-operate with the investigation as is normal, professional practice, including supplying relevant documentation when requested by the Panel.

Timescale

The investigation should be undertaken with sufficient pace to enable resulting recommendations to be implemented as quickly and effectively as possible. It is expected the Panel will complete the hearing over the course of 4 weeks (not necessarily continuous weeks) and will complete the report within a further 6 weeks.

On the basis of current information, it is expected that the Panel will make its best endeavours to complete the work and produce its report by the end of December 2020. After a period of factual accuracy checking, it is expected that the final report for publication will be produced within a further 4 weeks.

Resources

Resources for the investigation will be provided by NHS Improvement. A Panel Secretary will be appointed by NHS Improvement with the Chair's agreement to support the Panel. NHS Improvement will provide proofreading support before publication.

The hearing will take place virtually. NHS Improvement/NHS England will provide the necessary resources to enable a virtual hearing and will ensure that the hearing is publicised so that members of the public may observe the public elements of the hearing.

Data Protection

The Panel and Panel Secretary will process personal data and confidential information in accordance with relevant data protection laws and the common law duty of confidentiality.

Annex 1 – Terms of Reference for the Review and Stage 1 investigation

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