VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent review of unexpected deaths, April 2012-December 2015

A report for

Norfolk and Suffolk NHS Foundation Trust

25 May 2016

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1. Introduction

1.1 Norfolk and Suffolk NHS Foundation Trust (NSFT) provides mental health and social care services across Norfolk and Suffolk. It formed on 1 January 2012 after the merger of Norfolk and Waveney Mental Health NHS Foundation Trust and Suffolk Mental Health Partnership Trust.

1.2 The trust headquarters is in Norwich. The trust serves a population of 1.5 million and provides services that include children and adolescent mental health, drug and alcohol, community, crisis resolution, inpatient, secure, liaison, learning disabilities, wellbeing and improved access to psychological therapies.

1.3 Services are broadly commissioned by five clinical commissioning groups (CCGs) in Norfolk and two in Suffolk. Services are also commissioned via specialist commissioning from NHS England, for example secure services and a children's inpatient service. The Norfolk Recovery Partnership (NRP), the trust's substance misuse service, is commissioned by Public Health England (PHE).

1.4 Services are structured across five geographical areas:

- West Norfolk;
- Central Norfolk;
- Great Yarmouth and Waveney;
- West Suffolk; and
- East Suffolk.

1.5 Investigations into serious incidents (SIs) at the trust e.g. unexpected patient deaths are managed by the patient safety team. The majority of investigations are delegated to the locality but are quality assured by the patient safety team. The patient safety team (typically the root cause analysis[1] (RCA) facilitators, specifically recruited by the trust to produce/improve RCA reports) undertake the more complex investigations.

[1] Root cause analysis (RCA) is a systematic process for identifying root causes of problems or events and an approach for responding to them.

1.6 NHS England released data in January 2016 about the number of unexpected deaths reported by mental health trusts in England, including NSFT. The release of information was in response to a freedom of information (FOI) request submitted by the Rt Hon Norman Lamb, MP for North Norfolk. Between April 2012 and September 2015 this data identified the trust as reporting the most unexpected deaths of all mental health trusts in England. However, there are problems with this data as we explore later.

1.7 In February 2016 the chief executive, on behalf of the board of NSFT, commissioned Verita to undertake an independent review of unexpected deaths reported by the trust between April 2012 and December 2015.

1.8 The purpose of this review is to examine the trust's systems and processes for reporting unexpected deaths and the quality of trust investigations. In addition, we undertook a comparison of the trust rates of unexpected deaths against national trends; a review of its progress with the latest national requirements for mortality review; and an appraisal of the trust suicide prevention strategy. The trust also commissioned NHS England to review its governance arrangements for investigating deaths in the context of the new NHS SI framework.

1.9 The independent review team consisted of senior consultant Kathryn Hyde-Bales, consultant Charlie de Montfort and director Chris Brougham. Geoff Brennan, senior consultant, provided expert mental health advice. Ed Marsden, managing partner, was the partner lead for the review. We refer to the review team as 'we' from now on.

2. Terms of reference

2.1 The trust drafted the terms of reference. It described these as *"developed to include many of the specific questions put to the Trust, including those from families who have been bereaved by suicide"*. We provided comments on the terms of reference.

a) To examine how consistent the Trust's internal process of investigation are and if they are sufficiently rigorous for lessons to be learnt
   - That there is consistency in the process of investigation, with involvement of relevant and objective staff
   - That the process for review of RCA reports is rigorous, and that report authors are challenged when appropriate
   - That families and carers have the opportunity to contribute to the terms of reference and process of investigation

b) To examine the depth of the Trust's analysis of data in identification of themes and priorities for action*
   - That there is sufficient overview and identification of themes arising from incidents
   - That there is frequent overview of data by the Trust Board of Directors, and appropriate actions taken and monitored, including sharing of learning internally and externally

c) To compare the Trust's rates of unexpected deaths with national trends and determine (as far as possible according to the constraints of data) if the Trust is an outlier in terms of numbers, patterns or trends in unexpected deaths

d) To examine how the Trust has progressed with the latest national requirements for mortality review
   - That the Trust is responding to national guidance on establishing mortality review procedures

e) To appraise whether the Trust's priorities for suicide prevention internally and system-wide are the correct ones
   - That the Trust has sufficiently strong links with Public Health and system partners to take action across populations
   - That the Trust's internal suicide prevention strategy has sufficient focus on priority areas for action.

*****To include consideration of the following:
   - Were levels of care and supervision adequate?

- Are there any trends in relation to availability of community or in-patient treatment, discharge arrangements, and issues for people with dual diagnosis?
- To consider whether there were specific themes or trends in the profiles of patients and their families.
- Are there trends that indicate concerns in specific localities or services?

As part of the terms of reference the trust set out its position in relation to data released by NHS England, saying that it was not comparable with other trusts for the following reasons:

- *"It is not standardised for the size of the trust, NSFT is one of the largest trusts in the country and would be expected to record more deaths.*
- *It does not cover comparable services for instance the majority of trusts do not offer drug and alcohol services as NSFT does.*
- *There are differences in reporting and investigation thresholds, as evidenced in the Mazars report into Southern Health".*

In addition, the Trust will receive a report from NHS England (East DCO team):

To offer a consideration of the governance arrangements of investigating deaths within NSFT against consideration of the new NHS SI Framework to outline:

- whether deaths are reported in line with the new SI framework and investigated within a timely manner
- that there is a rigorous and standardised process for determination of unexpected deaths requiring serious incident investigation.

3. Executive summary and recommendations

3.1 Norfolk and Suffolk NHS Foundation Trust (NSFT) commissioned Verita in February 2016 to undertake an independent review of unexpected deaths at the trust between April 2012 and December 2015.

3.2 NHS England released data in January 2016 in response to a freedom of information (FOI) request by Rt Hon Norman Lamb, MP for North Norfolk. This data identified the trust as being the highest reporter of unexpected deaths in England between April 2012 and September 2015. The trust knew about an increase in the number of unexpected deaths both locally and nationally. As a result, the trust board commissioned this review to examine its systems and processes for SI reporting and the quality of its individual investigations. It also sought to compare trust rates of unexpected deaths against national trends; a review of its progress with the latest national requirements for mortality review; and an appraisal of the trust suicide prevention strategy.

Trust RCA investigation process

3.3 We reviewed the trust's internal investigation process to consider if it was sufficiently rigorous and whether lessons were being learnt from the reports. We reviewed 126 RCA reports of unexpected deaths in the community and inpatient settings against a framework we created based on National Patient Safety Agency (NPSA) and NHS England guidance. Our framework covered a number of factors including the terms of reference, investigation team, analysis, recommendations and engagement with families.

3.4 Overall we found that the trust's RCA investigation process meets trust and national requirements but improvements can be made in following it. The trust's RCA investigation reports we reviewed followed the trust policy but their analysis or wider exploration of service and care management problems could be improved. We found that the quality of RCA reports was inconsistent. The reports typically contained generic terms of reference that did not always include additional terms of reference required in certain circumstances. The reports contained reasonable chronologies but the principles of RCA were not consistently demonstrated in them. National benchmarks were rarely used to evaluate trust practice. Local benchmarks e.g. trust policies were used more readily but we found that they were often not applied as part of analysis. The reports tended to set out local policy

(what should have been done) but failed to say whether what happened was in line with trust policy and practice. In many cases the report authors were unable to identify the root cause of the patient's death, although sometimes this could have been a reasonable conclusion.

3.5 We could not draw out many common themes in relation to patient factors and service level issues, e.g. dual diagnosis or discharge from services, from the reports we sampled because these themes do not readily emerge. Furthermore the majority of the reports we reviewed featured recommendations that were not SMART[2]. Both of these factors are likely to have implications for the trust in terms of missed opportunities for organisational learning. RCA reports that do not produce themes that are easily identifiable or recommendations that convert to learning limit thematic analysis. Across the reports we sampled the quality of analysis was not sufficiently rigorous but the trust's recruitment of RCA facilitators, the first of which was appointed in September 2014, has improved this. The RCA facilitators were appointed after the trust recognised its weakness in this area. A further two RCA facilitators, to be renamed investigation and improvement managers (IIMs), will be appointed by the trust following this review.

3.6 In terms of a national context we note the recently published report[3] (May 2016) from the Department of Health's Healthcare Safety Investigation Branch. The report comments on a range of shortcomings that exist in current incident investigation practices across the healthcare system. The report describes specific problems such as investigations being delayed, protracted and of variable or poor quality. The report also details that, within healthcare organisations, safety investigation is often poorly resourced with limited access to the required expertise and insufficient allocation of time being key problems.

3.7 We reviewed how far the trust engaged with bereaved relatives during RCA investigations. The trust aims to do this by sending a letter of condolence from the chief executive within three days of knowledge about the service user's death. It includes an invitation to be involved in any investigation. However, often the trust does not know of a death until later and in some instances the trust needs to spend time identifying contact details for next of kin. In such cases contact is made at the earliest opportunity. The RCA investigation lead usually follows this initial contact shortly afterwards, with a second letter to make an introduction and establish a point of contact for the duration of the

[2] Specific, Measurable, Achievable, Realistic, Time-bound
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/522785/hsibreport.pdf

investigation. Whether this second letter is sent depends on circumstances - for example, whether the next of kin has expressed an interested in being involved. The trust translates letters if the family does not speak English. The trust sends a final letter at the end of the investigation to offer to share the report with the family.

3.8 We found that the trust's level of engagement with families had improved after the introduction of duty of candour. Complete lack of engagement, according to evidence in the individual RCAs that we reviewed, dropped from nearly 40 per cent to nearly 16 per cent. Despite this improvement, engagement beyond a letter of condolence remained at less than 40 per cent both before and after the introduction of the regulation. However our findings are based only on whether engagement with the family is documented in the individual RCA reports. The trust should seek confirmation of engagement beyond a letter of condolence in these cases.

3.9 We have concerns about the trust's current process of engaging and supporting families. It would be more constructive if the trust were to meet families to offer condolences and outline any investigation to be undertaken, rather than doing this by written correspondence. We accept that engaging with bereaved families is a challenge all trusts face and for which there is no simple solution. However, we recommend that the trust try in the first instance to arrange a face-to-face meeting with families both to offer condolences and explain any investigation to be undertaken. We raised this with the trust during our review. The trust responded by initiating the appointment of two additional IIMs, formerly known as RCA facilitators, to enable better family liaison, increase the central investigation resource and improve the quality of RCA reports.

Board level oversight

Reporting to the board

3.10 We reviewed the trust board minutes (private and public) from 2012 to 2015 to see the extent to which the board had overview of unexpected deaths and whether appropriate action was taken and monitored, including the sharing of learning internally and externally.

3.11 Between 2012 and 2015 the trust board regularly received a *Patient safety report* that provided information about unexpected deaths in the community. The report detailed statistics, trends and pertinent information from recent RCAs.

3.12 Our opinion is that the trust board holds a monitoring role in relation to unexpected deaths in the community. We have seen evidence that unexpected deaths are routinely reported to the board but little evidence in board minutes of action beyond this to explore themes or learn lessons. However this work is conducted by the executive committee, on a weekly basis, and the quality governance committee (QGC), on a monthly basis. Both of these groups have executive representation and the latter has non-executive representation. The QGC also has governors in attendance. We recommend that there is more detailed discussion at board meetings about unexpected deaths to ensure that learning is being applied across the trust.

Learning lessons

3.13 The trust has taken positive steps in relation to learning lessons at a local level. Thematic reviews into unexpected deaths in the community – commissioned internally and externally – were reported to the board in 2013, 2014 and 2015. We found evidence of questions or actions being generated at board level, but not necessarily at board meetings, as a result of information from these reports being shared.

3.14 An internal review led by a trust non-executive was presented to the board in December 2013. The report found that the level of unexpected deaths at the trust was lower than the national average. The board minutes note that some lessons were learned. The QGC's predecessor was the service governance committee (SGC). It held a meeting in July 2014 where a discussion took place about the implementation of the action plan from this report. The implementation plan document is included in the SGC minutes and lists recommendations, actions, timeframes, responsible leads and evidence of action taken. All recommendations had been acted on either partially or completely.

3.15 The public board noted in August 2014 that the trust had commissioned an independent review of SIs in the Norfolk Recovery Partnership (NRP), for which learning lessons was a key part. However, we found no evidence in the board minutes that the findings of this review were shared or explored by the board as a whole. The report was

presented to the SGC, which had board level representation (both executive and non-executive) in September 2014.

3.16 West Norfolk CCG commissioned an external review of deaths across mental health services in 2014. The trust commented on the terms of reference. The review was briefly referenced at board meetings and the board minutes say the findings were never reported to the board. A draft version of the report was referenced at the July 2014 SGC meeting and an update on actions taken was sought by the SGC at the October 2014 meeting.

3.17 Board members sometimes raised concerns about unexpected deaths but they appear not to have been substantially explored. The trust's *Patient safety reports* are noted and numbers reported (particularly in the public board minutes) but the board minutes contain little evidence that issues were followed in board meetings. However, the activity of the QGC and the executive committee shows that some board members are involved with following up on learning from unexpected deaths.

3.18 The QGC was overhauled in 2015 and is now chaired by the trust chair. It is the trust's primary channel for monitoring and exploring learning from unexpected deaths in the community. A detailed *Patient safety report* is routinely submitted to the QGC. The committee has a work plan for the year ahead and intends to investigate fully any new concerns.

3.19 The QGC annual report (2015) found some patterns across the unexpected deaths reviewed, in general relating to the breakdown of incidents per service line. An increase in deaths of patients in liaison services was recognised by the trust which set up a learning event to discuss it. A report was subsequently submitted to the QGC in January 2016.

3.20 The trust has a number of channels for monitoring unexpected deaths and undertaking thematic analysis but the themes and learning do not readily emerge from individual RCA reports.

3.21 The trust undertakes reviews of unexpected deaths but there are some missed opportunities for learning lessons.

3.22 We found some good practice, such as learning events and working groups. These encouraged learning.

Working groups

3.23 The trust has taken positive steps in relation to learning lessons at a local level. A learning from SIs (serious incidents) working group was piloted in Suffolk in 2015. This work is locally driven and aims to improve learning from SIs with a view to sharing themes and good practice. Early signs suggest that this work had a positive impact. We saw examples of the group's work and it emphasises learning lessons. The director of operations for Norfolk recently set up a similar group to review SIs in Norfolk and Waveney with input from the Suffolk group.

3.24 It is too soon to know if any learning derived from these groups has become embedded in clinical practice. The Norfolk working group had met only twice at time of writing and the success of the group is yet to be proven. We recommend that the trust set itself a schedule to progress and align the work of the two groups and to agree a date to evaluate their work.

Data analysis

3.25 In considering the data on unexpected deaths we noted the lack of national data on which to base analysis. This is outside the trust's control and is a national issue. National data about unexpected deaths in mental health trusts offers limited means for making meaningful comparisons between mental health trusts. NHS England report this in their December 2015 FOI response. Many datasets are produced only for non-specialist acute trusts or provide only 'counts' (absolute values) rather than 'rates' (relative values), making it difficult to draw concrete trust-level comparisons. Furthermore it is difficult to be certain that investigating/reporting practices relating to unexpected deaths are consistent across trusts. The classification of incidents is a local decision made in accordance with NHS England's SI Framework. This again makes trust level comparisons difficult. We strongly recommend that the trust tell NHS England about the lack of meaningful, comparative data in this area to avoid potential misrepresentation and misinformation.

3.26 We provide a contextual view of the trust's numbers of unexpected deaths according to the FOI data among national trends to identify (as far as possible according to constraints of data) if the trust could be an outlier.

3.27 We analysed variables that can reasonably be considered to account for a mental health trust in a particular area recording high levels of unexpected deaths. We considered national and regional data on:

- populations served by mental health trusts in England;
- suicide rates;
- demographics (age, gender and unemployment);
- indices of deprivation;
- levels of mental health and illness;
- investigation thresholds;
- the risk profiles of mental health trusts in England, in terms of whether they offer a substance misuse service; and
- reporting practices.

3.28 Using the FOI data, the size of population served does not explain the differences in reported rates of unexpected death. This is contrary to our expectation and suggests that the data could be misleading.

3.29 We compared numbers of suicides at the local authority level for 2013 with the national average. Most local authorities in Norfolk and Suffolk are at or below the national average.

3.30 We conclude that the number of suicides in Norfolk and Suffolk is not higher than the national average.

3.31 The percentage of 30-59 year-old males, a demographic known to be at high-risk of suicide, in the East of England for 2012, 2013 and 2014 has remained between 23-24 per cent in line with the national average.

3.32 We made comparisons at the local authority level on the rate of admissions to hospital for alcohol related conditions (2013) against the national average (645 per 100,000 population). Norwich (960 per 100,000 population) and King's Lynn and West Norfolk (744 per 100,000 population) are the only two local authorities in Norfolk and Suffolk that had a significantly higher rate. All other local authorities in Norfolk and Suffolk are at or below the national average.

3.33 We cannot conclude from PHE data that there is a greater need for alcohol services in Norfolk and Suffolk, relative to the national average. We were not permitted access to PHE's National Drug Treatment Monitoring System so cannot comment on the regional prevalence of drug use.

3.34 Norwich CCG (286 per 100,000 population) and Great Yarmouth and Waveney CCG (243 per 100,000 population) had a significantly higher than the national average (191 per 100,000 population) number of emergency admissions for self-harm per 100,000 population. These are the only CCGs in the closest geographical range of NSFT that have a significantly higher rate than the national average.

3.35 Other than Norwich CCG and Great Yarmouth and Waveney CCG, the CCGs closest to NSFT did not have significantly more than the national average number of emergency admissions for self-harm.

3.36 The level of unemployment in Norfolk and Suffolk is in line with the national average.

3.37 The Department for Communities and Local Government's (DCLG) *Index of multiple deprivation* does not reveal regional imbalances in deprivation that could account for a high number of unexpected deaths being recorded at the trust.

3.38 The CCGs closest to NSFT did not record more than the national average number of bed days in secondary mental health care hospitals.

3.39 The presence of a substance misuse service in a trust's services may cause trusts' to record a high number of unexpected deaths but because substance misuse services are not homogenous it is difficult to reach a definitive conclusion here.

3.40 The number of unexpected deaths the trust recorded, according to the FOI data, is likely to be determined by the fact that the trust adopts an early SI reporting culture and reports incidents at a rate that is substantially higher than the national average for mental health trusts.

Mortality review

3.41 NHS England launched a programme of mortality review, *The national retrospective case record review (RCRR)*, the pilot for which was scheduled to start in the first quarter of 2016.

3.42 The trust formed a mortality group which first met in March 2016. The trust medical director (the group's chair) wrote to NHS England to ask for guidance about undertaking the work in a mental health setting. At time of writing the medical director has not received a reply. The trust has set up a database – which went live in April 2016 – to capture information about its mortality work.

Suicide prevention

3.43 The trust's suicide prevention work takes place across three streams:

1) the trust-wide suicide prevention strategy;
2) the Norfolk multi-agency suicide prevention group; and
3) the Suffolk multi-agency suicide prevention group.

3.44 The trust is drafting a suicide prevention strategy, the final copy of which was unavailable for review at time of writing but is due to be in place by September 2016. The previous version covered 2013-15.

3.45 Suicide prevention work in both Norfolk and Suffolk is multi-agency and is led by PHE. The two groups are at different stages of development.

3.46 The trust is engaged with PHE and system partners through the Norfolk and Suffolk multi-agency suicide prevention groups.

3.47 The trust demonstrated multi-agency work in Norfolk on suicide prevention but lacked an overall strategy. Such strategy is PHE's responsibility and is out of the trust's direct control. Work on this is in its infancy and continues.

3.48 The Norfolk suicide prevention group had a number of meetings and had a relatively strong multi-agency membership that included the police, NHS England, Healthwatch, Norfolk county council, and the Norfolk coroner. However the group lacks an overall strategy. Notable practice from the group included a pilot with Norfolk police that placed trust staff in police control rooms. The director of nursing said that feedback about this work had been positive and helped prevent unnecessary 136[4] sections. She added that the suicide prevention group was constructive in information-sharing and networking.

3.49 We acknowledge that PHE is tasked with leading suicide prevention work but the trust and county council co-chair this multi-agency group. We cannot say from the evidence who was driving the work of the Norfolk group. Trust representatives at this group felt the group was uncoordinated and told us they were working on the trust internal strategy with a view to asking PHE to use it as a template for a county strategy.

3.50 The trust showed a strategic approach to developing its Suffolk suicide strategy (led by PHE). The Suffolk suicide prevention group was smaller than the one in Norfolk but it had undertaken more strategic work and had a draft suicide prevention strategy. It also had a pilot project with the Samaritans and at a trust level a group called the learning from SIs (unexpected deaths and near misses) group.

3.51 The trust could show that it had taken positive steps in relation to its own suicide prevention work (independent of the multi-agency groups) in Suffolk, particularly in the work of the lead clinician for East Suffolk. PHE is tasked with leading multi-agency suicide prevention work in the county. However, the trust could take a more prominent role in this work in light of the positive pilot work they are undertaking. We note examples of good work by the trust in this area, such as a workshop in 2014 at Lynford Hall that sparked interest in the multi-agency groups.

3.52 The trust lead clinician for East Suffolk played an instrumental and positive role in developing the Suffolk suicide prevention work.

3.53 The trust showed areas of good practice in multi-agency work with the police (Norfolk) and the Samaritans (Suffolk).

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[4] The police use section 136 of the Mental Health Act to take patients to a 'place of safety' from a public place, if they feel there is a mental health issue.

3.54 We found evidence in the trust board minutes to indicate that the board monitors suicide prevention. The results of suicide audits were presented to the public board in 2013, 2014 and 2015.

Next steps

3.55 We were struck by the enthusiasm and drive among staff we interviewed. They wanted to improve the way the trust managed unexpected deaths. We were shown a number of examples of innovative approaches to collaborative working and suicide prevention. Our review did not extend to interviewing frontline trust staff therefore we cannot comment as to whether this sentiment is replicated in the localities. Ultimately any change in culture should be set by the leadership team. We think that, subject to addressing the recommendations set out above, the trust is well positioned to improve its systems and processes for managing unexpected deaths.

Recommendations

R1 We recommend that the patient safety team carries out an audit to assure itself that every investigation has specific TOR relevant to the case that allow for the capture of:

- how far back the investigation goes;
- who commissioned the investigation;
- who is on the investigation team;
- the key lines of enquiry;
- clear RCA and use of appropriate benchmarks; and
- SMART recommendations.

This should take place **within three months** of the board formally accepting this report.

R2 The patient safety team should ensure that all unexpected deaths are treated like any other SI in respect of applying the statutory requirements of duty of candour. This should take place **within three months** of the board formally accepting this report.

R3 The patient safety team should continue to ensure that frontline staff have training and support to enable them to constructively engage and work with bereaved families. The

training needs of frontline staff should be reviewed **within three months** of the trust board formally accepting this report.

R4 The patient safety team should review its process of involving bereaved families with a view to developing a more engaged, communicative and face-to-face approach. Any changes in practice should be evaluated **within six months** of implementation.

R5 The patient safety team should build on progress already made by ensuring that each investigation team is sufficiently independent and has the correct skills and knowledge.

R6 The patient safety team should develop as a priority a quality assurance checklist/toolkit for all RCAs to promote a consistent approach to quality assurance. The quality of the RCA investigation reports should be evaluated **six months** after this checklist is introduced.

R7 The trust board should develop its role beyond monitoring unexpected deaths. These include:

- learning sessions e.g. localised trust pilot work;
- exploration of (anonymised) case studies;
- exploration of the results from thematic reviews;
- design and implement a programme of sharing learning from thematic reviews with measurable outcomes across the trust; and
- seeking assurance that learning flows from 'ward to board' and back.

R8 The trust should prioritise an aligned programme of work for the two SI working groups and undertake a review of progress **within nine months** of its implementation.

R9 The trust should tell NHS England about the shortage of meaningful, comparative data relating to unexpected deaths across mental health trusts to avoid potential misrepresentation and misinformation.

R10 The trust board should take a more active role in developing and promoting the trust-wide suicide prevention strategy. This should include officially identifying a board-level champion for the work, contributing to the draft strategy, agreeing a programme of

implementation and protecting time at board level for review and evaluation of the strategy.

R11 The trust should ensure that the intention to increase the funding of the lead clinician for East Suffolk to facilitate work in Norfolk is realised.

R12 The trust should ensure as a priority that multi-agency best practice and learning are shared between the two suicide prevention groups with a view to developing a uniform approach under its trust-wide suicide prevention strategy.

R13 The trust should as a priority develop a timeline of implementation of its suicide prevention work and strategy and undertake a follow-up review of progress made in **six to nine months**.

4. Approach and methodology

Testimonial evidence

4.1 We interviewed 11 members of trust staff. We sent each a letter of invitation, a guide for interviewees and the terms of reference for the review. Interviews were recorded and transcribed. Each interviewee was provided with a copy of their transcript and given an opportunity to review it for factual accuracy.

4.2 We wrote to 22 stakeholders including local MPs, local CCGs and the county coroners, inviting them to partake in the review. Eight of these parties responded to declare their interest in being involved with the review. We were also contacted by a number of other agencies who wished to contribute to the review. A full list of those interviewed is listed at Appendix A.

4.3 We submitted points to the trust at the end of April that cover comments we received by stakeholders outside the trust, that fell outside of our terms of reference.

4.4 We met with two families during the course of our review. In accordance with our terms of reference we were not reinvestigating individual cases – rather we were looking at trust systems and processes. We therefore did not proactively contact families to be involved in our review. We felt that to do so would cause unnecessary distress. However, we spoke to those families who contacted us or the trust about the review. We would like to thank them for their time and for speaking to us openly.

Documentary evidence

4.5 We reviewed national and local policies and trust documents as part of this review. These include:

- NHS England and NPSA guidance;
- trust policies that included investigating and reporting SIs, undertaking investigations, engaging with families and duty of candour;
- board and sub-committee minutes;
- patient safety reports and details of trend analysis into unexpected deaths;

- 126 trust RCA reports;
- trust and national data on unexpected deaths between 2012 and 2015; and
- details of the trust's suicide prevention and mortality review work.

4.6 A full list is given at Appendix B.

Serious incident (SI) review methodology

4.7 We undertook a review of a sample of trust SI reports to examine consistency and quality. Of 349 SI reports relating to unexpected deaths for April 2012 to December 2015, we requested a sample of 126.

4.8 We were not commissioned to carry out individual case reviews on the RCA reports we sampled and as such we did not seek the materials reviewed by each RCA team whilst they were carrying out their investigations. Our findings are based on information included in the final RCA reports.

Sampling strategy

4.9 We used a stratified random sampling technique to select the sample. We were satisfied that a sample size of 126 with confidence level 95 per cent and margin of error ±7 per cent would be representative and achievable given the timescale of the project.

4.10 First, the total population of SIs relating to unexpected deaths was stratified by NHS financial year and in accordance with the parameters of our terms of reference (April 2012 to December 2015), into four strata. We did this to make sure the sample was representative of the wider population and allowed for longitudinal analysis between the four years. Table 4.1 demonstrates this breakdown.

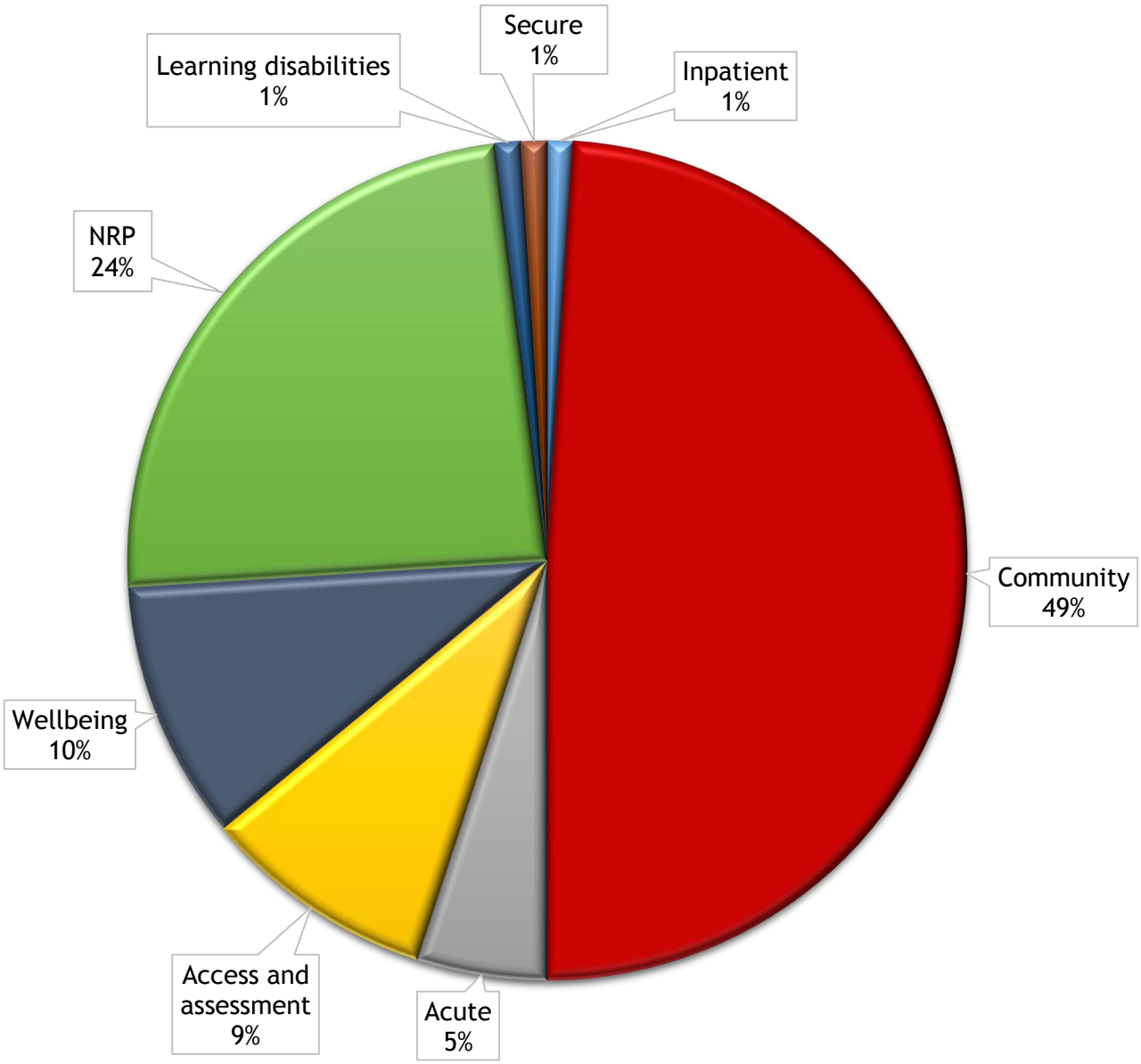
Table 4.1 – The distribution of RCA reports in our sample by year.

	Total population		Sample		
Year	Number	%	Number	%*	Number (rounded)
1 (April 2012 – March 2013)	61	17.43	21.96	17.43	22
2 (April 2013- March 2014)	96	27.43	34.56	27.43	35
3 (April 2014 – March 2015	114	32.86	41.4	32.86	41
4 (April 2015 – Dec 2015)	78	22.29	28.08	22.29	28
Total	349	100	126	100	126

*The same proportions were used in the sample. However, in order to reach integers we rounded (final column).

4.11 We stratified the SIs within each of these four years across the trust's eight service lines. We did this to ensure that each service line was represented proportionately to the volume with which the SIs occur. This technique also enabled us to analyse trends within and between service lines. Our categorisation of the SIs across service line was verified by the trust's patient safety team to ensure that our process was accurate. Within each of these sub-strata we selected the required number of RCA reports at random using a random number generator. A full breakdown of the 126 RCA reports, by year and by service line is included at Appendix C. The distribution of the SIs in our sample, and accordingly across the entire 349 population, is represented in chart 4.1 below.

Chart 4.1 – The distribution of the trust's SIs categorised as unexpected deaths by service lines (April 2012 – December 2015). This distribution is reflected in the sample.



Analysis of the sample

4.12 In order to review each of the reports in our sample in a standardised and comparable way we devised a review framework based on NPSA and NHS England SI guidance. The review team assessed each RCA report against this framework. A copy of the framework appears at Appendix D.

4.13 To ensure consistency across the review team, we reviewed each other's analysis (five SIs each) for triangulation. This was to test for any biases. We compiled a database of our analysis from which we extracted descriptive statistics and themes.

The structure of this report

4.14 In the following sections of the report we provide our comments and analysis on the themes outlined in the terms of reference. These themes are:

- section 5 - themes arising from unexpected death investigation reports;
- section 6 - board level oversight;
- section 7 - analysis of data;
- section 8 - national mortality review; and
- section 9 - suicide prevention.

5. Themes arising from unexpected death investigation reports

Introduction

5.1 In this section we discuss the themes arising from the 126 investigation reports into unexpected deaths that we reviewed.

5.2 Conducting proportionate investigations and analyses of all unexpected deaths is important to identify whether the death was avoidable. Even if cases were not avoidable, an investigation might highlight issues or organisational learning.

5.3 We assessed the following areas:

- the terms of reference;
- being open with patients and their relatives and duty of candour;
- the investigation team;
- the chronology;
- analysing key themes and whether benchmarks of good practice were used;
- recommendations;
- timeliness of reports; and
- RCA themes.

5.4 In addition to these assessments we include a number of tables that detail demographic and service information that we found in the reports we reviewed.

The terms of reference

5.5 The NPSA investigation toolkit[5] provides guidance for healthcare providers on developing the terms of reference (TOR) for an investigation. It says the TOR should be agreed between the commissioner (the person who has asked the investigation team to carry out the investigation) and the investigation lead before the investigation. The TOR should:

[5] *The National Patient Safety Agency (2005) root cause analysis investigation tools: a guide to investigation report writing following root cause analysis of patient safety incidents.*

- *"state who has commissioned the investigation (and at which level in the organisation);*
- *set the scope and boundaries of the investigation (how wide and how far back to investigate);*
- *clearly state the aims and objectives of the investigation and desired outputs;*
- *highlight any known specific problem or issues to be addressed;*
- *set the timescales for the report and for reviewing progress on the action plan; and*
- *be shared with those affected by the incident so they are aware of what is being investigated and add any other points that they would like to be reviewed."*

5.6 Developing and using clear TOR for an investigation ensures that the commissioners, investigators and those affected by the incident are clear about what is being investigated and what is not. Good TOR enable investigators to determine key lines of enquiry and stay focused. Good TOR also provide confidence to commissioners, those affected by the incident and the public that the investigation is proportionate and robust.

Comment and analysis

The trust RCA template includes a copy of generic terms of reference and capacity to add other TOR depending on circumstances. All the reports we reviewed contained TOR but most were generic and therefore did not highlight key lines of inquiry specific to each case. It is important that when generic terms of reference are used, all and any additional items applicable to the TOR are captured.

The trust has put actions in place since our review so that the TOR are agreed with locality managers and lead clinicians at the outset of the investigation to promote the use of specific TOR for each case.

Families are given the opportunity to comment/ask questions at the beginning of an investigation and the trust told us that it intends to strengthen this process. We discuss this further in the duty of candour section.

Recommendation

R1 We recommend that the patient safety team carries out an audit to assure itself that every investigation has specific TOR relevant to the case that allow for the capture of:

- how far back the investigation goes;
- who commissioned the investigation;
- who is on the investigation team;
- the key lines of enquiry;
- clear RCA and use of appropriate benchmarks; and
- SMART recommendations.

This should take place **within three months** of the board formally accepting this report.

Being open with patients and their relatives and duty of candour

5.7 We start by focusing on the being open policy because approximately one third of the reports we reviewed were written before the duty of candour obligations came into place.

5.8 In 2004, the NPSA developed the *Being open policy*[6]. The purpose of the policy was to provide a best practice framework for healthcare providers to create an environment where patients, their carers, healthcare professionals and managers feel supported when things go wrong and have the confidence to act appropriately. The framework gives healthcare organisations guidance on how to develop and embed the principles of openness. The steps of are outlined below:

- *"acknowledging, apologising and explaining when things go wrong;*
- *conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring; and*
- *providing support for those involved to cope with the physical and psychological consequences of what happened."*

[6] *NPSA: being open when patients are harmed*

5.9 The guidance advises that saying sorry is not an admission of liability. Involving and supporting those who have been affected by an incident is important because if done properly, patients know that their concerns and distress have been acknowledged and are reassured that the organisation will learn lessons to prevent harm to someone else. According to the guidance, a culture of openness also improves the reputation of a trust.

Duty of candour

5.10 The statutory Duty *of candour*[7] (2014) makes it clear that healthcare providers must promote a culture that encourages candour, openness and honesty at all levels. The regulation says this should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body.

5.11 The *Duty of candour regulation* states that healthcare providers must:

- *"tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification;*
- *provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification;*
- *advise the relevant person what further enquiries the provider believes are appropriate;*
- *offer an apology;*
- *follow up the apology by giving the same information in writing, and providing an update on the enquiries; and*
- *keep a written record of all communication with the relevant person."*

5.12 The trust told us that it aims to send a letter of condolence to bereaved families from the chief executive within three days of being notified of an unexpected patient death. The letter said:

[7] http://www.cqc.org.uk/content/regulation-20-duty-candour

"As is our policy after the death of one of our patients we will be carrying out a review of our involvement with xxx which we will be happy to share with you once it is complete. If there are any issues or concerns you would like us to include or look at, or if you would like a copy of the report, then please contact xxxx"

5.13 Unless the trust hears from a bereaved family that it does not want to engage in the review, the lead investigator for the RCA investigation sends them a follow-up letter. This letter introduces the investigator, advises that an investigation will take place and invites the family to engage in the investigation. In some instances the trust will not be able to get in touch with a family immediately, for example, if the patient did not provide next of kin details. In such cases the trust may have to wait for the coroner to provide contact details.

5.14 The patient safety and complaints lead told us that when families did not reply to the trust letters, a final letter was sent once the RCA report was complete. This letter told families that the investigation was complete and offered to share the report with them.

5.15 A member of the patient safety team told us:

"What we could do a bit better is perhaps stagger the information that we give so that we just send our condolences in the initial stage, and then perhaps a couple of weeks later give them a named contact. It is really difficult because everyone grieves differently."

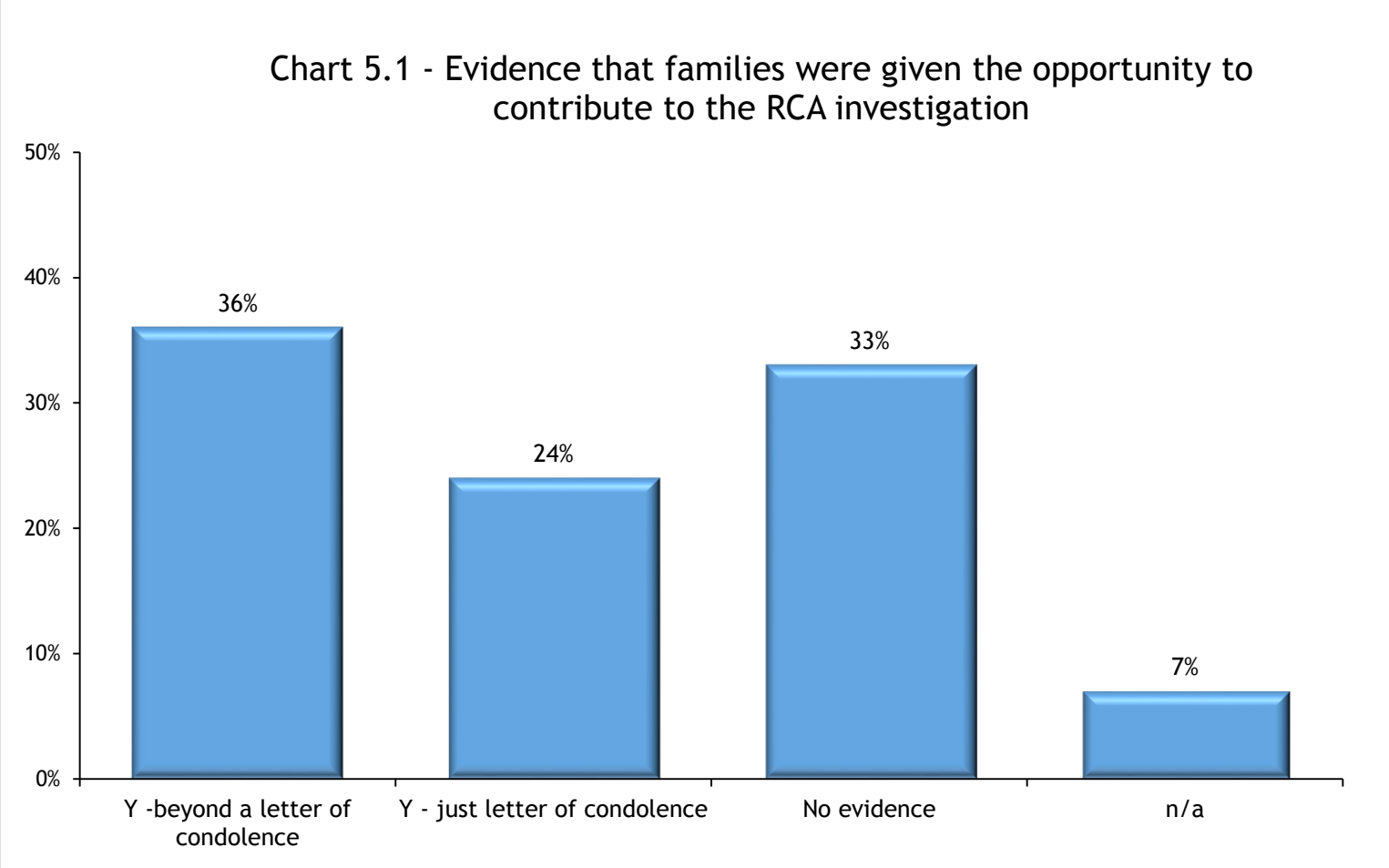
Comment and analysis

In 60 per cent of the reports we reviewed, we found evidence written in the report[8] that the trust had sent the letter of condolence to families affected by an unexpected death. As shown in chart 5.1 we found in 36 per cent of the reports that the trust gave the families the opportunity to contribute to the investigation, beyond just sending them the letter of condolence. This may have been, for example, the locality manager

[8] It should be noted that should a report not have included written evidence that the family was sent the letter of condolence this does not eliminate the possibility that the letter of condolence was sent to the family.

sending a supplementary letter or making a telephone call. In the remaining 24 per cent, the trust appeared to only send the family a letter of condolence.

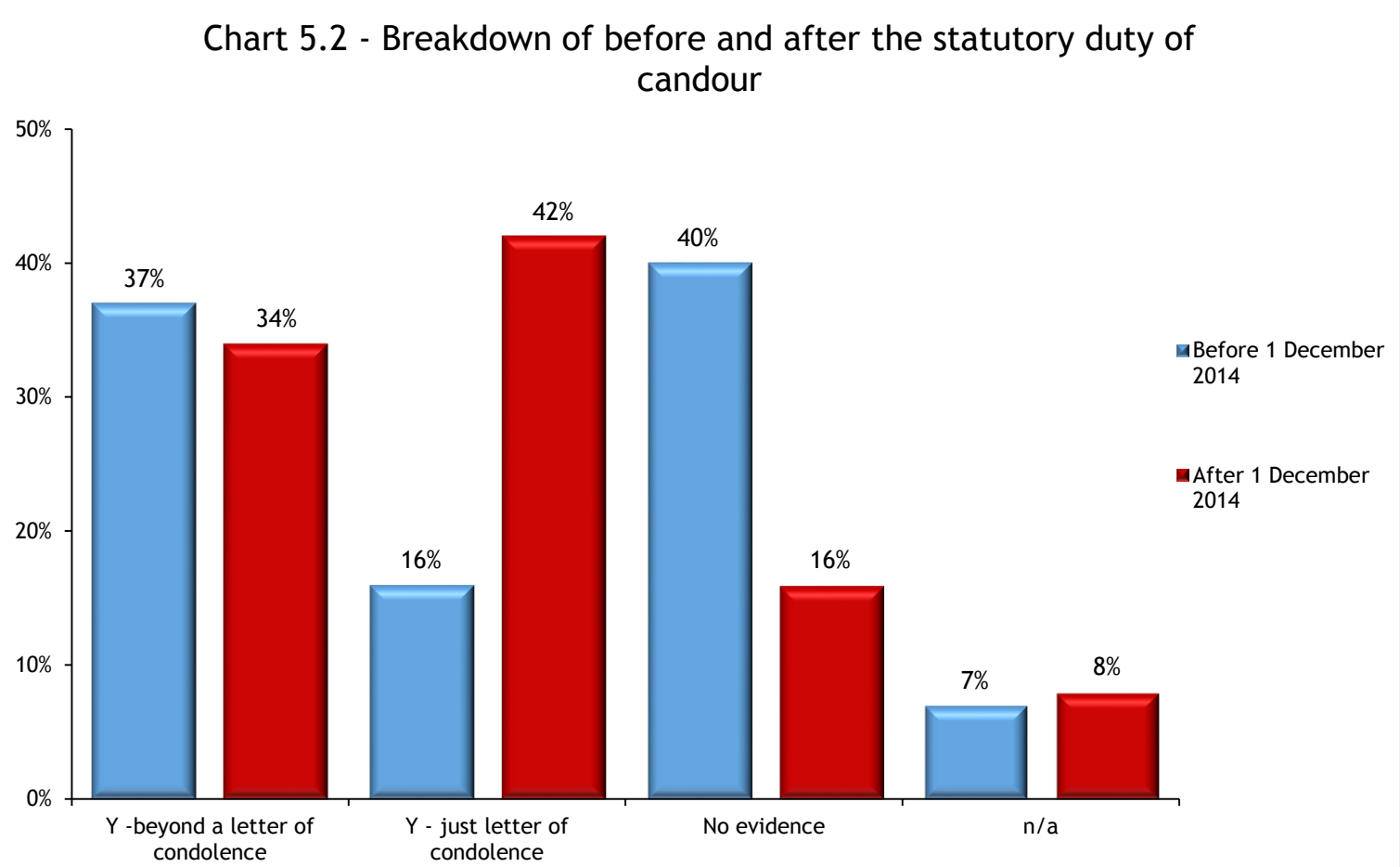
In 33 per cent of the reports there was no written evidence that the trust sent the family the letter of condolence, corresponded with them to tell them about the investigation, or shared a copy of the investigation report with them. In 7 per cent of the reports it was stated that no next of kin was identified.



The statutory duty of candour was introduced for NHS bodies in England from 27 November 2014. Chart 5.2 provides a breakdown of how the trust performed at giving families the opportunity to contribute to the SI investigation process before and after 1 December 2014.

From the SIs that occurred on or after 1 December 2014, 76 per cent of the reports recorded that the trust had sent the letter of condolence to families who had been affected by an unexpected death. In 34 per cent of the reports we found that the trust gave the families the opportunity to contribute to the investigation process as well. In

almost half of the reports (42 per cent) we found that the trust just sent the family a letter of condolence. In 16 per cent of the reports there was no written evidence that the trust sent the family the letter of condolence, corresponded with them to tell them about the investigation, or shared a copy of the investigation report with them. In 8 per cent of the reports no next of kin was identified.



5.16 All trust staff we spoke to acknowledged the difficulties in engaging with bereaved families but we were left with a sense that they felt they offered a better level of engagement than our review suggests. The evidence we reviewed suggests limited evidence of engagement with families that is in line with trust policy. This may be because the relevant section of current RCA report template is not routinely completed and therefore does not accurately inform the reader whether the report will be shared with the family or not – we base our comments on the RCA investigation reports we read. In the report template there are sections called *Involvement and support of patients and relatives* and *Distribution list/shared learning* but how these are completed appears to be largely at the report writer's discretion.

5.17 We understand that some patients do not wish to provide next of kin/family details. In such cases the trust works with the coroner to deliver a letter inviting the family to contact the trust.

5.18 The patient safety team agreed with us that the timing of engagement with families is sometimes difficult to judge appropriately. The patient safety team acknowledge that families have varying needs and preferences. We agree with them that there is an element of unknown when it comes to choosing the best type of communication to use in a given case and this can be difficult to judge. The patient safety team told us examples of the trust adapting to the varying needs of families. In some cases, the trust sets up an early meeting between the family and a director. In other cases families ask for a period of time before the trust engages and the trust strives to accommodate this, without leaving communication too late. The trust translates letters if the family does not speak English. Members of the trust's patient safety team told us they did not think all staff were equipped to provide the support that families needed. They added that they did not think there was enough support for staff to fulfil this aspect of their role.

5.19 We spoke to the Norfolk coroner about her view on how the trust engaged with families. She said it was a common theme at inquests that families did not feel they had been engaged by the trust, either when their relative was under the care of the trust or after their death. However, she felt the trust tried to engage positively with families during the inquest process (e.g. meet with them before the inquest or offer a meeting afterwards).

Comment and analysis

The trust has made progress in engaging and supporting families. The current process is based on sending a letter of condolence, a follow-up letter from the RCA investigator and a final letter of invitation for the family to read the report. We think that the trust can improve on this process. We accept that engaging with bereaved families is a challenge that all trusts face and there is no simple solution. Equally some families may not wish to be involved in any investigation undertaken. However, in the first instance we recommend that the trust try to meet with families both to offer their condolences and to explain any investigative work that will be undertaken. This is in keeping with the spirit of duty of candour. We raised this with the trust during our review. The trust is now appointing two extra RCA facilitators (to be called

investigation and improvement managers (IIMs)). The trust told us this would improve family engagement because the IIMs would act as family liaison and address concerns or questions.

Engaging with bereaved families is challenging and we agree with the patient safety team that not all staff may be equipped to do this. In accordance with our terms of reference we have not interviewed individual frontline staff about this but have found in our experience (outside this review) that clinical and nursing staff find engaging with bereaved families one of the most challenging aspects of their role. It is the responsibility of the trust to ensure that staff are appropriately supported and trained to engage constructively and supportively with families.

We spoke to two bereaved families, explaining that we were not reinvestigating individual cases (in accordance with our terms of reference). The trust told us that both families wanted to speak to us. We accept that two is not a representative sample but in both cases the families felt the trust had engaged[9] with them poorly throughout the investigation process. The families said they had been involved in lengthy dialogue with the trust, in excess of 18 months, but still had not had their concerns/questions answered. Both families told us they had not been invited to contribute to the RCA investigation and found the RCA report that was produced to be inadequate. In both instances the trust conceded that mistakes had been made in terms of how they engaged with these families. However the trust informed us that one of the families we spoke to did have input to the TOR for the RCA investigation. When the family raised concerns about the quality of the final RCA report, the trust set up an additional investigation that was conducted by two trust non-executives.

We note the coroner's comments in relation to the trust engaging with families. While the coroner's comments suggest that the trust is willing to work with families the trust should engage with families more frequently before the inquest and needs to examine how and when they do this in light of our recommendations.

We return to duty of candour later when we discuss board oversight.

[9] We have separately fed back to the trust concerns the families raised in relation to the care and treatment given to their relatives.

Recommendations

R2 The patient safety team should ensure that all unexpected deaths are treated like any other SI in respect of applying the statutory requirements of duty of candour. This should take place **within three months** of the board formally accepting this report.

R3 The patient safety team should continue to ensure that frontline staff have training and support to enable them to constructively engage and work with bereaved families. The training needs of frontline staff should be reviewed **within three months** of the trust board formally accepting this report.

R4 The patient safety team should review its process of involving bereaved families with a view to developing a more engaged, communicative and face-to-face approach. Any changes in practice should be evaluated **within six months** of implementation.

The investigation team

5.20 We now focus on the investigation teams involved in the RCAs. There are several principles about making sure an investigation team is fit for purpose. The good practice guidance on investigating serious mental health incidents[10] advises that the investigation team should ideally comprise people of appropriate seniority, objectivity and authority, and be fully trained in the RCA/investigation techniques. In addition, the investigation team should:

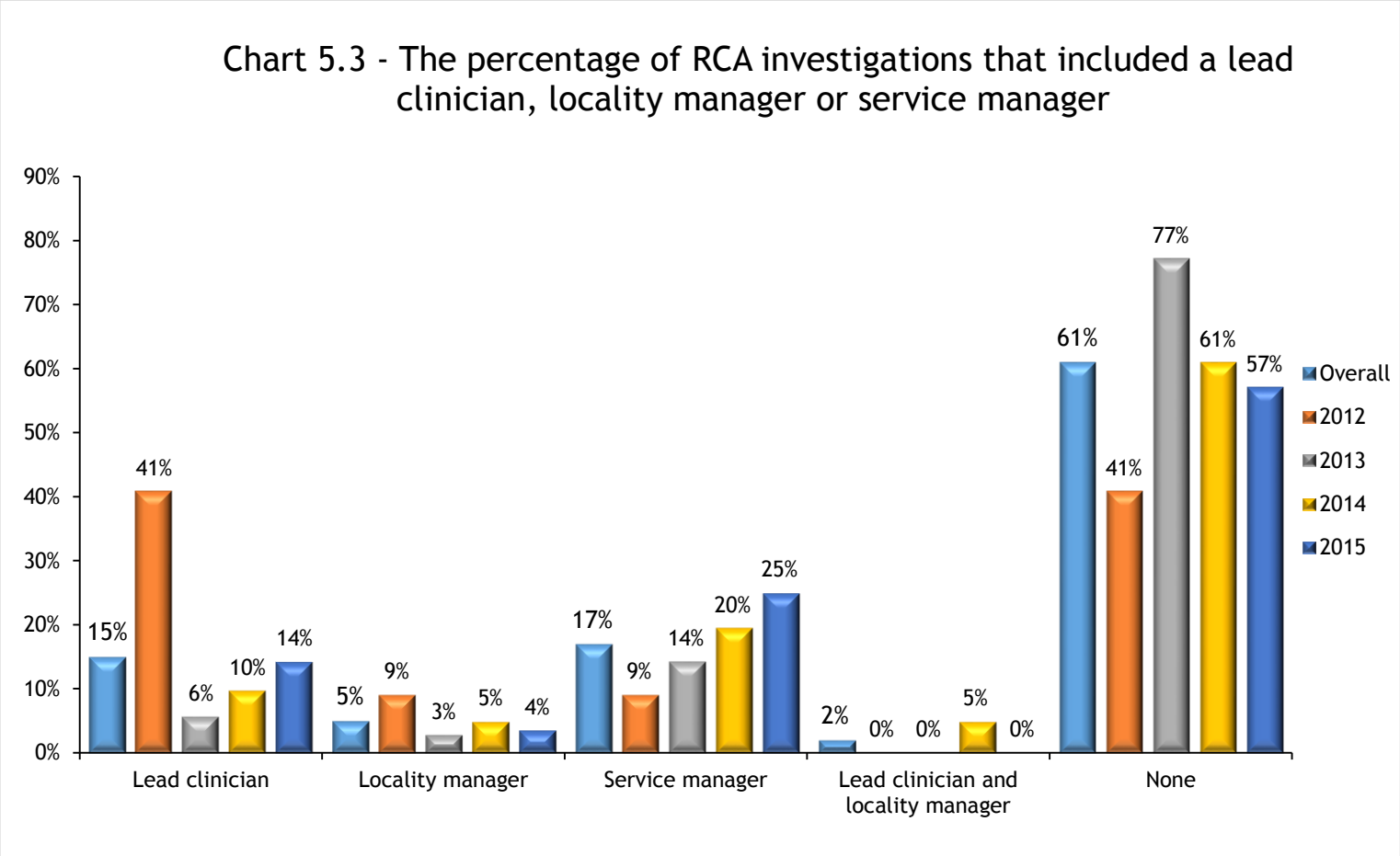
- consist of 2-4 people who are independent of the treatment and care of the service user;
- consist of people with the right skills; and
- have access to specialist advice when necessary.

Comment and analysis

In 94 per cent of reports an investigation team conducted the investigation. The remaining 6 per cent were carried out by an individual. Whilst this is encouraging to

[10] *Investigating serious mental health incidents good practice guidance* (NPSA 2008)

see, our review just examined the RCA reports and we could not establish from this information whether the investigation teams were independent, of sufficient seniority, whether the team had been trained in investigative skills or whether the teams sought specialist advice. The RCA reports listed the job titles of team members but not their experience. In accordance with our terms of reference the focus of our review has been on the information contained in the reports, not to carry out individual case reviews. We therefore did not seek this information from elsewhere.



The patient safety team asked us to look at the proportion of the RCAs we reviewed that involved either the lead clinician, service[11] or locality manager as it was interested to know whether these staff groups are involved appropriately in the RCA investigation process. Just over 60 per cent (illustrated in chart 5.3) of the RCA investigations we reviewed did not involve a lead clinician, service or locality manager

[11] A service manager is a different role to an operations manager.

which indicates that there should be a drive to ensure these staff groups are engaged in the RCA investigation process.

Since 2013 there has been a steady increase in lead clinician and service manager engagement and the proportion of review teams without representation from the staff groups we looked at has decreased. This is encouraging to see and the trust should look to continue this trend.

The trust says that RCAs must involve a lead clinician, operations manager or nominated deputy. We found that nearly 80 per cent of all of the RCAs we reviewed had a member of staff at this level. Deputies were involved in 30 per cent of cases. We have not included nominated deputies in chart 5.3.

Recommendation

R5 The patient safety team should build on progress already made by ensuring that each investigation team is sufficiently independent and has the correct skills and knowledge.

The chronology

5.21 Developing a chronology is an important part of the investigation because it provides a record of the events leading up to and immediately after the incident. Sometimes a number of chance occurrences and coincidences combine to create the circumstances in which an incident can happen. The investigation report should include a summary of the key points so that the reader can gain a clear understanding of the events leading up to the incident.

Comment and analysis

We found 94 per cent of cases included a chronology of events leading up to the incident. Whilst this is encouraging to see we were unable to find out whether the chronology went back far enough or included all the necessary key events because it

was outside our terms of reference to look at patient clinical records in the style of individual case reviews.

We make a recommendation about ensuring that terms of reference define how far back an investigation goes.

Analysing key themes and the use of benchmarks

5.22 NPSA good practice guidance says that any problem in care or service delivery should be analysed to determine any underlying causes (contributory factors and root causes) and the lessons to be learnt. The NPSA also recommend that benchmarks of good practice are used such as national and local benchmarks (policies, procedures and guidelines) to find out what should happen and then see what did happen at the time of the incident.

5.23 We looked at the application of local and national benchmarks in the RCA reports and the subsequent level of analysis.

5.24 Members of the patient safety team said that they were sometimes concerned by the variability of RCAs undertaken in the localities. The patient safety team recognised that day to day workloads, additional and increasing expectation of RCAs[12] and doing the task on an infrequent basis may hinder the ability of staff in localities to produce good quality reports. The patient safety team understood that the RCA facilitators or IIMs, whose primary role is to conduct RCAs, are better equipped and have more time to undertake investigations.

5.25 The patient safety team told us that there were some localities where ownership was better. The patient safety team has worked hard to improve locality ownership including developing the *Top ten* policies for staff to refer to when carrying out RCAs, quality workshops with matrons and key learning posters and newsletters to disseminate learning across the trust.

[12] The trust and the review team recognised that the audience for RCA investigation reports has grown since their introduction. The reports must suit to a range of readers including coroners and families.

5.26 We found that the reports completed by the trust RCA facilitator who has been in post since September 2014 (a second has only recently been recruited and therefore their reports did not notably feature in our sample) were of a good standard. In these reports the level of analysis undertaken was significantly better than in other reports.

5.27 The Norfolk coroner told us she found the analysis in some of the trust's RCA reports to be unclear and written in a style unsuited to external audiences e.g. families.

5.28 The director of nursing told us the trust intended to immediately recruit two extra RCA facilitators (to be renamed investigation and improvement managers (IIMs)) to strengthen this resource. They will be trained in the use of investigative analytical tools. The director of nursing told us that the trust would be consulting with NHS England to ensure it has an up-to-date analytical model in place. The trust would also ensure that a pool of trained investigation managers, separate to the IIMs, is available to ensure trust-wide capacity for investigation and that clinical staff are trained in investigation techniques.

5.29 The trust intends to develop enhanced training for investigation and improvement managers and for locality-based investigation managers. An e-learning package will be developed for all other clinical staff. These training packages are scheduled to be in place by August 2016.

Comment and analysis

The trust already applies the principles of NPSA practice but we felt that there were areas in which improvements could be made, particularly in relation to the application of benchmarks. Too often we found that the RCA investigations did not demonstrate whether national and/or local benchmarks were used in the analysis. This means that underlying issues may not have been found or addressed resulting in missed opportunities for learning. In general we found that national benchmarks were rarely used (less than 15 per cent of the RCA investigations appropriately referenced or partly[13] referenced national policy) though local policies were more likely to be referenced (51 per cent of report partly or appropriately referenced local policy).

[13] Some RCA investigation reports did reference a local or national policy but did not comprehensively set out all of the policies we would expect to be taken into consideration as part of the analysis

However in instances where local benchmarks were referenced these were not always appropriately applied to the analysis within the report (e.g. the RCA investigation report would refer to trust policy, by saying what should have happened) but failed to say whether it had been followed.

We found examples in the reports of contributory factors[14] being incorrectly identified such as the death of grandparent or taking illicit substances. Furthermore the reason for a death was often incorrectly identified as the root cause (e.g. a heroin overdose) on several occasions as opposed to the true root cause derived from the care management problems (should there have been a true root cause). Sixty five per cent of the reports we reviewed did not identify a root cause. Whilst we understand that it is sometimes not possible to identify a root cause we are concerned that this number appears to be high. Given that we found the level of analysis in the RCA reports to be generally weak we cannot establish whether it is reasonable that a root cause was not identified in over half of our sample.

We asked the trust if they quality assured their investigation reports using a checklist. They said they did not use a specific written checklist but that reports were read and checked before being signed off. Their checking system involves an initial quality review by the patient safety team. If the report is not considered good enough it is returned to the author with a list of follow up questions to explore. This is followed by a feedback stage which provides an opportunity for members of each review team (including external agencies) to comment on the report. A final check is then carried out by the patient safety team as well as the legal team (in the case of unexpected deaths). Finally a member of the patient safety team signs off the report as completed.

The trust could further develop this good practice by solidifying an agreed model for assuring the quality of reports. This would help to ensure that key issues are properly scrutinised, allowing for themes to readily emerge. Themes did not readily emerge from the RCAs that we reviewed.

[14] Contributory factors are factors that either influenced or caused a single event or chain of events that contributed to the incident. The factors may have had either a negative or a positive effect, e.g., some may have mitigated or minimised the outcome of the incident.

We note that members of the patient safety team involved with the quality review stage have a high number of reports to deal with, sometimes 10 to 15 a week, on top of their additional professional commitments. The trust should consider whether additional resource is needed here to improve the level of analysis in the reports or whether the newly recruited IIMs should have responsibilities in this area.

Recommendation

R6 The patient safety team should develop as a priority a quality assurance checklist/toolkit for all RCAs to promote a consistent approach to quality assurance. The quality of the RCA investigation reports should be evaluated **six months** after this checklist is introduced.

Developing SMART recommendations

5.30 NPSA guidance says that recommendations should be clearly linked to identified root cause(s) or key learning point(s). They should:

- *"address all of the root causes and key learning points;*
- *be designed to significantly reduce the likelihood of recurrence and/or severity of outcome;*
- *be clear and concise and kept to a minimum wherever possible;*
- *be Specific, Measurable, Achievable, Realistic and Time-bound (SMART) so that changes and improvements can be evaluated; and*
- *be prioritised wherever possible."*

Comment and analysis

Only 29 per cent of reports contained recommendations that were SMART. Our methodology only classified reports as containing SMART recommendations if 100% of the report's recommendations were SMART. Examples of non-SMART recommendations we found in the RCA reports include:

- ***"since withdrawal of policy, the pathway remains unclear around;***
    - ***use of leave beds;***
    - ***consideration should be given to mandatory internal training; and***
    - ***clinical team leader to remind staff of…"***

These recommendations are vague and the trust should aim to ensure that recommendations such as these ones are considered unacceptable in future RCA reports.

Timeliness of reports

5.31 We intended to examine the extent which the trust completes its RCA reports on time. NHS England guidance introduced in 2015 says that all serious incident investigations e.g. unexpected death investigations should be completed within 60 working days.

5.32 There is no standardised way to assess whether each of the reports in our sample were completed on time. Until recently, the trust data for logging whether a report is completed on time, does not account for any legitimate extensions that are made to report timeframes e.g. for toxicology reports. As such, presenting the data that is available would be misleading.

5.33 We spoke to the patient safety team about the timeliness of reports. A member of the team told us that the trust was *"quite good"*, noting that in January 2016 only two reports out of 20 missed the deadline and that 14 out of 17 hit their target in February.

5.34 The trust informed us that it now keeps an accurate log of whether each RCA report is completed on time. This change has been brought about by the desire to measure internal performance and new requirements from the trust's commissioners.

Comment and analysis

It is important that the trust keeps an accurate log of whether RCA reports are completed on time, taking into account any legitimate extensions that have been granted. This will enable the trust to analyse their progress on completing reports on

time and identify any themes that contribute to reports not being completed in a timely manner.

RCA themes

5.35 We analysed our sample of 126 RCA investigation reports to look for common themes that emerged. As we note above, we found the level of analysis in the reports to be weak which made it difficult to identify whether there were key themes in relation to clinical issues (e.g. dual diagnosis, discharge arrangements, service delivery problems etc.)

5.36 We could not find any major trends from the 126 reports that we examined. In this section we focus on three themes which emerged from a small number of reports.

Discharge planning and arrangements for discharge

5.37 The National Institute for Health and Care and Excellence (NICE) scoping paper[15] outlines that poor transition between inpatient service user mental health settings and community has negative effects on people using services, their families and communities. The paper details that poor discharge planning can lead to a lack of continuity, personalisation and the necessary support for the person with mental health problems and their family.

5.38 In the sample of RCA reports we found that there were examples where discharge arrangements could have been planned better. Examples of poor practice include:

- no proper discharge plan in place;
- discharge without the care plan, CPA and risk assessment being updated;
- limited or no liaison with service user's GP;
- discharge from the CRHT without a face to face meeting with the service user;
- rationale for discharge from service unclear; and
- no crisis plan in place.

[15] *NICE guideline: Transition between inpatient mental health settings and community or care home settings - draft scope for consultation*

5.39 The reports in our sample did not evidence whether there are any underlying issues leading to these mistakes and in few cases the issues highlighted above were considered to have contributed to or caused the unexpected death.

Dual diagnosis

5.40 People with a dual diagnosis can present a challenge to mental health services. The NICE scoping paper[16] advises that these people are at a higher risk of relapse in terms of both substance misuse and mental health problems, readmission to hospital self-harm and suicide. People with a dual diagnosis might need a range of services including NHS, social care and voluntary sectors.

5.41 The trust provides mandatory training for dual diagnosis and a one day training programme for substance misuse and another for dual diagnosis. The trust also has policies, procedures and guidance in place to support staff in caring and treating services users with dual diagnosis.

5.42 We found that that approximately 10 per cent of the reports in our sample involved a service user who had been diagnosed with a dual diagnosis.

5.43 Issues arising from these investigation reports included:

- the need for better interagency communication and liaison;
- staff not accessing trust training;
- staff not adhering to trust policy and guidance on dual diagnosis; and
- staff not being able to access the different electronic record keeping systems in in-patient services and substance misuse therefore information between services not shared.

5.44 The reports in our sample did not evidence whether there are any underlying issues as to why these mistakes happened and again, in few cases the issues highlighted above were considered to have contributed to or caused the unexpected death although they were seen as a concern.

[16] *NICE Guideline scope Severe mental illness and substance misuse (dual diagnosis)*

Care coordination

5.45 The care coordinator works in partnership with service users and agencies to arrange and establish a care plan. The care coordinator has the responsibility for coordinating care, keeping in touch with the service user, ensuring that the care plan is delivered and reviewed as required. The trust has established policies, procedures and guidance in place for CPA and care coordination.

5.46 In the RCA reports we found issues relating to care coordination regarding:

- high case loads;
- care coordinators had not completed mandatory risk assessment and management training at the time of the incident;
- service user having 5/6 care-coordinators in past six months (this occurred during organisational change and the issue was reported to have been resolved);
- no access to electronic record system;
- care coordinator feeling under pressure due to workload - lack of formal support and processes to manage workload at the time; and
- no evidence of formulation or care/crisis plan.

5.47 The reports in our sample did not evidence whether there were any underlying issues as to why these mistakes happened and, as above, few of the issues highlighted above were considered to have contributed to or caused the unexpected death although some were recorded as a concern.

5.48 The trust informed us that it is aware of these issues and, following a CQC inspection in October 2014, has put extensive improvement programmes in place to address them. The trust told us about reaching a mandatory training compliance level of 78 per cent, putting enhanced risk assessment training courses (DICES[17]) in place and recruiting staff in the community setting. To help with coordination, the trust has had a single electronic record system in place since May 2015 and we were told by our interviewees that staff have found this system beneficial for accessing all clinical records in a crisis. We were told by the trust that it has prioritised ensuring that all community patients have a crisis and care plan. A trust-wide audit will take place in May 2016.

[17] The DICES risk assessment and management system is a training course accredited by the Association for Psychological Therapies.

Patient profile

5.49 We set out tables below detailing descriptive information about the profile of patients. It should be noted that the following information was taken from the RCA reports and therefore often prior to a coroner's inquest.

5.50 Table 5.1 below sets out descriptive information about the gender and age of the patients who died unexpectedly.

Table 5.1 - Profile of patients in the sample

Average age of patient across entire sample (126)	**Gender split across entire sample (126)**
Male (45 years 11 months)	Male 73 (58%)
Female (47 years 8 months)	Female 42 (33%)
	Not known 11 (9%)

Locality

5.51 Table 5.2 sets out the number of RCA reports we reviewed from each locality in the trust, the highest numbers for which came from Central Norfolk (35) and NRP (30) [18].

Table 5.2 – RCA reports in our sample by locality

Locality name	**Number of SIs reviewed**
Central Norfolk	35
Norfolk Recovery Partnership (NRP)	30
East Suffolk	17
Wellbeing	13
Gt. Yarmouth and Waveney	12
West Suffolk	11
West Norfolk	8
Total	126

[18] Each locality differs in size and as such variance in the frequency of SIs and unexpected deaths across localities may be a result of this and not due to poor performance in a particular locality.

Community deaths – drug and alcohol

5.52 Table 5.3 describes the number and percentage of community deaths related to drugs, alcohol or both.

Table 5.3 - Community deaths relating to drug and alcohol

Death related to:	Number	%	Combined
Alcohol	13	21%	
Illicit drug	5	8%	
Both	10	16%	45%
None of above	34	55%	55%
Totals	62	100%	100%

5.53 Forty five per cent of the community deaths we sampled had a link to alcohol or illicit drugs.

5.54 Of the remaining 34 community deaths, the causes are outlined in table 5.4.

Table 5.4 - Community deaths not relating to drug and alcohol

Overdose of prescribed medication	7
Hanging	7
Not known	7
Natural causes	3
Found in river/sea/broad	3
Fell from building/bridge	3
Hit by train	2
Self-harm (cut wrists/neck)	1
Set themselves on fire	1
Total	34

5.55 Table 5.5 sets out the same analysis for the wellbeing[19] service deaths.

Table 5.5 - Wellbeing service deaths

Hanging	5
Not known	4
Alcohol	1
Overdose of prescribed medication	1
Found dead in burning car	1
Self-inflicted gunshot wounds	1
Total	13

5.56 Table 5.6 sets out the same analysis for the Norfolk Recovery Partnership (NRP) service.

Table 5.6 - Norfolk Recovery Partnership (NRP) service deaths

Overdose of prescribed medication (generally methadone)	10
Illicit drug	6
Illicit drug and alcohol	5
Not known	3
Alcohol	2
Hanging	1
Plastic bag over head	1
Self-inflicted stab wound	1
Head injury inflicted by someone else	1
Total	30

5.57 Table 5.7 sets out the same analysis for the acute service.

[19] The wellbeing service is aimed at service users experiencing mild to moderate depression, stress or anxiety.

Table 5.7 - Acute service deaths

Fell from high building	2
Not known	2
Found in river	1
Overdose of prescribed medication	1
Fall	1
Total	7

5.58 Table 5.8 sets out the same analysis for the access and assessment service.

Table 5.8 - Access and assessment service deaths

Hanging	5
Not known	2
Intentional ingestion of anti-freeze	1
Overdose of prescribed medication	1
Alcohol	1
Fell from cliff	1
Total	11

5.59 The one inpatient death was related to choking. The one learning disability death was related to an overdose of prescribed medication. The one secure services death was a hanging.

5.60 We were unable to comment on specific themes or trends in the profiles of patients' families as this information was not included in the RCA reports that we reviewed.

Comment and analysis

The quality of analysis in the RCA reports was generally weak. This has prevented us from drawing out common patient/clinical themes from them but we note the following descriptive information:

- *we are unable to comment on the exact number deaths relating to suicide because we only looked at RCA reports (in accordance with our terms of reference) which are generally produced before coroners' inquests;*
- *the highest number of unexpected deaths were in Central Norfolk (35) and NRP (30);*
- *45 per cent of unexpected deaths in the community involved drug or alcohol; and*
- *58 per cent of unexpected deaths in our sample were male, 33 per cent were female and in 9 per cent of cases the gender of patient was not identifiable in the RCA report.*

We identified no significant trends in the RCA reports in relation to cause of death or service beyond these points. We could not identify any themes in relation to service users' families based on the information contained in the investigation reports.

In terms of a national context we note the recently published report[20] (May 2016) from the Department of Health's Healthcare Safety Investigation Branch. The report comments on a range of shortcomings that exist in current incident investigation practices across the healthcare system. The report describes specific problems such as investigations being delayed, protracted and of variable or poor quality. The report also details that, within healthcare organisations, safety investigation is often poorly resourced with limited access to the required expertise and insufficient allocation of time being key problems.

We have identified areas where the trust should make improvements to its RCA process - e.g. terms of reference, investigation team, investigation analysis, recommendations and engagement with families. We have set out recommendations in parallel with our

20 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/522785/hsibreport.pdf

analysis. The trust board has a fundamental role in developing RCA investigation and learning as a whole. We discuss this further in section 6.

Finding

F1 The current RCA investigation process meets trust and national requirements but improvements can be made in following it.

6. Board level oversight

6.1 The Healthcare Quality Improvement Partnership[21] (2015) identifies ten themes of good governance that include transparency and public reporting, systems and structures, quality and safety and working at and across boundaries. This guidance draws attention to duty of candour regulation and the responsibility on trusts to give stakeholders assurance in relation to trust services and resources:

> *"The overall principle is that the organisation accepts the need for candour, that openness builds confidence and that early disclosure supports early improvement"*

6.2 The guidance says in relation to systems and structures:

> *"In governance terms… the organisation must have structures and processes in place to identify and benchmark itself against relevant best practice and to track and report compliance against relevant standards and targets. It must ensure a clear line of sight from the front line of service delivery through to board level on quality and safety."*

6.3 The guidance describes a variety of methodologies that trusts may use to ensure they have strong systems and processes in place. In relation to patient safety, these include risk reporting, incident analysis and mortality and morbidity reviews.

6.4 The Healthy NHS Board Principles for Good Governance[22] (2013) says effective NHS boards demonstrate leadership by undertaking three key roles:

- *"Formulating strategy for the organisation.*
- *Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.*
- *Shaping a positive culture for the board and the organisation."*

[21] http://www.good-governance.org.uk/wp-content/uploads/2015/01/GGH-Main-.pdf
[22] http://www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf

6.5 The healthy board principles also highlight that the board has a key role in safeguarding quality and so needs to give appropriate scrutiny to the key facets of quality – effectiveness, patient safety and patient experience. Effective scrutiny relies primarily on the provision of clear, comprehensible summary information to the board.

6.6 This section focuses on whether the board has sufficient overview of unexpected deaths, whether themes arising from unexpected deaths are discussed and whether appropriate actions are taken and monitored, including sharing of learning internally and externally.

Reporting to the board and lessons learnt

6.7 We reviewed the trust board minutes (private and public) from 2012 until late 2015 to see the extent to which the board had overview of unexpected deaths. We found that in 2012 and 2013 unexpected deaths were typically reported to the board quarterly via the *Patient safety and quality report*.

2012

6.8 In March 2012 it was reported to the board that unexpected deaths in the community were increasing. However there is limited discussion in the board minutes about this and it is unclear the extent to which the board explored this issue. In March 2012 the private minutes said:

> "[Director of nursing] *gave details on the serious incidents (SIs) which had taken place since the last meeting. There is a regional trend for an increase in SIs being recorded in secondary care wellbeing services for unexpected deaths in the community, as these would previously have been recorded by the GPs and primary care services. A meeting has been arranged by the SHA to look at this trend."*

6.9 The board did not ask the director of nursing to provide an update about this at a later date. No further action was minuted in the board minutes.

6.10 Similarly, engagement with families in relation to unexpected deaths was raised in the public board minutes in August 2012:

> "[Non-executive director] *asked what approach the trust used in involving families in the serious incident review process.* [Director of nursing] *explained that where there is an unexpected death* [chief executive] *writes to the family to offer condolences and support and to identify the named link person within the trust. This process has proved valuable since families often appreciate being included and can offer helpful insights as to how services can be improved."*

Comment and analysis

We do not think that the trust's mechanisms for engaging with families were effective at that time. Despite progress being made, as discussed in section five we think that improvements could still be made to the mechanisms that are in place today. The trust has taken action to improve in this area by recruiting additional IIMs.

2013

6.11 We found a similar pattern of reporting to the board in 2013, when the *Quality and safety report* was the main way of reporting unexpected deaths (quarterly). The minutes reflect that unexpected deaths were reported to the board but say nothing about the extent of any discussion. The exception was in December 2013 when the *Community serious incidents result in death – working party report (The working party report)* was presented to the public part of the board. The report detailed a review of 20 unexpected deaths in the community. Members of the working party included members of the patient safety team, a trust non-executive director (the report author), the deputy medical director, lead clinicians for both counties, a Suffolk locality manager and the trust safeguarding lead.

6.12 The December public minutes accompanying the report say that the number of deaths at the trust is lower than the national average and adds:

> *"The report explains that the number of deaths in Norfolk and Suffolk is lower than the national average, and that the number of deaths of people known to our services*

is also lower than for mental health trusts in England. No errors of omission or commission were identified in the review that caused (or could have prevented) the deaths."

6.13 The meeting minutes concluded:

"[Medical director] *highlighted the link between this report and the annual suicide audit. The conclusion was that NSFT provides safe services and* [was] *not out of line with the national picture. No evidence suggests services are becoming less safe or that any deaths were caused as a result of the implementation of TSS* [trust service strategy]. *There are some lessons to be learned which will be followed up."*

6.14 The minutes did not say what these lessons are or who was responsible for overseeing any learning except that the director of nursing should share the report with Healthwatch and the coroner's office. The director of nursing was also tasked with creating a suicide prevention group. This report, as well as the West Norfolk CCG report (discussed shortly), prompted improvements to structure and process including the appointment of RCA facilitators and an extension of the level 2 process to crisis resolution home treatment (CRHT) deaths.

6.15 We reviewed *The working party report*. It considered 20 consecutive community deaths (across trust services) between 21 March and 16 July 2013. The working party was formed in response to a report presented to the trust board by the director of nursing and governance in June and July 2013 about unexpected deaths in the community. The report focused on a number of factors including case allocation, clinical supervision, risk assessment and management, transfer of care and discharge issues. The report also outlines descriptive factors including patient demographics and localities. The report concludes:

"… in spite of the criticisms made of NSFT's RCA process, the vast majority of the 30 [sic] *internal investigation reports it reviewed identified relevant service and care delivery issues of concern appropriately… The working party is unable to comment on whether appropriate steps have been taken and learning consolidated in everyday practice"*

Comment and analysis

We note the small sample size used in the working party review – something the authors themselves noted – but believe that notwithstanding it provides a thorough analysis of the 20 cases and draws out relevant themes for consideration.

The working party report is a good example of the trust undertaking in-depth analysis into unexpected community deaths, but if the exercise were to be repeated, it would be helpful to expand the sample size with a view to exploring whether lessons had been learnt and if any practice had changed as a consequence.

6.16 There is evidence that the private board considered whether lessons were being learned. The September 2013 minutes record that KPMG (KPMG had been engaged by the trust to help review changes implemented after the merger) had noted during the course of its work with the trust that learning lessons was an issue. The chair had met KPMG and reported back in relation to governance:

> *"It was felt that there is a transparent process in identifying areas for improvement and lessons learnt from Serious Incidents but there was not a robust process to check the implementation of lessons learnt throughout the organisation and whether any changes are made to practice as a result."*

2014

6.17 Reporting of unexpected deaths to the board increased in 2014. They were reported to the board almost monthly (as opposed to quarterly) in 2014. The director of nursing reported in February 2014 that further work would be required to review 38 deaths across the Norfolk Recovery Partnership (NRP) to establish whether the number of deaths was high in the context of the client group. The board minutes contain no further information about this review but it was presented to the service governance committee (SGC)[23] in September 2014 with an action plan that was monitored internally and alongside PHE. The recruitment of a governance facilitator followed this review.

[23] The SGC had both executive and non-executive representation

6.18 The private board minutes record in March 2014 that West Norfolk CCG intended to commission an independent external review into unexpected deaths in the community, the terms of reference for which the trust provided comment on.

6.19 A trust non-executive director referenced the draft of the review in the July private board minutes though largely in an information only context:

> "[non-executive] *advised that since the report that the SGC had received drafts of both West Norfolk CCG's independent investigation of community deaths and the external investigation of the NRP."*

6.20 The director of nursing raised the *West Norfolk CCG review* again during the August private board to highlight issues in relation to RCA process and risk assessment:

> "[Director of nursing] *provided a verbal update… the report had included valid observations and that the clinicians in West Norfolk had taken the results well.* [Director of nursing] *said that the review had highlighted a need to improve RCA processes and risk assessments and that Lorenzo* [the trust new electronic patient record management system] *would help with the latter."*

6.21 In 2014 the board considered improving their learning from incidents. The public board minutes of August 2014 record that the trust had commissioned an independent review of SIs in the NRP that began in April 2014. The minutes said:

> *"This* [review] *was in response to an apparent increase in the number of deaths being reported by the newly commissioned service, although there was no comparison for trend… Despite this, the board was keen to establish if the number of deaths being report was within the range expected… being able to implement lessons learned from previous incidents was also an area of concern…The recommendations in the final report will augment the service's improvement plan, and form part of quality monitoring by commissioners. This will also be discussed at the trust's SGC."*

6.22 The external *West Norfolk CCG review* of community deaths was discussed at the August 2014 public board. The minutes say:

> *"The locality is developing an action plan in response to the report, with trust-wide learning being carried through by the patient safety team, and will be discussed at SGC."*

Comment and analysis

We note that the external West Norfolk CCG review was first raised in March 2014 but it was agreed only in September 2014 that it be shared with the board. We found no reference to the review in the October private board meeting minutes and it is unclear if the report was circulated to the board. Similarly, the report is referenced in the August public board minutes, which say the report will be circulated in September, but the minutes we have reviewed do not evidence that a final version was shared with the whole board. The review was briefly referenced in the August 2014 public board minutes, but minutes suggest that detailed board discussion of the final outputs of this review were limited. The review is not discussed again in the 2014 public or private board minutes. However we were informed by the trust that the report went to the SGC in August 2014 with an update on actions taken in October 2014. The SGC had both executive and non-executive representation. We were informed by the trust that recommendations from this review led to improvements being made beyond West Norfolk.

Similarly, the review of SIs in the NRP is referenced in the August 2014 public minutes but not explored further. The minutes say the review findings will be discussed at the SGC and there is evidence that the report went to the SGC meeting in September 2014, with an action plan. This action was monitored internally and alongside PHE. We would have expected the report to be discussed at board level given that the findings were to contribute to the service improvement plan and be used for quality monitoring.

6.23 The trust gave us a copy of the *West Norfolk CCG review*. The review examines seven SIs and provides an overarching commentary, drawing out themes that include risk assessment, senior staff involvement and documentation. The review extends beyond the

reporting of SIs and takes into consideration the trust SI policy, which it criticises. In particular, it is critical of the policy in relation to engaging/supporting service-users and families and/or carers. It says:

> *"This approach aims to be sensitive and compassionate at a time of possibly great distress. In practice it has meant that the voice of the family is frequently missing from the Serious Incident Review. Additionally it appears to have created in the RCA Facilitators organising the review and writing the report both a lack of confidence with involving the family as well as an absence of curiosity as to the families perspective as active seeking of the families view from the 'named' contact by the RCA Facilitator also appeared to be missing"*

6.24 The report further highlights concerns in relation to learning:

> *"…we believe that significant opportunities for learning from SI investigations are perhaps being missed."*

6.25 The report recommends:

> *"The trust should analyse figures for suicide regularly comparing them against national figures but should not rely on high or low rates of suicide as an indicator of a safe or of a dangerous service. Instead SI investigations should be subject to thematic review and more in depth analysis."*

2015

6.26 The reporting of unexpected deaths to the board reduced in 2015. The trust's *Patient safety report* was tabled on a quarterly basis at the public board. These reports covered a number of areas including a themed analysis of the wellbeing service (May), findings from a review of incidents in the wellbeing service (July), and duty of candour (November).

6.27 The director of nursing and medical director presented the 2013/14 audit of suicide and death of undetermined intent annual report to the October public board. The minutes say:

"The report included analysis of the increase in unexpected deaths. It should be noted that when the numbers were compared to the increase in the number of service users accessing services, there was actually a reduction in unexpected deaths per 1,000 service users"

6.28 We found that the private board minutes contained limited discussion about unexpected deaths and there is limited exploration of the subject beyond the quarterly *Patient safety report*, in the public board meeting minutes. The reports themselves are detailed (e.g. SI trends, incident reporting) but we cannot ascertain from the minutes the extent of the discussion and exploration they generated.

Comment and analysis

The trust board minutes showed that unexpected deaths (in terms of numbers) were consistently reported to the board. Equally in the early stages of the trust's formation, concerns were raised at board level in relation to high levels of unexpected deaths in the community. Problems are noted and external/internal reviews are referenced but we found little evidence recorded in the minutes of board examination. However the executive committee (which aims to meet weekly to develop opportunities for quality improvement, amongst other responsibilities) and the QGC (or its predecessor, the SGC), which have executive representation and the latter of which has non-executive representation, act as the forums for further exploration of issues/concerns and these vehicles now work well. The review led by a non-executive director and work in Suffolk (outlined shortly) are examples of actions taken by the board as a result of monitoring trends in unexpected deaths.

We found limited evidence of lessons learnt (specifically in relation to unexpected deaths) being reported to the whole board. We found that RCA investigations (which include a lessons learnt section) were sometimes included in the trust's Patient safety report submitted to the board but nothing in the minutes suggested a broader discussion. We were told by the trust that service user, carer or staff stories are submitted to the private board every two months. These stories have included service users and their families for whom suicide has featured. These stories are not minuted in any detail due to confidentiality. We found limited evidence in the board minutes

of the trust engaging with external parties e.g. the county council, housing agencies and the police in relation to sharing learning at this level. The exception to this is the trust's multi-agency work in relation to suicide prevention which we discuss in section 9 of this report.

There was a sense of acceptance by the board as a whole in relation to the rationale offered for the elevated unexpected deaths. Concerns raised at the board appear never to have been substantially explored. However they are covered in the executive committee and QGC (or SGC) minutes. The trust's patient safety reports are noted at board meetings and numbers reported (particularly in the public board minutes) but the board minutes alone contain little evidence to suggest that issues were followed up. For example, the findings of the 2014 independent review of the NRP were not shared with the whole board. It was however included in the executive committee and QGC meeting minutes, which both have executive representation and the latter of which has non-executive representation, act as the forums for further exploration of issues/concerns and these vehicles now work well.

We note that the Department of Health published its Learning from mistakes league table[24] in March 2016. The trust was ranked 223 out of 230 trusts. It should be noted that the methodology for devising this league table has been criticised for lacking consistency. Nevertheless our work tends to reinforce this conclusion, in view of whole board examination of learning from unexpected deaths.

Across our interviews and documentary review we were told about notable interventions that the trust has made including a learning event in November 2015 focusing on a recent increase in deaths of people seen in liaison services (from which a report was made to the QGC in January 2016). The trust informed that they are planning a similar learning event in the summer of 2016. The work of the SI group in Suffolk (discussed shortly) is another good example of the trust undertaking in-depth analysis into unexpected deaths.

[24] https://www.gov.uk/government/publications/learning-from-mistakes-league

Findings

F2 Unexpected deaths are routinely reported to the board but the board minutes suggest little discussion about them takes place. However, the executive committee and the QGC are the forums for exploring and this system works well.

Recommendation

R7 The trust board should develop its role beyond monitoring unexpected deaths. These include:

- learning sessions e.g. localised trust pilot work;
- exploration of (anonymised) case studies;
- exploration of the results from thematic reviews;
- design and implement a programme of sharing learning from thematic reviews with measurable outcomes across the trust; and
- seeking assurance that learning flows from 'ward to board' and back.

Further monitoring

6.29 Unexpected deaths are reported and monitored at the trust via a number of processes. The patient safety report is submitted to:

- the board;
- service governance committee (SGC);
- quality governance committee (QGC) (formerly the service governance committee); and
- the executive committee.

6.30 The trust chair told us that he took over chairing the QGC in the summer of 2015. Its purpose is to provide assurance to the board about the quality of trust services. We were told that the committee had not been working as intended prior to the summer of 2015 and that it needed to be overhauled. The revised committee has a standard agenda and attendance by locality managers is mandatory. The locality lead clinician or modern matron

must attend in their absence. The purpose of their presence at the meeting is to have clear service lines across each locality reporting to the committee. Locality governance groups report to the QGC. The chair told us that the committee had a work plan for the year e.g. quarterly reporting on restraint and seclusion but would also respond in depth to any new concerns.

6.31 We reviewed the patient safety team's reports to the QGC. The report contains a section for trend reporting. This details the number of deaths, locality and comparison in relation to previous monthly figures. In addition to the monthly reports, the committee provides an annual update.

6.32 We reviewed the QGC's most recent annual report dated 28 July 2015, which covered April 2014 to March 2015. It gives overall figures for each type of incident, including unexpected deaths in community and inpatient settings. It sets out comparative data for 2013 to 2014. The number of unexpected deaths in the community increased from 95 to 130 over the two years. The report provides further analysis in relation to unexpected deaths by locality and comments on the numbers. For example:

> *"Without weighting localities per population served, West Suffolk Community Teams had five suicide/took own life which is above all other localities. The five cases involved four males in adult age range. There was no correlation in diagnosis…"*

6.33 The report also provides descriptive analysis of the RCA report recommendations – noting that they vary significantly in scope and resource demand. For example, 'recommendation by type' e.g. training, record keeping, application of policy, and 'examples of good practice or proportionate practice by type'. The report notes that frontline learning has been a problem for the trust but that steps have been taken to improve this, including the introduction of new initiatives which we discuss further under *Working groups*.

6.34 We were provided with evidence from the trust that quality issues were tackled effectively across 2014 and 2015. In 2015 the committee introduced a *Learning lessons report*, delivered at each meeting, which highlights issues with RCA reports, such as around CPA, which the committee then uses to examine practice across the trust and benchmark against national data.

Comment and analysis

The QGC annual report (2015) identified some patterns across the unexpected deaths reviewed, in general relating to the breakdown of incidents per service line. An increase in deaths of patients seen in liaison services was recognised and the trust set up a learning event to tackle this.

The 2013 Working party report and 2014 NRP report did not draw many common themes, though this may be partly due to small sample sizes. This corresponds with our own finding that it was difficult to draw out common themes across the RCAs.

6.35 The patient safety team gave us a copy of the trust's *Norfolk Recovery Partnership review of deaths (2015)* in April 2016. It will be submitted to the QGC. It examined the deaths of service users who had either died while they were having treatment or within six months of leaving the service.

6.36 The report provides demographics on this patient group, breaking down information by gender, presenting substance type i.e. drug or alcohol, cause of death and locality. The report also contains a lessons learnt section. We found little evidence of lessons learnt in the report. Of the 36 unexpected deaths, 19[25] RCAs had been undertaken and the report did not draw out themes in relation to these beyond the following excerpt:

> *"Of the RCA reports which were available there were* [a] *greater number of comments of good practice than there were recommendations made, there were no recurring themes of recommendations found."*

6.37 The recommendations and good practice are detailed in the report appendices.

Comment and analysis

The NRP (2015) report is largely restricted to descriptive analysis and contains a number of illustrative charts. The trust review contains limited thematic analysis other than to note that the unexpected deaths are increasing due to drug use, and - as

[25] Cause of death was yet to be confirmed in the other 17 cases.

reported by PHE – "possibly accelerating". The report sets out actions undertaken in relation to this. For example, 200 naloxone[26] take-home packs were given to service-users. The report set out indications that respiratory disease was becoming a significant cause of death in NRP, and noted smoking cessation training for staff was to be increased along with "considering what links to acute death care can be established".

We conclude that this report sets out clear demographics about patient deaths (including unexpected deaths) but contains little review beyond this, particularly in relation to lessons learnt.

Working groups

6.38 The director of operations for Norfolk said she had recently set up a working group to look at SIs in Norfolk and Waveney because the senior operational team and some executives had concerns about a suspected increase in unexpected deaths in July 2015. At the time of writing two meetings have taken place. She told us that the group intended to build on the work of the *Suffolk SI review group* (see below) and that the lead clinician for East Suffolk had attended the second meeting to explain how that group was set up. It had been agreed that a psychology lead clinician will oversee the Norfolk group and liaise with the East Suffolk lead as required.

6.39 At the time of writing the group does not have terms of reference but the director of operations for Norfolk told us she expected to adopt a similar approach to that of the Suffolk group and thought the two groups would become aligned in the long term, for example, perhaps meeting quarterly to share findings.

6.40 The SI review group in Suffolk (the pilot began in July 2015) reports to the Suffolk senior operational team and governance/quality meetings at local and trust level. The lead clinician for East Suffolk told us the group had been created in response to an increase in suicides in the autumn of 2014.

6.41 The terms of reference for the group describe its purpose as:

[26] Medication used to block the effect of opioids, particularly during an overdose.

"Review SI reports, from a multi-disciplinary perspective, in order to identify themes and good practice to learn from."

6.42 The group has a number of aims:

- *"not re-investigate but to use existing reports as far as possible;*
- *reduce SIs and the recurrence of themes;*
- *improve practice and quality;*
- *identify systemic obstacles to learning;*
- *inform training needs;*
- *inform good practice through application of relevant clinical evidence and guidance."*

6.43 Work originally focused on a review of 11 SIs (RCA reports) and moved to the creation of a quarterly review group. Members of the SI review group are the modern matrons, the lead clinicians from wellbeing, access and assessment, community and acute services (medical and non-medical), the deputy medical director in Suffolk and members of the patient safety team.

6.44 The trust gave us a copy of the pilot paper, *Learning from serious incidents* (July 2015), reviewing SIs (focusing on unexpected deaths and near misses) that happened in April, May and June 2015. The pilot paper said learning from incidents had been a problem:

"This pilot was developed in Suffolk following a group of unexpected deaths in East Suffolk. This review illustrated the benefit of reviewing a group of SIs and highlighted the lack of learning opportunities that could adequately assess the emerging themes."

6.45 The report contains a *what can we learn?* section detailing themes relating to demographic information, mental health, physical health and risk assessment. The lead clinician for East Suffolk told us:

"…we look at the collective group around themes. The aim of that is to obviously look for patterns, which has been actually really helpful, but also to take the issue away from the teams so that it is a bit anonymised to help them to be more

objective and to be less focusing on blame etc.[27]*, to help learning, and then access… we combine* [the report] *with the team learning space where the experiential learning cycle could be completed, facilitated by psychologists to start with."*

6.46 She told us the purpose of the SI review group was to encourage learning among staff. Before the group was formed she found that RCA reports were being discussed at the end of the meeting when staff started to leave due to competing demands on time: it had become somewhat of a tick-box exercise. The new format was designed to counter this. She told us the group would produce quarterly reports and share them with staff through the governance groups in their services.

6.47 In conjunction with the *Learning from serious incidents report* the lead for East Suffolk gave us the *East Suffolk SUIs (serious untoward incidents) resulting in death of the service user – draft report*. This report provides analysis of the 11 cases in terms of patient factors (e.g. engagement style, diagnosis), staff factors and service factors.

6.48 The SI pilot work is relatively new but we discussed with the lead clinician for East Suffolk whether any noticeable changes in practice had taken place. She told us that staff were given more opportunity to learn from incidents. She added that the first report had identified challenges with producing good quality RCA reports – which were passed to the patient safety team. This has resulted in modern matrons in Suffolk being identified as potential supervisors for staff writing the reports. She went on to say that the SI review group was a valuable means of embedding and sharing learning even though it was resource-heavy. The pilot identified a theme of risk involved with a lack of objectivity due to the investigation panel being too close in relationship to the service where the SI occurred.

6.49 She added that the work was relatively small and could be expanded to facilitate the development of the trust's suicide strategy. We discuss this further under section 9.

[27] Teams were not passing blame to one another. However they could potentially feel blamed in accordance with the proximity of the SI to them. The collective group around themes was a means to help focus on learning and to reduced harm to teams resulting from experiencing SIs.

Comment and analysis

The trust has taken positive steps in developing working groups to learn from SIs, particularly in Suffolk. These should be how staff learn from unexpected deaths. We note that the recent pilot paper, Learning from serious incidents, sets out a number of helpful questions for RCA teams to ask themselves aimed at overcoming potential bias, ensuring reflective practice and engaging with families/carers.

It is too soon to ascertain if any learning derived from these groups has/will become embedded in clinical practice. The Norfolk working group has met only twice at the time of writing and the success of the group is yet to be proven due to its infancy. With this in mind we recommend that the trust set itself a schedule to progress and align the work of the two groups and to agree a date to evaluate their work.

Findings

F3 The trust has a number of channels for monitoring unexpected deaths and undertaking thematic analysis but the themes and learning do not readily emerge from individual RCA reports.

F4 The trust undertakes reviews of unexpected deaths but there are some missed opportunities for learning lessons.

F5 We found some good practice, such as learning events and working groups. These encouraged learning.

Recommendation

R8 The trust should prioritise an aligned programme of work for the two SI working groups and undertake a review of progress **within nine months** of its implementation.

7. Analysis of data

7.1 Our terms of reference ask us to provide a contextual view of the trust's number of unexpected deaths in the context of national trends to identify (as far as possible according to constraints of data) if the trust is an outlier.

7.2 We encountered serious limitations when retrieving data. The national data about unexpected deaths in mental health trusts offers limited means for making meaningful comparisons between mental health trusts. NHS England report this in their FOI response as we comment on the next section. Many national datasets are produced only for non-specialist acute trusts such as the HSCIC's summary hospital-level mortality indicator, which reports on mortality at trust level. The HSCIC's mental health minimum dataset (MHMDS) provides data at the mental health trust level, but the data contains gaps and are not standardised for factors such as the varying populations served by each mental health trust. The MHMDS provides 'counts' (absolute values) rather than 'rates' or (relative values), making it difficult to make trust level comparisons using this dataset alone. Furthermore it is difficult to be certain that investigating/reporting practices relating to unexpected deaths are consistent across trusts. The classification of incidents is fundamentally a local decision in accordance with NHS England's SI Framework. This again makes trust level comparisons difficult. We strongly recommend that the trust flags the gap in meaningful, comparative data this area to NHS England to prevent data from causing potential misrepresentation and misinformation.

7.3 We looked at variables that could reasonably be considered to account for a mental health trust in any particular area recording high levels of unexpected deaths. We considered national and regional data on:

- populations served by mental health trusts in England;
- suicide rates;
- demographics (age, gender and unemployment);
- indices of deprivation;
- levels of mental health and illness;
- investigation thresholds;
- the risk profiles of mental health trusts in England, in terms of whether they offer a substance misuse service; and
- reporting practices.

7.4 Bearing in mind the limitations of the data we have mostly used secondary data for this review. Secondary data was generally collected from the Office of National Statistics (ONS), the Health and Social Care Information Centre (HSCIC), the National Reporting and Learning System (NRLS), NHS England, PHE and the Department for Communities and Local Government (DCLG). A full list of data sources used is included at Appendix E.

7.5 We generally include the latest available data and in some cases, due to a lag between data being recorded and reported, this has been from 2013 at the latest.

7.6 One of the trust's drivers for commissioning this review was a freedom of information request by the Rt Hon Norman Lamb submitted to NHS England. We comment on this in the first section of this section.

The freedom of information request

7.7 The Rt Hon Norman Lamb submitted a freedom of information (FOI) request in December 2015 asking, among other information, for data on:

> *"The number of serious incidents recorded in mental health trusts across 2012-15 that were unexpected or avoidable patient deaths."*

7.8 NHS England responded[28] in January 2016, with information from their Strategic Executive Information System (StEIS)[29]. They provided data as absolute values from trusts categorised by the CQC as providing mental health services[30] in 2015. The data included the total of a) SIs and b) unexpected deaths at each mental health trust in England from April 2012 to December 2015. The data were categorised by year and trust. The full table can be found at Appendix F.

7.9 The data consisted of absolute values, not relative or weighted values. As such they are not designed to provide context for comparing trusts. This is acknowledged by NHS

[28] NHS England's response to the FOI can be found at Appendix F
[29] StEIS is a database used for the notification of appropriate parties that Serious Incidents have occurred and to manage progress of subsequent investigations, in accordance with the Serious Incident Framework 2015. Serious incidents are reported by trusts to their commissioners using StEIS. StEIS relies on assumptions made about the accuracy of the description of incidents.
[30] http://www.cqc.org.uk/content/monitoring-trusts-provide-mental-health-services

England. Our aim in this analysis is to provide some context to the data by analysing underlying variables that could account for the number of unexpected deaths - 359 according to the FOI data - recorded at NSFT from April 2012 to December 2015.

7.10 NHS England's FOI response included data from 57 mental health trusts in England. NHS England said:

> *"these trusts differ significantly in size and type of mental health services they provide, as well as other types of health care services they provide, in addition to mental health services."*

7.11 The data were not standardised for underlying variables such as the size of trust or for the comparability of services. NHS England recognises that it is difficult to draw meaningful comparisons between trusts based only on these data.

7.12 NHS England also commented on problems in determining whether an incident is classified as 'serious' because the decision is made locally, albeit in accordance with NHS England's SI Framework (2015). The framework offers guidance on what defines a SI but warns:

> *"There is no definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents".*

7.13 The framework defines circumstances in which a SI must be declared and recognises that the inevitable borderline cases rely on the judgement of the people involved. The framework asserts that SIs relating to unexpected deaths in the NHS include:

> *"Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in unexpected or avoidable death (this is distinct from death which occurs as a direct result of the natural course of the patient's illness or underlying condition where this was managed in accordance with best practice)".*
>
> *"Whilst a serious outcome (such as the death of a patient who was not expected to die) can provide a trigger or identifying serious incidents, outcome alone is not always enough to delineate what counts as a serious incident".*

7.14 Given that local judgement is used in defining SIs, it is not possible without systematic comparison of practices across individual trusts to state definitively that data are consistently compiled and are thus genuinely comparable. As outlined towards the end of this section, NHS England's director of commissioning operations (DCO) team is conducting a study in parallel with this review to find out if NSFT has a rigorous and standardised process for determining unexpected deaths requiring SI investigations. This work aims to look at investigation thresholds in other trusts to see if some investigate unexpected deaths more readily than others, which may account for the number of unexpected deaths recorded.

7.15 NHS England says in its FOI response that the StEIS database, from which it provided the data, was designed to allow commissioner oversight of individual SI investigations and not to support trend analysis. Before May 2015 StEIS did not systematically collect information on whether the trigger for a SI investigation was an unexpected death. This makes it difficult to accurately identify through StEIS which SIs were triggered by unexpected deaths before this date.

7.16 It is recognised in the 2015 Mazars report[31] that a range of terms used in association with deaths (e.g. expected, unexpected, avoidable and premature) exist. The Mazars report states that there is no clear, single definition either of an expected or an unexpected death. This opens the possibility of variation between trusts around what constitutes an unexpected death. The fact that different trusts can have different criteria for undertaking an investigation (referred to as investigation thresholds) further contributes to making comparisons between mental health trusts difficult. Similarly different incident reporting rates, as recorded by the NRLS, compound the difficulties with comparing mental health trusts on unexpected death data at the national level.

7.17 In this section we seek to bring some context to the absolute values in the NHS England FOI response in order to provide the trust with insight on whether its numbers, patterns and trends in unexpected deaths are significantly higher than those of other trusts. Each of the following sections cover an underlying variable that could account for high levels of unexpected deaths. We start by looking at variables that manifest outside the trust (population sizes, suicide rates, demographics (age and gender), indices of deprivation, and levels of mental health and illness) before commenting on variables that manifest inside the trust (investigation thresholds, the risk profile of services and reporting practices).

[31] https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

Populations served by mental health trusts in England

7.18 We start by examining the population served by each mental health trust to determine whether a relationship exists between this variable and the number of unexpected deaths recorded.

7.19 We ranked 56[32] mental health trusts in England by population served (appendix G) using latest CQC reports or recent trust documentation as sources for population estimates. It should be noted that these population estimates may include the populations to which a mental health trust provides community services. We contacted some individual trusts to verify the estimate of their population. NSFT is listed as serving a population of 1,500,000, ranking it 11th. The average population served by the 56 mental health trusts is 1,043,240, so the trust serves a greater population than most mental health trusts in England.

7.20 A Pearson product-moment correlation coefficient was computed to assess the relationship between the size of the population and the number of unexpected deaths recorded. This coefficient provides a measure of the strength of a linear association between two variables – essentially if one variable increases or decreases in direct proportion to the other. We found no significant correlation between the two variables, with an R-squared value of 0.0616, showing that only 6 per cent of the total variation in unexpected deaths can be explained by size of population served. In other words, 94 per cent of the total variation in unexpected deaths remains unexplained when looking at the size of the population served.

Comment

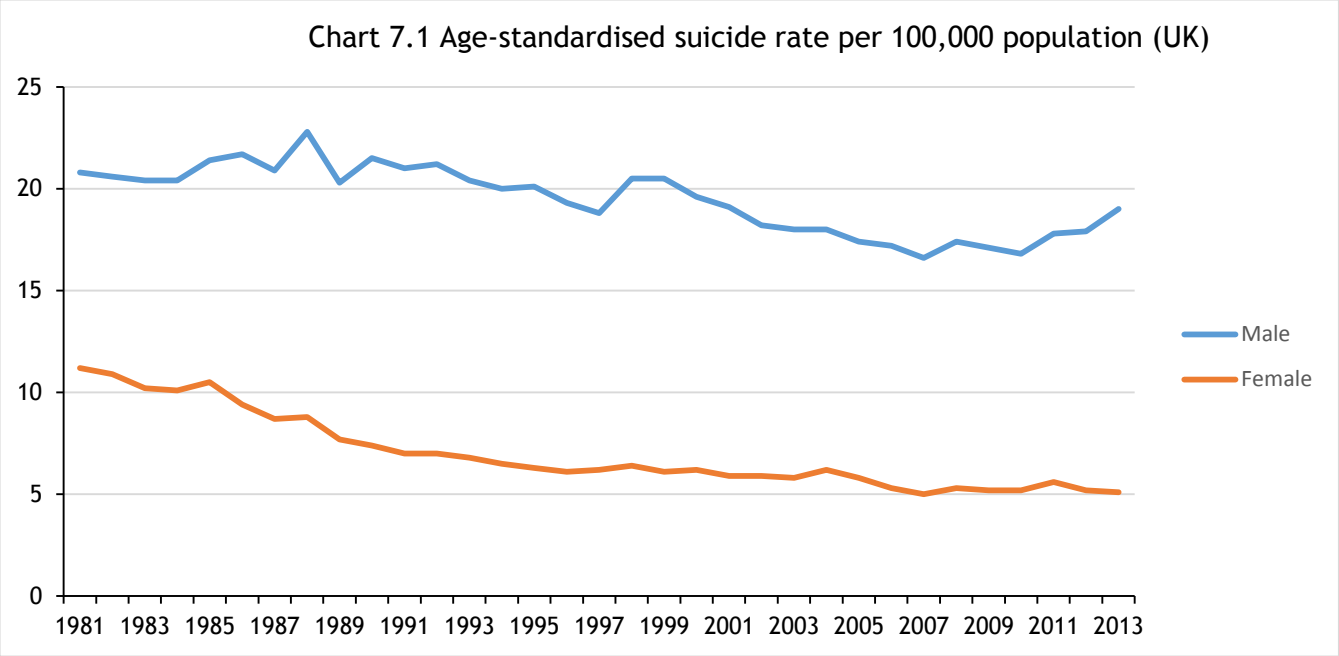
The lack of a positive correlation here is surprising. We would expect that trust's that serve larger populations record larger numbers of unexpected deaths. The fact that no correlation exists suggests that the data are misleading.

[32] Data from Tavistock and Portman NHS Foundation Trust was removed from this analysis due to difficulties with formulating a size of population served statistic.

National suicide trends

7.21 We looked for national and regional differences in suicide rates. We established whether the demographic served by NSFT has a disproportionately high or low number of people most at risk of suicide.

7.22 The most recent ONS suicide data (February 2015) shows that between 1981 and 2007 national age-standardised suicide decreased. Since 2007 there has been a gradual rise. The female rate has stayed relatively constant whereas the male rate has increased significantly, leading to an overall increase since 2007. The most recent data on record is for 2013. Of the total number of suicides registered in 2013 in the UK, 78 per cent were male and 22 per cent were female. Suicide rates have been consistently lower in females than in males throughout the period covered by the data.

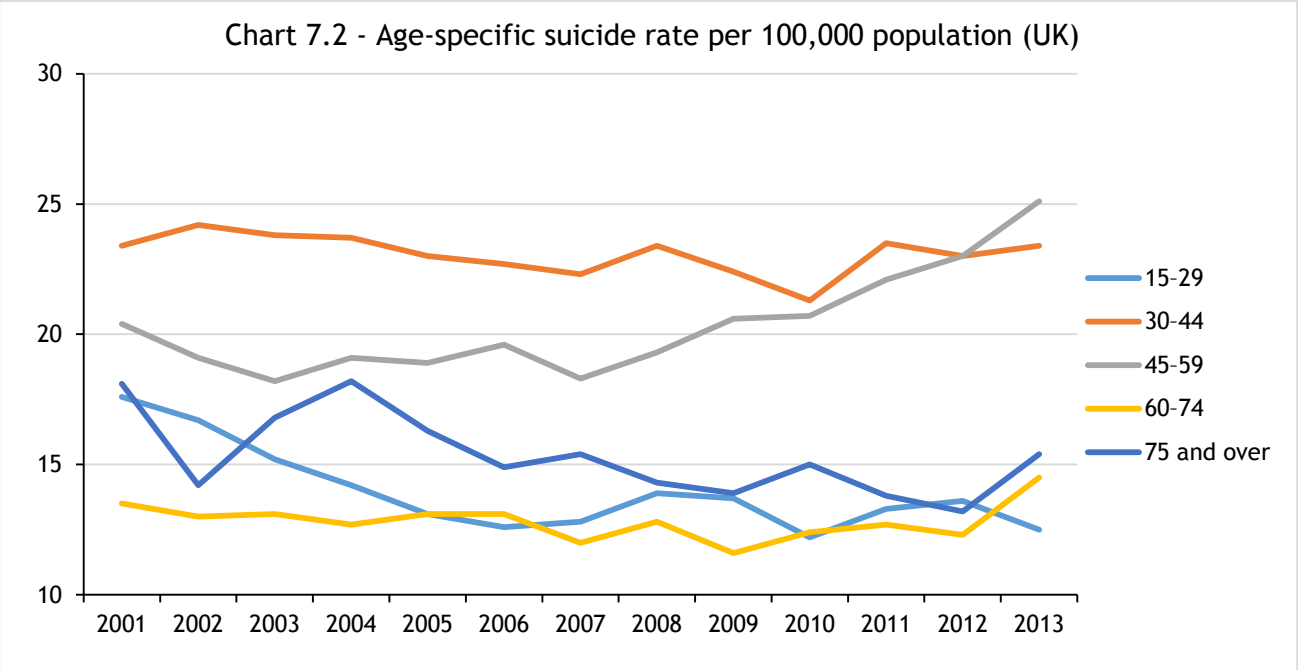


7.23 Studies have shown suicide and non-fatal self-harm increase at times of increased unemployment. One such study, by Barr et. al.[33] (2012), found that each annual 10 per cent increase in the number of unemployed men was associated with a 1.4 per cent increase in

[33] Barr, B; Taylor-Robinson, D; Scott-Samuel, A; McKee, M & Stuckler, D (2012) Suicides associated with the 2008-10 economic recession in England: time trend analysis, BMJ (Clinical research ed.), 345.

the number of suicides from 2000 to 2010. A review by the Samaritans (2012[34]) found that middle-aged men in lower socioeconomic groups were at particularly high risk of suicide. The review finds that suicidal behaviour results from the interaction of a range of complex factors such as unemployment, economic hardship, a lack of close social and family relationships, the influence of a historical culture of masculinity and personal crises such as divorce. Those with a mental illness have a higher suicide risk than the general population (Windfuhr and Kapur, 2011[35]).

7.24 Men aged 30-44 had the highest suicide rate in the UK, from 1995 to 2012. In 2013, men aged 45 to 59 showed the highest rate of any age group, having increased since 2007 to reach 25.1 deaths per 100,000 people. The ONS shows that suicide remains the leading cause of death in England and Wales for men aged between 20 and 34 (24 per cent of all deaths in 2013) and for men aged 35 to 49 years (13 per cent of all deaths in 2013). Of the 4,722 suicides among people aged 15 and over in England (2013) more than three-quarters were male (78 per cent).



[34]http://www.samaritans.org/sites/default/files/kcfinder/files/press/Men%20Suicide%20and%20Society%20Research%20Report%20151112.pdf
[35] Windfuhr, K & Kapur, N (2011) Suicide and mental illness: a clinical review of 15 years findings from the UK National Confidential Inquiry into Suicide, British Medical Bulletin, 100, 101-121

Suicides trends by region

7.25 The ONS and HSCIC provide data segmented by, among other geographies, Government Office Regions (GORs) before 2011 and Regions after 2011. The map below shows the boundaries of each region and was provided by the HSCIC. NSFT is one of five that operate in the East of England.

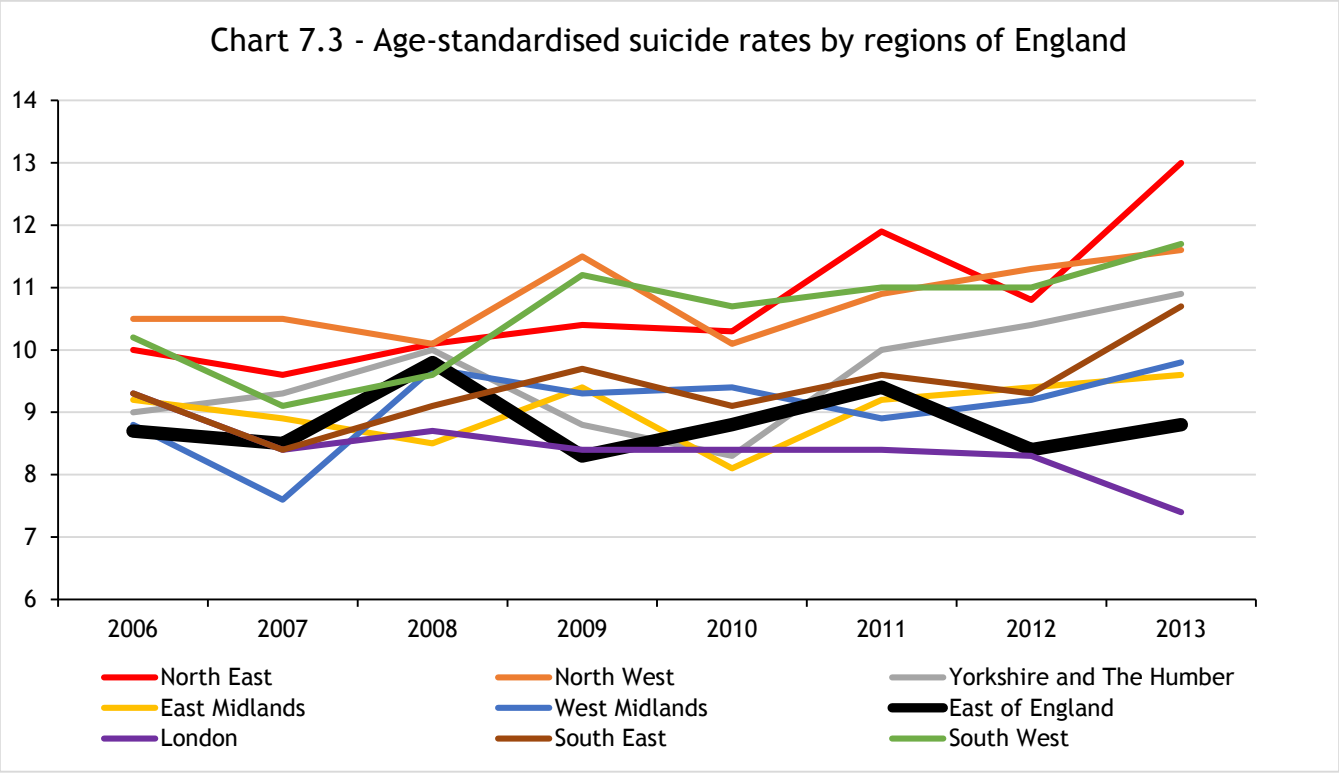
Image 7.1 - Map of England by region

7.26 The ONS provides data on suicides in England by region[36]. In 2013 the suicide rate was highest in the North East, at 13.8 deaths per 100,000 people and lowest in London at 7.9. The average for England was 10.7 per 100,000. The suicide rate in the East of England was 9.4 deaths per 100,000 people with 14.9 for men and 4.1 for women.

Table 7.1 - Suicide rates by region in 2013

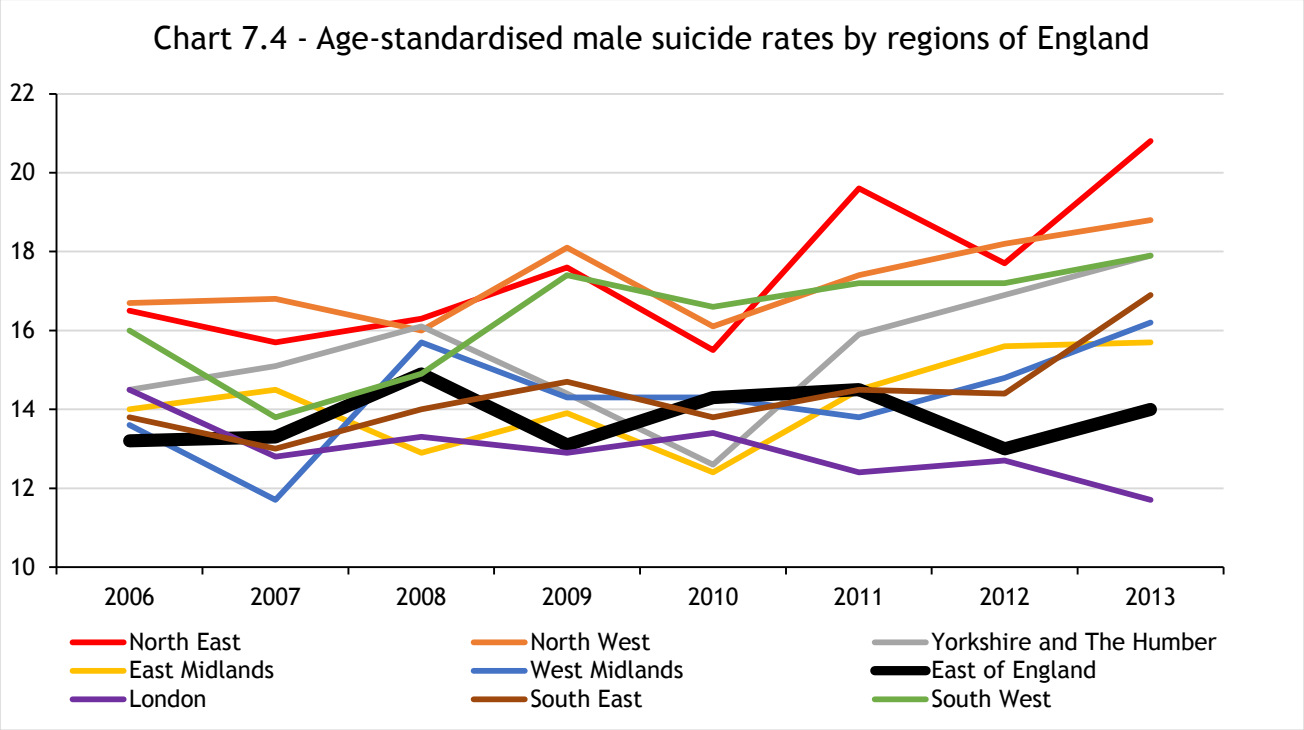
2013	Male		Female		All persons	
	Deaths	Rate	Deaths	Rate	Deaths	Rate
England	3,684	17.2	1,038	4.6	4,722	10.7
North East	229	22.1	66	5.9	295	13.8
North West	567	20.0	148	5.0	715	12.3
Yorkshire and The Humber	407	19.1	95	4.3	502	11.6
East Midlands	307	16.7	77	4.0	384	10.2
West Midlands	384	17.2	91	3.9	475	10.4
East of England	353	14.9	103	4.1	456	9.4
London	395	12.4	121	3.7	516	7.9
South East	627	18.0	193	5.2	820	11.4
South West	415	19.0	144	6.3	559	12.5

7.27 Between 2006 and 2013 suicide rates were highest in the North East, the North West and the South West, with the lowest rates in London and the East of England.

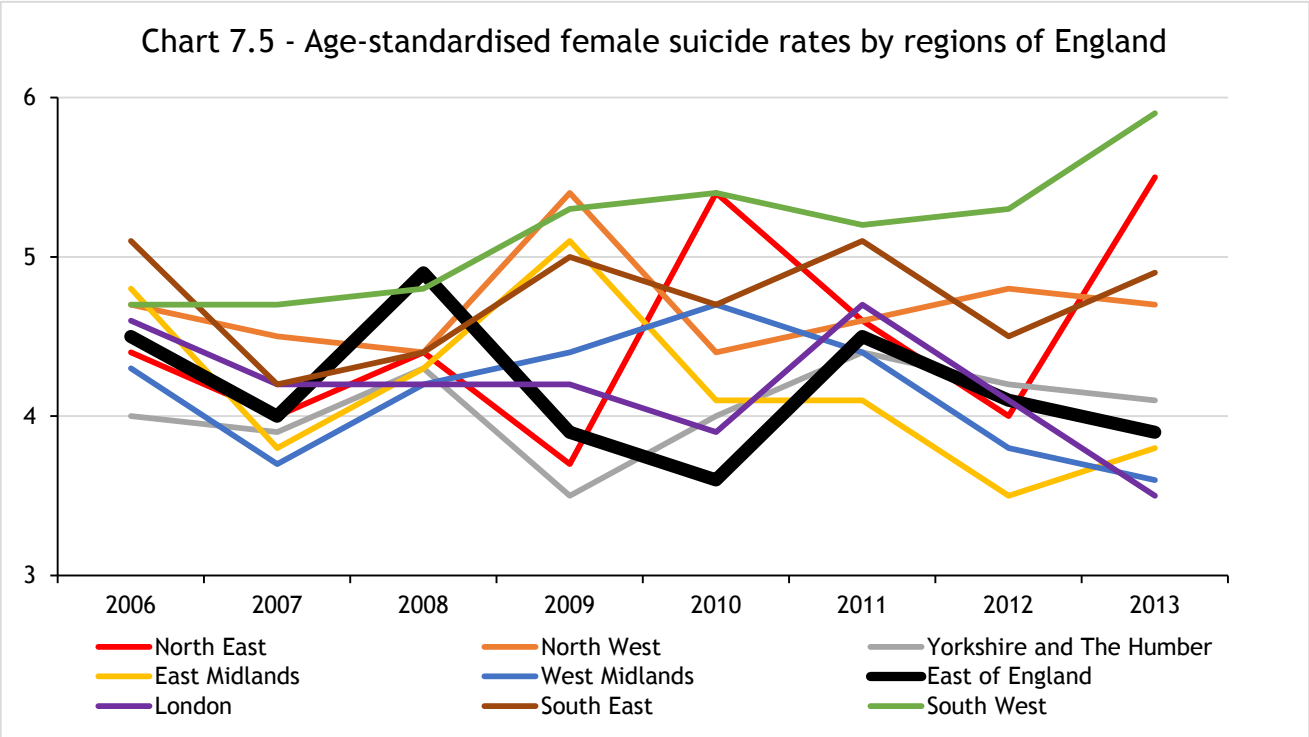


[36] http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesintheunitedkingdomreferencetables

7.28 Similarly, between 2006 and 2013 suicide rates among males were highest in the North East, the North West and the South West with the lowest rates in London and the East of England.



7.29 Between 2006 and 2013 suicide rates among females were highest in the North East, the South East and the South West with the lowest rates showing yearly fluctuations but typically in London and Yorkshire and The Humber.



7.30 The data show that suicide rates in the East of England are in line with national average. As such, looking at the data using this geographical breakdown, it is not possible to conclude the trust recorded a high number of unexpected deaths because of a relatively high suicide rate in the area.

7.31 We looked at the number of suicides by local authority for the year 2013 within the East of England region to draw comparisons within the region and nationally, at the local authority level. Within the East of England region, the number of suicides at the local authority levels was highest in Norwich (24), Ipswich (22), Colchester (22), Broadland (18) Tendring (17). Three of five of these local authorities are located within Norfolk and Suffolk (Norwich, Ipswich and Broadland). Stevenage (1), Hertsmere (3), Welwyn Hatfield (4), Mid Suffolk (5) and Suffolk Coastal (5) had the lowest rates. Two of these local authorities are located within Norfolk and Suffolk. When looking at local authorities in Norfolk and Suffolk we observe that, compared against the average for the East of England, they are represented by both highest and lowest recorders of suicides – i.e. there is no discernible pattern.

7.32 When making comparisons with the national average number of suicides per local authority across 2013 (14.5) Norwich (24), Ipswich (22), Broadland (17) and Great Yarmouth (16) are the only local authorities in Norfolk and Suffolk that had a higher rate. The ten other local authorities within Norfolk and Suffolk are in line with or lower than the national average number.

7.33 These data do not demonstrate regional imbalances, at the local authority level, in suicide numbers that could account for the high number of unexpected deaths the trust recorded.

Demographics

7.34 We were given access to the HSCIC's population statistics database[37] to analyse population demographics in England by region, gender and five-year age band. The database contains data by national level, local authority level, CCG, year, gender and age bands. We used these data to look at regional population characteristics to see if any anomalous characteristics of the East of England region could lead to the trust recording the largest

[37] http://www.hscic.gov.uk/psd

number of unexpected deaths of any mental health trust in England, according to the FOI data.

7.35 Given the evidence regarding 30-59 year old males being a high-risk suicide demographic group, we segmented the population statistics database to identify any imbalances across regions in England on the proportion of this demographic within each region's population.

7.36 The tables below outline the percentage of 30-59 year-old men in the 15+ year-old population, by region for the years 2012, 2013 and 2014 (latest available data).

Table 7.2 - The percentage of 30-59 year-old men in the 15+ year-old population (2012)

2012			
	Total number	% of total population	Rank
London	1776902	26.39%	1
South East	1733964	24.19%	2
East of England	1166012	24.00%	3
East Midlands	895671	23.70%	4
North West	1383783	23.69%	5
Yorkshire and Humber	1035517	23.65%	6
West Midlands	1089135	23.61%	7
North East	503198	23.18%	8
South West	1020101	22.84%	9

Table 7.3 - The percentage of 30-59 year-old men in the 15+ year-old population (2013)

2013			
	Total number	% of total population	Rank
London	1819327	26.72%	1
South East	1741920	24.12%	2
East of England	1170711	23.92%	3
North West	1383028	23.63%	4
Yorkshire and Humber	1035844	23.58%	5
East Midlands	896584	23.57%	6
West Midlands	1091177	23.53%	7
North East	501723	23.04%	8
South West	1022581	22.74%	9

Table 7.4 - The percentage of 30-59 year-old men in the 15+ year-old population (2014)

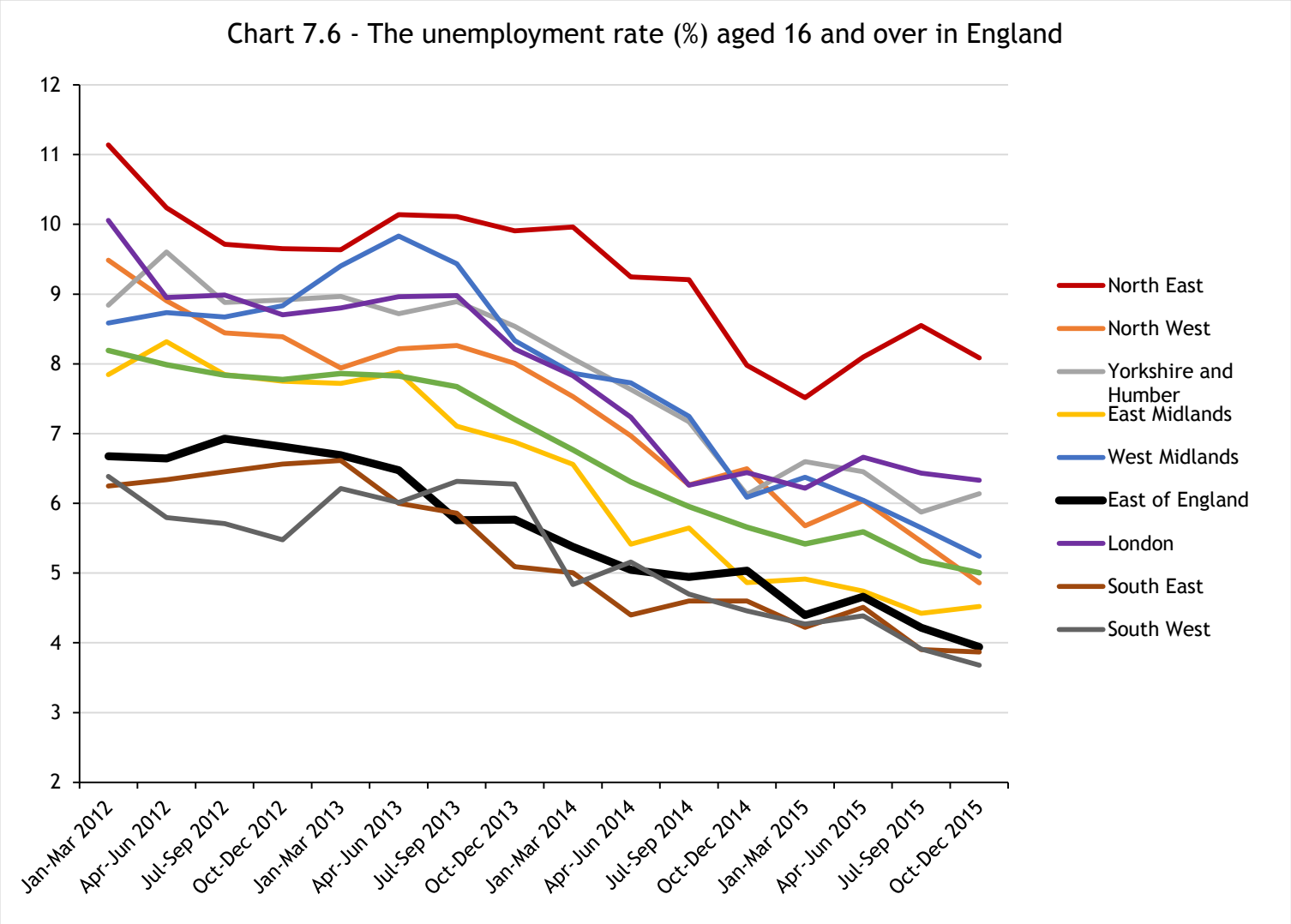
2014			
	Total number	% of total population	Rank
London	1862538	27.00%	1
South East	1750888	24.02%	2
East of England	1178783	23.83%	3
North West	1383553	23.55%	4
Yorkshire and Humber	1035040	23.47%	5
East Midlands	899538	23.44%	6
West Midlands	1093593	23.43%	7
North East	499696	22.88%	8
South West	1025091	22.60%	9

7.37 The percentage of 30-59 year-old males in the 15+ year-old population in the East of England for 2012, 2013 and 2014 has remained between 23-24 per cent.

7.38 This is in line with average and does not present a regional imbalances that could account for the high number of unexpected deaths the trust recorded.

Unemployment trends by regions

7.39 *The Samaritans review* (2012[38]) suggests that there are many different drivers of suicidal behaviour but that unemployment is a significant one. The ONS provides data on regional labour markets[39] via its Labour Force Survey on a rolling three-monthly basis. We examined longitudinal trends by region in England from January 2012 to December 2015.



7.40 Between 2012 and 2015 unemployment rates were highest in the North East, the West Midlands, Yorkshire and Humber and London. The lowest rates were found in the South East, the South West and the East of England.

[38] http://www.samaritans.org/sites/default/files/kcfinder/files/press/Men%20Suicide%20and%20Society%20Research%20Report%20151112.pdf

[39] http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/headlinelabourforcesurveyindicatorsforallregionshi00/current

7.41 These data do not demonstrate regional imbalances in the rate of unemployment that would account for the number of unexpected deaths the trust recorded.

7.42 We looked at unemployment rate data at the local authority level and found that none of the local authorities located in Norfolk and Suffolk feature in the list of 50 local authorities with the highest rate of unemployment in 2012, 2013, 2014 or 2015. Furthermore, the average unemployment rate across the 14 local authorities in Norfolk and Suffolk were below with the national average rate for 2012, 2013, 2014 and 2015. This is shown in table 7.5.

Table 7.5- The average unemployment rate across the 14 local authorities in Norfolk and Suffolk compared to the national average (2012, 2013, 2014 and 2015).

	2012	2013	2014	2015
Average unemployment rate across 14 local authorities in Norfolk and Suffolk	6.5	6.2	5.2	3.9
Average unemployment rate across all local authorities in England	7.1	6.7	5.6	4.6

7.43 For the four years mentioned, amongst these 14 local authorities the unemployment rate was consistently higher than the national average in only Ipswich, Norwich and Great Yarmouth. For 2012, 2013 and 2014 the rate was consistently higher than the national average in Waveney. In 2012 and 2013 the rate was higher than the national average in King's Lynn and West Norfolk and in 2013 it was higher than the national average in Breckland. Thus, the majority of the 14 local authorities in Norfolk and Suffolk had an unemployment rate that was in line with or below the national average for the years 2012, 2013, 2014 and 2015.

7.44 We cannot conclude that the level of unemployment alone, in Norfolk and Suffolk has contributed to a high number of unexpected deaths recorded at NSFT relative to other areas in England as the level of unemployment in Norfolk and Suffolk is in line with the national average.

The department for communities and local government's deprivation index

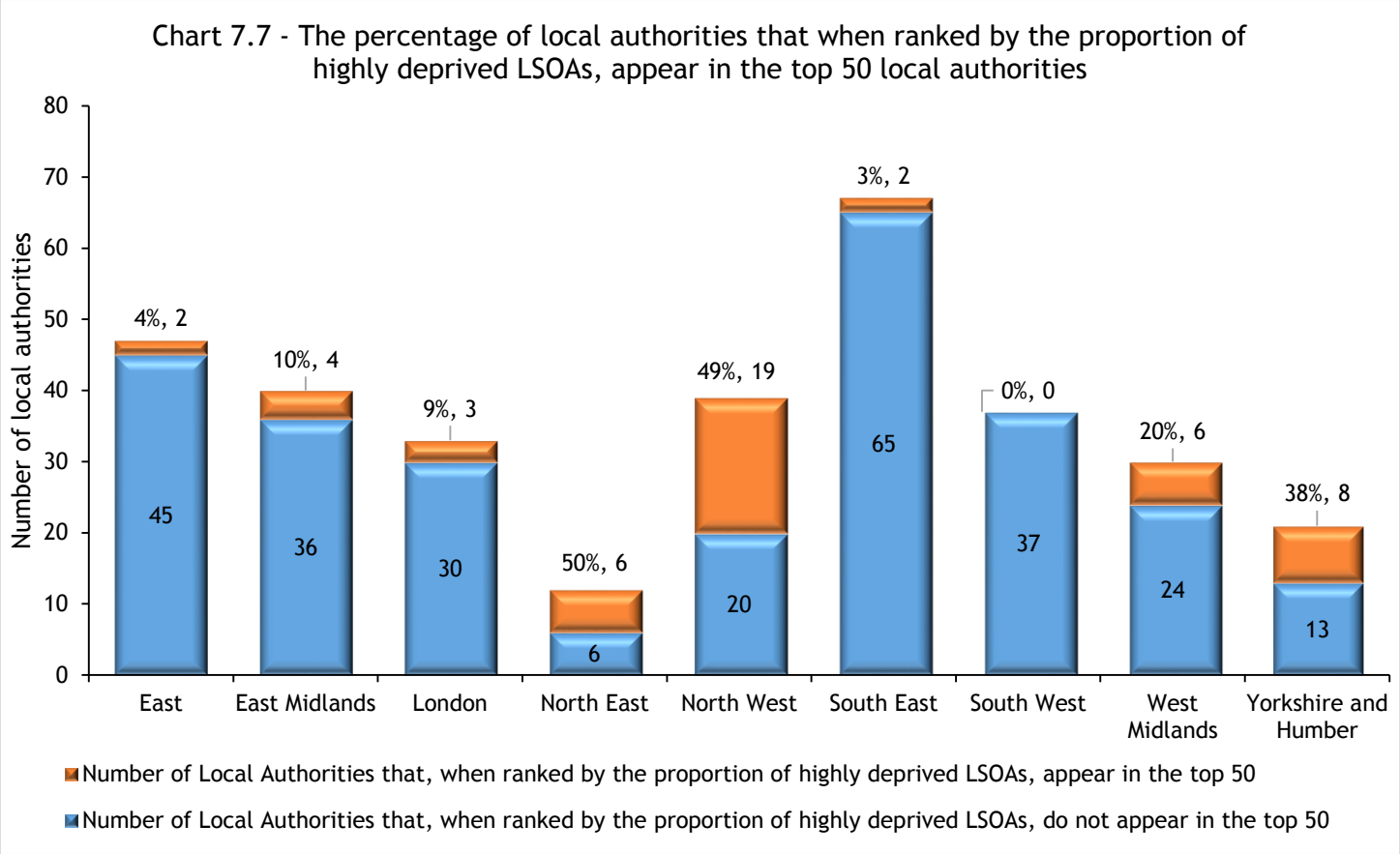
7.45 The Department for Communities and Local Government (DCLG) produces *English indices of deprivation* which measure relative levels of deprivation in 32,844 small geographical areas known as *Lower-layer super output areas* (LSOAs). The DCLG and its predecessor have calculated local measures of deprivation in England since the 1970s. The *English indices of deprivation* (2015) are based on 37 indicators, organised across seven domains of deprivation that are weighted[40] and combined to form the *Index of multiple deprivation* (IMD 2015). This is an overall measure of multiple deprivation of people in an area and is calculated for every LSOA in England. Each area in England is ranked according to its level of deprivation relative to that of other areas.

7.46 The patterns of deprivation across England are complex. Concentrations of deprivation occur in large urban conurbations, areas that have historically had large-scale industry, manufacturing/mining sectors and coastal towns. The IMD 2015 ranks all 32,844 areas and allows users to identify the most deprived set of neighbourhoods.

7.47 Middlesbrough, Knowsley, Kingston upon Hull, Liverpool and Manchester are the five Local Authorities (there are a total of 326) with the largest proportion of highly deprived (proportion of LSOAs in most deprived 10 per cent nationally) neighbourhoods in England, ranging from 49 per cent in Middlesbrough to 41 per cent in Manchester.

7.48 Of the 47 local authorities in the East of England region, when ranking all of England's local authorities on their percentage of highly deprived LSOAs[41], only two local authorities appear in the England's top 50: Great Yarmouth (26 per cent, ranked 20) and Norwich (20 per cent, ranked 38). Chart 7.7 shows, by region, the percentage of local authorities that appear in the top 50 when ranked by the proportion of highly deprived LSOAs.

[40] These domains and their weightings are Income Deprivation (22.5 per cent); Employment Deprivation (22.5 per cent); Health Deprivation and Disability (13.5 per cent); Education, Skills and Training Deprivation (13.5 per cent); Crime (9.3 per cent); Barriers to Housing and Services (9.3 per cent); and Living Environment Deprivation (9.3 per cent). Definitions can be found at Appendix H
[41] In the most deprived 10 per cent nationally



7.49 According to these data, when local authorities (and their LSOAs) are grouped into regions, the North East region has the highest percentage (50 per cent) of local authorities that accommodate highly deprived LSOAs. This percentage for the North West region is 49 per cent. The figure for the East of England region is only 4 per cent, 2 of 47 local authorities. The average across the 9 regions is 20 per cent.

7.50 These data do not indicate regional imbalances in deprivation that would account for a high number of recorded unexpected deaths the trust.

Public Health England's (PHE) Community Mental Health Profiles Tool

7.51 We examined indicators that compare levels of mental health and illness across various geographies to provide context to the data on unexpected deaths provided by NHS England in the FOI response. Comparing levels of mental health and illness in the East of England, and its CCGs, with other CCGs and regions in England could help to explain variance in the number of unexpected deaths recorded at mental health trusts.

7.52 PHE's *Community mental health profiles tool* presents comparative data on the levels of mental health and illness, treatments and outcomes across England. The tool presents data across a number of indicators that show the state of mental health and illness across each CCG. A full list of the tool's indicators that we considered is included at appendix I.

7.53 Data from the tool indicate that the East of England as a whole across 2012-13 (the latest available data) had rates of depression incidence similar to the national average (1 per cent of total number of patients compared with 1.1 per cent), that depression and anxiety prevalence (according to GP survey data) were slightly below the national average (10.8 per cent compared with 12 per cent) and that the prevalence of schizophrenia, bipolar affective disorder and other psychoses as recorded on general practice systems was slightly below average (0.77 per cent compared with 0.84 per cent). The general picture from this data is that the levels of mental health and illness in the East of England region are not significantly higher than in other regions. See appendix J for the full table.

7.54 Of the 19 CCGs in the East of England region, Great Yarmouth and Waveney CCG recorded depression prevalence and incidence rates, anxiety prevalence rates and schizophrenia, bipolar affective disorder and other psychoses prevalence rates that were higher than the national average. Other CCGs in the East of England region, such as Herts Valleys CCG, Cambridgeshire and Peterborough CCG and Mid Essex CCG, had lower than the national average rates across these indicators. There is considerable variation within the East of England region. There is no clear picture that the CCGs in the locality of NSFT have a higher than national average scores across these indicators. See appendix J for the full table.

7.55 Data from the tool shows that for the latest available data (reporting period of either 2012-13 or Q1 of 2013-14 or Q3 of 2013–14), the East of England had a higher than the national average percentage of mental health patients with a diagnosis (24 per cent of people in contact with mental health services compared with 17.8 per cent). The region also had a lower than average number of :

- adult detentions per 100,000 population (8.6 compared with 15.5);
- adult attendances at A&E for a psychiatric disorder per 100,000 (189.5 compared with 243.5);

- bed days in secondary mental health care hospitals per 100,000 population (3341 compared with 4686); and
- adults in contact with mental health services per 100,000 population (1411 compared with 2160).

7.56 Across the rest of the indicators the region did not notably deviate from the national average. See appendix J for the full table.

7.57 The CCGs within closest geographical range of NSFT did not record higher than the national average number of bed days in secondary mental health care hospitals per 100,000 population. However Great Yarmouth and Waveney CCG, Ipswich and East Suffolk CCG and Norwich CCG did have a higher than national average percentage of mental health service users who had been inpatients in a psychiatric hospital. Ipswich and East Suffolk CCG, West Suffolk CCG and West Norfolk CCG had a higher than the national average rate of attendances at A&E for a psychiatric disorder per 100,000. Across the CCGs located nearest the NSFT there is no clear trend that these CCGs had higher rates than the national average across the indicators and thus cannot explain the high number of unexpected deaths recorded at the trust.

7.58 Data from the tool shows that for the latest available data (reporting period of either 2012-13 or Q1 of 2013-14 or Q3 of 2013–14) the East of England, as a whole, had a higher than the national average percentage of CPA adults in employment and a higher than national average rate of recovery for Improving Access to Psychological Therapies treatment. See appendix J for the full table.

7.59 Of the CCGs within the closest geographical range of NSFT Norwich CCG, Great Yarmouth and Waveney CCG, West Norfolk CCG, North Norfolk CCG and South Norfolk CCG had a lower than the national average number of people on a Care Programme Approach (CPA) per 100,000 population. Of the CCGs within the closest geographical range of NSFT only Norwich CCG and Great Yarmouth and Waveney CCG had a higher than the national average number of emergency admissions for self-harm per 100,000 population.

Investigation thresholds

7.60 As mentioned in the introduction to this section, having looked at variables that manifest outside the trust we will now continue our analysis by looking at variables that manifest inside the trust (investigation thresholds and reporting practices).

7.61 The trust asked the NHS England East Director of Commissioning Operations (DCO) team to produce a report that considered governance arrangements for investigating deaths in the trust against consideration of the SI Framework outlining:

> *"whether deaths are reported in line with the new Framework and investigated within a timely manner; and that there is a rigorous and standardised process for determination of unexpected deaths requiring serious incident investigation"*

7.62 We asked to see the trust's incident data, relating to expected and unexpected deaths as recorded on Datix from April 2012 to December 2015 to validate whether the investigation of unexpected deaths was consistent. This would help to establish that the trust's investigating practices were consistent and systematic. Examining this variable provides insight on whether the trust has a relatively high or low threshold for categorising and investigating unexpected deaths. This threshold can influence the number of unexpected deaths that are recorded, for example a low threshold (relative to other mental health trusts) could account for a higher number of unexpected deaths being recorded.

7.63 The trust provided the Datix data and informed us that the parallel project being conducted by the NHS England East DCO team, as outlined in the Terms of Reference, was examining investigation thresholds. In order to avoid duplication we agreed with the trust that the NHS England DCO team alone would conduct work on examining this variable.

7.64 The NHS England DCO team will look to compare investigation thresholds across mental health trusts in the East of England. At time of writing the work has revealed that NSFT reports deaths of its service users in line with the new NHS SI Framework and investigates these deaths in a timely and appropriate manner. The team's interim report is at appendix K. It is an interim report because the work on comparing investigation thresholds between trusts is ongoing.

Risk profiles of services

7.65 Differences in the kind of services each mental trust provides could account for differences in the number of unexpected deaths. The inclusion of 'high risk' services in a trust's profile, for example a substance misuse/drug and alcohol service, could skew the number of unexpected deaths recorded across trusts. NSFT allude to this in the background section of our terms of reference:

> *"It is the trust's position that the data released by NHS England is not comparable for the following reason(s): it does not cover comparable services for instance the majority of trusts do not offer drug and alcohol services as NSFT does".*

7.66 Mental health trusts are inherently heterogeneous. They differ on a number of variables, including the services they offer and their size as mentioned earlier in this section.

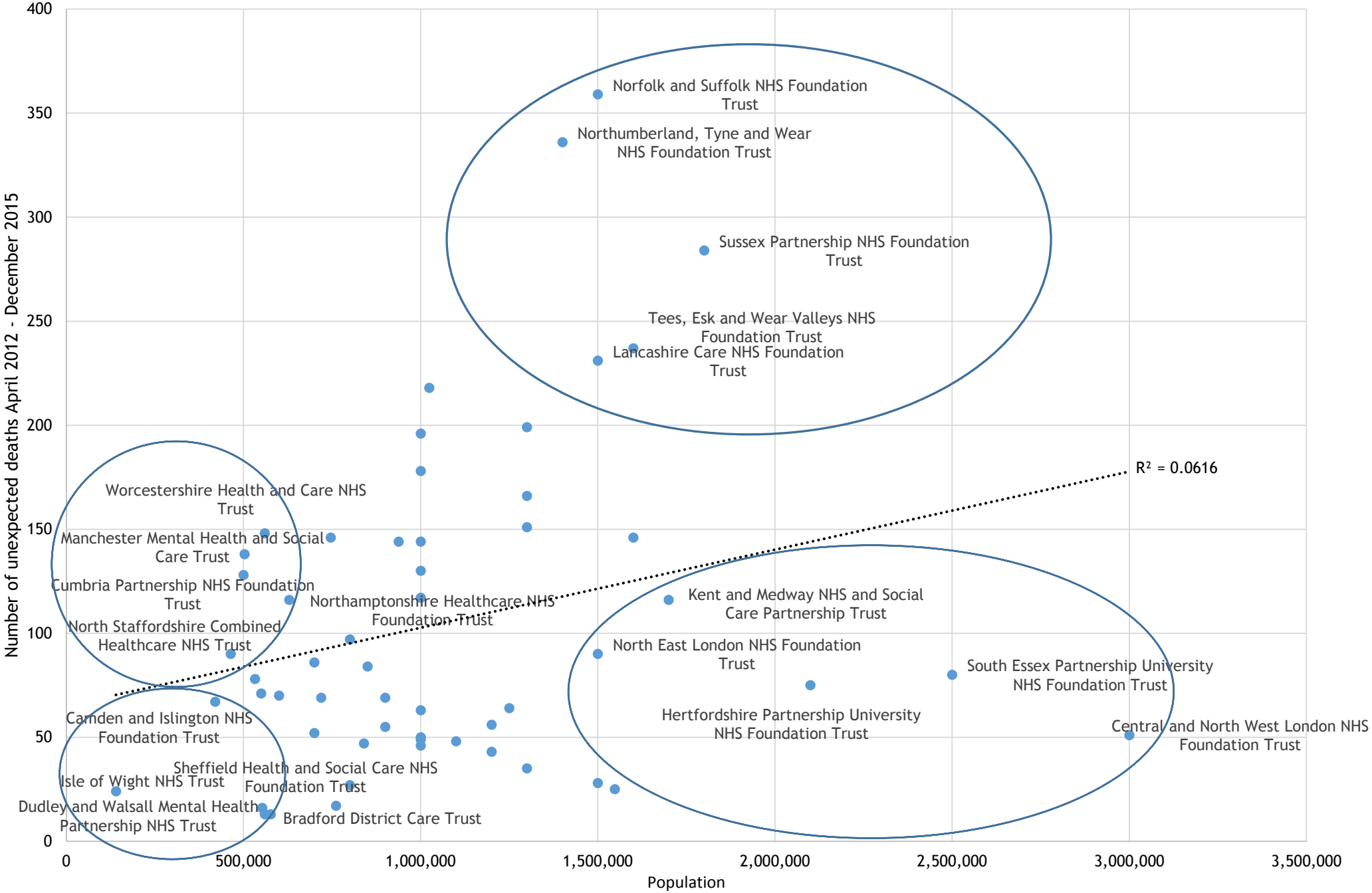
7.67 NSFT has a substance misuse/drug and alcohol service known as the Norfolk Recovery Partnership (NRP). It provides advice and treatment for adults, under 18s and those in prison with drug and alcohol problems across Norfolk.

7.68 To assess whether the trust's provision of the NRP service skews the number of unexpected deaths it records, we clustered the distribution of mental health trusts into four groups in accordance with their position on a scatter plot looking the relationship between population size and the number of unexpected deaths according to the FOI data (chart 7.8). These four groups are listed below.

1. High number of unexpected deaths/high population.
2. High number of unexpected deaths/low population.
3. Low number of unexpected deaths/high population.
4. Low number of unexpected deaths/low population.

7.69 We placed five trusts into each group as seen in chart 7.8. Should it be true that the presence of a substance misuse service contributes to the number of unexpected deaths recorded we would expect to see that the trusts clustered in groups one and two offer a substance misuse service whereas the trusts clustered in groups three and four do not.

Chart 7.8 - The relationship between population served and number of unexpected deaths



7.70 We found that all 20 of the trusts were registered by the CQC as providing a substance misuse/drug and alcohol service. It should be noted that CQC registered substance misuse services vary in size and scope. It is not possible to identify whether a particular substance misuse services is a full commissioned community service, such as NRP, using the data we have analysed. Without approaching individual trusts for an explanation of their services, a means for doing so is not obvious.

7.71 NRP works with a broader remit than many other addiction contracts. Because it is a comprehensive, full commissioned community service, it may see higher rates of death than more limited services. The trust informed that the NRP service accounts for at least 25 per cent of the trust's unexpected deaths which is in line with the proportion of NRP unexpected deaths in our sample (24 per cent).

7.72 Tables 7.6 and 7.7 compare the CQC registered substance misuse services in the 'high population/high number of unexpected death group of trusts' with the 'high population/low reporting group of trusts' to assess any similarities and differences in the substance misuse/drug alcohol services provided.

Table 7.6 - The list of CQC registered services across high population/high number of unexpected deaths group.

Group 1	List of CQC registered substance misuse services
Norfolk and Suffolk NHS Foundation Trust	• Carlton Court • Chatterton House • Coastlands – Northgate • Fermoy Unit • Hellesdon Hospital • Julian Hospital
Sussex Partnership NHS Foundation Trust	• 78 Crawley Road • Amberstone Hospital • Chalkhill • Connolly House • Department of Psychiatry • Dove Ward • Healthcare HMP Ford • Langley Green Hospital • Meadowfield Hospital • Millview Hospital • Oaklands Centre for Acute Care • Selden Centre • Southview • The Chichester Centre • Trust HQ

	• Woodlands
Northumberland Tyne and Wear NHS Foundation Trust	• St Nicholas Hospital
Tees, Esk and Wear Valleys NHS Foundation Trust	• Friarage Hospital Mental Health Unit • The Briary Unit • Trust HQ
Lancashire Care NHS Foundation Trust	• Burnley General Hospital • Chorley and South Ribble Hospital • Guild Lodge • HMP Preston • Ormskirk Hospital • Royal Blackburn Hospital • Royal Preston Hospital • Sceptre Point • The Orchard

Table 7.7 - The list of CQC registered services across high population/low number of unexpected deaths group

Group 3	List of CQC registered substance misuse services
Central and North West London NHS Foundation Trust	• HMP and YOI Holloway • HMP Winchester • HMP Woodhill • Hillingdon Hospital Mental Health Site • IRC Harmondsworth • Stephenson House
South Essex Partnership University NHS Foundation Trust	• Kingsley Ward Centre • Trust Head Office
Hertfordshire Partnership University NHS Foundation Trust	• Albany Lodge • Kingsley Green • Lister Adult Mental Health Unit
Kent and Medway NHS and Social Care Partnership Trust	• Littlestone Lodge • Trevor Gibbens Unit • Trust Headquarters
North East London NHS Foundation Trust	• Sunflowers Court • Woodbury Unit

7.73 It is reasonable to conclude that the presence of a substance misuse service in the profile of a trust's services causes a trusts to record a high number of unexpected deaths although we have not obtained data on the exact number of patients in contact with these services.

7.74 We used PHE's *Outcomes framework data tool* to assess whether the trust has a relatively high need for alcohol services in its local geography compared with other geographies. The tool provides data on a number of indicators relating to a wide spectrum of public health issues.

7.75 We looked at the tool's indicator 2.18 which provides an age standardised rate (per 100,000 population by region) of admissions to hospital where the primary diagnosis is alcohol attributable or a secondary diagnosis is alcohol attributable. This rate is calculated by PHE using data from the HSCIC's Hospital Episode statistics database and the ONS's mid-year population estimates. Appendix L is exported from the tool for the 2013-14 reporting period. Compared with the national average, the East of England region has a lower rate, indicating a relatively low demand for alcohol services in the area when making comparisons at this level of geography.

7.76 We looked at this indicator in more detail, across local authorities to draw comparisons within the region and nationally, at the local authority level. Within the East of England region, the rate of admission for alcohol related conditions is highest in Norwich, King's Lynn and West Norfolk, Tendring, Harlow and Cambridge. Two of these five local authorities are located within Norfolk and Suffolk. Brentwood, Welwyn Hatfield, St Albans, Rochford and East Hertfordshire had the lowest rates. None of these local authorities are located within Norfolk and Suffolk. Within Norfolk and Suffolk, there are local authorities that have lower than the average regional (East of England) rate such as Suffolk Coastal and Waveney. However all other local authorities within Norfolk and Suffolk have a similar or higher rate than the regional average. See appendix L for the full table.

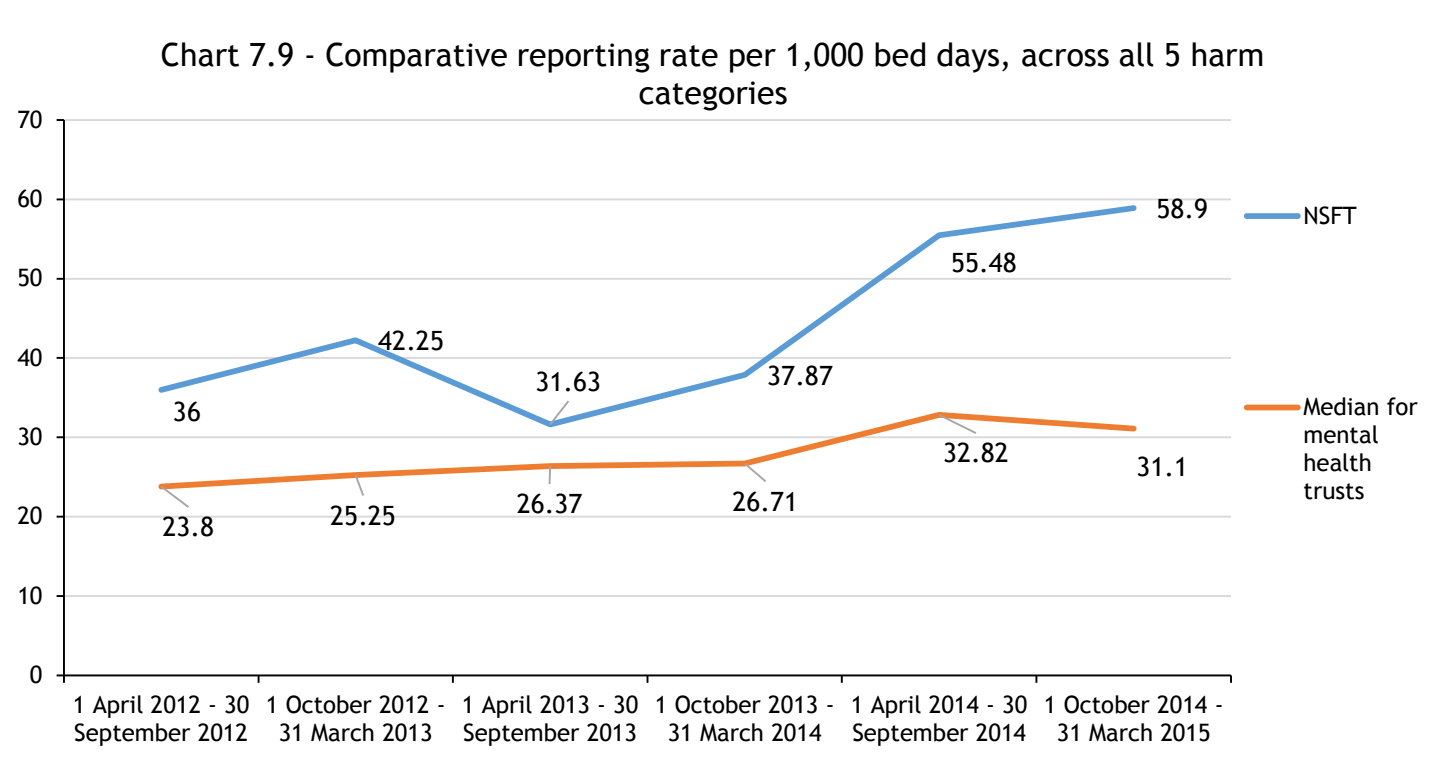
7.77 When making comparisons with the national average Norwich and King's Lynn and West Norfolk are the only two local authorities in Norfolk and Suffolk that had a higher rate. All other local authorities within Norfolk and Suffolk fall in line with or are lower than the national average rate. This data, therefore, provides no evidence that there is a greater need for the alcohol services in Norfolk and Suffolk, relative to the national average, so does not provide a rationale for the number of unexpected deaths[42]. See appendix L for the full table.

[42] It should be noted that the trust does not provide inpatient services for substance misuse, however indicator 2.18 provides a proxy for demand on alcohol services in a given area.

The National Reporting and Learning System

7.78 The trust, like all trusts, usually uploads information to the National Reporting and Learning System (NRLS) on a monthly basis. The NRLS is used to report patient safety incidents and compare trusts of a similar type on their rate of reporting per 1,000 bed days. The NRLS is available to the CQC and forms part of its intelligent monitoring system for determining risk. Trusts upload all patient safety incidents once managers have declared them complete. The incidents are rated in five degree-of-harm categories (none, low, moderate, severe and death).

7.79 Comparing rates of reporting between mental health trusts in England could help to explain variance in the number of unexpected deaths recorded in the FOI data.



7.80 Between 1 April 2012 and 31 March 2015 the trust consistently reported above the average number of incidents per 1,000 bed days for mental health trusts[43]. This is demonstrated in chart 7.9.

[43] It should be noted that the reporting rate does not necessarily reflect the total number of incidents at each trust.

7.81 High reporting rates are generally indicative of an open safety culture. NRLS states in its Organisation patient safety incident reports that:

> *"Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are. "*

7.82 It is possible that the number of unexpected deaths recorded by the trust is influenced by the fact that the trust reports incidents at a rate that is substantially higher than the national average for mental health trusts. That being said, there are mental health trusts that report incidents at a higher rate than NSFT. These trusts recorded fewer unexpected deaths across 2012-2015 according to the FOI data.

Overall findings and conclusions

7.83 We have provided a contextual view of the trust's numbers of unexpected deaths among national trends to identify (as far as possible according to constraints of data) if the trust is an outlier.

7.84 A Pearson product-moment correlation coefficient was computed to assess the relationship between the size of the population and the number of unexpected deaths recorded. This coefficient provides a measure of the strength of a linear association between two variables. We found no significant correlation between the two variables, with an R-squared value of 0.0616, showing that only 6 per cent of the total variation in unexpected deaths can be explained by size of population served. In other words, 94 per cent of the total variation in unexpected deaths remains unexplained when looking at the size of the population served only.

F6 Using the FOI data, the size of population served does not explain the differences in reported rates of unexpected death. This is contrary to our expectation and suggests that the data could be misleading.

7.85 When making comparisons at the local authority level on the rate of admissions to hospital for alcohol related conditions national average, Norwich and King's Lynn and West Norfolk are the only two local authorities in Norfolk and Suffolk that had a higher rate. All

other local authorities within Norfolk and Suffolk fall in line with or are lower than the national average rate.

F7 We cannot conclude from PHE data that there is a greater need for alcohol services in Norfolk and Suffolk, relative to the national average. We were not permitted access to PHE's National Drug Treatment Monitoring System so cannot comment on the regional prevalence of drug use.

7.86 We compared numbers of suicides at the local authority level for the year 2013 with the national average. The majority of local authorities within Norfolk and Suffolk are in line with or lower than the national average number.

F8 We conclude that the number of suicides in Norfolk and Suffolk is not higher than the national average.

7.87 The percentage of 30-59 year-old males, a demographic known to be at high-risk of suicide, in the East of England for 2012, 2013 and 2014 has remained between 23-24 per cent. This is in line with average.

F9 The East of England does not have a regional imbalance, compared to other regions in England, in the 30-59 year-old males demographic that would account for the high number of unexpected deaths the trust recorded.

F10 The level of unemployment in Norfolk and Suffolk is in line with the national average.

7.88 When local authorities (and their LSOAs) are grouped into regions of England, in the East of England region only 4 per cent of local authorities had highly deprived LSOAs in 2015. The average for this indicator across England's nine regions is 20 per cent.

F11 The Department for Communities and Local Government's (DCLG) *Index of multiple deprivation* does not reveal regional imbalances in deprivation that could account for a high number of unexpected deaths being recorded at the trust.

F12 The CCGs closest to NSFT did not record more than the national average number of bed days in secondary mental health care hospitals.

7.89 Of the CCGs within the closest geographical range of NSFT only Norwich CCG and Great Yarmouth and Waveney CCG had a higher than the national average number of emergency admissions for self-harm per 100,000 population.

F13 Other than Norwich CCG and Great Yarmouth and Waveney CCG, the CCGs closest to NSFT did not have significantly more than the national average number of emergency admissions for self-harm.

F14 The presence of a substance misuse service in a trust's services may cause trusts' to record a high number of unexpected deaths but because substance misuse services are not homogenous it is difficult to reach a definitive conclusion here.

F15 The number of unexpected deaths the trust recorded, according to the FOI data, is likely to be determined by the fact that the trust adopts an early SI reporting culture and reports incidents at a rate that is substantially higher than the national average for mental health trusts.

7.90 There are limitations with national level data comparing mental health trusts in England. There is a need for a national focus to bring the quality of data at the mental health trust level in line with the quality of data for acute trusts. This is a wider issue that if addressed, would allow for detailed, accurate and reliable trust level analysis across mental health trusts.

R9 The trust should tell NHS England about the shortage of meaningful, comparative data relating to unexpected deaths across mental health trusts to avoid potential misrepresentation and misinformation.

8. National mortality review

8.1 NHS England has launched a new programme of mortality review, the national *Retrospective case record review* (RCRR), the pilot for which is scheduled to begin in the first quarter of 2016/17. The purpose of the RCRR is to standardise reporting of hospital deaths across the NHS. NHS England's website says[44]:

> *"By establishing a consistent and rigorous process of RCRR, NHS England aims to improve the quality of care by helping hospitals to identify and learn from problems in health care that are thought to contribute to patient death and harm"*

8.2 At the time of writing, NHS England had contracted Healthcare Quality Improvement Partnership (HQIP) to oversee the procurement of a standardised methodology for all NHS trusts. The HQIP website says that the programme is still at the procurement stage.

8.3 The trust's first mortality group meeting took place in March 2016. It is chaired by the medical director. The trust patient safety and complaints lead told us he was involved in the mortality group work. Their first meeting agreed that the medical director should write to NHS England to ask for guidance specific to mental health trusts as opposed to acute hospitals. The trust has concerns that the current model designed for acute trusts would not necessarily transfer to a mental health setting.

8.4 We were told the trust has set up a database – which went live in April 2016 - to capture information about its mortality work. We were also told that the trust was trying to source information that included cause of death for individuals not referred to the coroner. The trust added that such information was not always readily available and it was considering approaching the council (e.g. information on births and deaths) for help.

Comment and analysis

The terms of reference for our review are to examine the trust's progress with national guidance in relation to establishing mortality review procedures. We found no guidance specifically tailored for mental health trusts and given the infancy of the

[44] https://www.england.nhs.uk/ourwork/patientsafety2/rcr-rev/

programme, we cannot comment on the trust's progress other than to note the trust had its first mortality group meeting in March 2016.

The patient safety team told us that the trust was still working out its approach to this new area. We note that neither the private or public board minutes for 2015 refer to the impending RCRR. We assume that the board's oversight of this work will change as guidance becomes available and NHS England's expectations of the trust become clearer.

9. Suicide prevention

9.1 The Department of Health strategy *Preventing suicide in England: A cross government outcomes strategy to save lives*[45] (2012) sets out six areas for action:

- *"Reduce the risk of suicide in key high-risk groups*
- *Tailor approaches to improve mental health in specific groups*
- *Reduce access to the means of suicide*
- *Provide better information and support to those bereaved or affected by suicide*
- *Support the media in delivering sensitive approaches to suicide and suicidal behaviour*
- *Support research, data collection and monitoring."*

9.2 The strategy identifies a number of factors to be taken into consideration by NHS staff, including at risk patient groups, individuals under the care of mental health services, the need to tailor approaches according to patient group e.g. people who misuse drugs and alcohol, those vulnerable due to socio-economic circumstances and the physical environment e.g. ligature points. This strategy also sets out the importance of supporting bereaved families.

9.3 The strategy emphasises the importance of effective local intervention, including the vigilance of staff, regular risk assessment of ward areas and that frontline staff be trained to work with high-risk patients.

9.4 The strategy highlights the role of PHE in supporting NHS trusts, local authorities and their partners to achieve improved public health outcomes that include suicide prevention.

9.5 Local authorities are responsible for leading initiatives into suicide prevention. PHE's *Guidance for developing a local suicide prevention action plan* (2014) is for public health staff in local authorities. The guidance highlights the importance of local authorities working with stakeholders that include mental health trusts, CCGs, coroners, the police, bereaved families and the voluntary/community sector: multi-agency working. It goes on to outline the need to:

[45] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

- monitor data, trends and suicide hot spots;
- engage with local media (including the Samaritans);
- work with transport partners to map hot spots; and
- work with local priorities to improve mental health.

9.6 We acknowledge that the PHE guidance is for local authorities but also note the extensive crossover with other agencies and believe that the points above are relevant to the trust.

9.7 *Preventing suicide in England: Two years on, second annual report on the cross-government outcomes strategy to save lives*[46] (2015) sets out research in relation to suicide prevention in parallel with noting areas of good practice/innovation and the need for further localised work. It emphasises the role of PHE in leading this work but also says that high-quality mental health services have an integral role in preventing suicide:

> *"To improve safety, mental health services should:*
>
> - *provide specialist community mental health services such as crisis resolution home treatment teams, assertive outreach and services for people with dual diagnosis.*
> - *Implement NICE guidance on depression.*
> - *Share information with criminal justice agencies.*
> - *Ensure physical safety, and reduce absconding on in-patient wards.*
> - *Create a learning culture based on multidisciplinary review."*

9.8 The National Institute for Clinical Health and Care Excellent (NICE) is developing guidance on suicide prevention for NHS trusts, which, at time of writing is scheduled for publication in April 2018.

9.9 This section considers the trust's own suicide prevention strategy against national policy and examines whether it has identified appropriate areas for action. We also consider the trust's links with PHE and other agencies with a view to providing a trust-wide approach to suicide prevention.

[46] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405407/Annual_Report_acc.pdf

9.10 The trust's suicide prevention work is divided into three streams:

- the trust-wide suicide prevention strategy;
- the Norfolk multi-agency suicide prevention group; and
- the Suffolk multi-agency suicide prevention group.

Trust suicide prevention strategy

9.11 The trust told us that its work in relation to developing a revised suicide prevention strategy was relatively recent. The trust gave us a copy of the trust's previous suicide prevention strategy (2013-15). We were told that a new strategy was being drafted and would be in place by September 2016. The trust director of nursing told us that the trust wanted a suicide strategy based on a five-year reduction to zero:

> *"There has been a bit of debate about whether that is the right thing to do or not but I think… keeping that in your head as you undertake an exercise or actually provide clinical care, it is quite a useful thing to think about. We will be able to measure our success on that strategy."*

9.12 She described the strategy group as a working group and said that it did not have terms of reference yet.

Comment and analysis

The suicide strategy that is currently in place is limited to statements of intent rather than explanations of how or when they will achieve such goals. The director of nursing told us that the 2013-2015 version of the suicide strategy did not have tangible, measurable outcomes and that this is something she is working to correct in the new version.

We found evidence in the trust board minutes to indicate that the board actively engaged in the development of a suicide prevention strategy. The public board in December 2013 announced that a suicide prevention group would be formed (led by the director of nursing). In addition the annual suicide audits were presented to the board

in 2013, 2014 and 2015. We found evidence in the minutes to indicate that the board has a role in leading the development of a suicide prevention strategy. The trust told us that overall strategy leadership sat with the director of nursing. It added that as part of this, the medical director oversaw the mortality review group, and that county-wide learning and leadership sat with the two directors of operations.

Recommendation

R10 The trust board should take a more active role in developing and promoting the trust-wide suicide prevention strategy. This should include officially identifying a board-level champion for the work, contributing to the draft strategy, agreeing a programme of implementation and protecting time at board level for review and evaluation of the strategy.

9.13 The trust is also working with PHE to develop suicide prevention strategies for Norfolk and Suffolk. This work is being led by PHE and is multi-agency. The trust director of nursing told us:

> *"Public Health have statutory responsibility for suicide prevention strategies across populations... but a great deal of the work seems to be left to us* [the trust]... *some other issues can only really be undertaken by Public Health, because they are population-wide strategies and interventions to which we can contribute."*

Norfolk multi-agency suicide prevention group

9.14 The draft[47] terms of reference for the group describe its overall purpose as:

> *"…to bring together key agencies within Norfolk to develop and deliver multi-agency plans that prevent suicides in the county, based on evidence of successful interventions and approaches."*

9.15 The terms of reference outline a number of key objectives that include:

[47] We asked for the terms for the terms of reference for the group and were given the draft.

"identify agencies that have a role in suicide prevention and reduction, and ensure that they are represented at the multi-agency group at a level to take action on behalf of the organisation."

And

"Use historic and real-time data (where available) to learn lessons about potentially effective interventions, including speaking with people who have attempted suicide."

9.16 The outcome indicators of the group are:

- "*progressive reduction in total number of suicides year on year, aiming to reduce by 30 per cent over five years?* [sic]
- *aim to reduce suicide in specific populations."*

9.17 The group reports to the Health and Wellbeing Board through its Healthwatch representative. The terms of reference do not mention a formal link to the trust internal strategy group discussed above.

9.18 The trust gave us the minutes of the Norfolk *Preventing death by suicide group meeting* dated 28 September 2015. The director of nursing co-chairs this meeting. The minutes say:

"...the purpose of the group was to meet regularly to come up with practical actions and strategies which may assist those individuals who may be contemplating taking their own lives."

9.19 Representatives from many agencies attend the meeting that includes trust staff, the Norfolk coroner, the police, Healthwatch, NHS England, Norfolk county council and the governor of the Suffolk[48] user forum. The trust chief executive attends the meeting. The trust director of nursing told us that Survivors of Bereavement by Suicide, a charity that aims to meet the needs and overcome the isolation of those bereaved by suicide, are invited to the group but to date had not attended. The group receives a copy of the minutes.

[48] The minutes clearly state that this individual is from Suffolk not Norfolk.

9.20 The minutes detail a review of Norfolk data on suicides, a discussion in relation to hotspots and successful strategies for suicide prevention e.g. engagement with CALM helpline and the role of social media in reaching younger patients.

9.21 The director of nursing told us about an initiative developed with the police in which trust staff are based in the police control room. This has helped both in dealing with emergencies and reducing unnecessary 136 sections[49]. She added that the police chief inspector for Norfolk was supportive and was also a member of the Norfolk multi-agency group.

9.22 The director of nursing was positive about the meeting with the Norfolk multi-agency group, describing it as an information-sharing and networking opportunity. For example, there had been helpful information sharing between the police and the coroner, looking at environmental hotspots and opportunities for intervention across agencies.

Comment and analysis

We acknowledge that PHE is tasked with leading suicide prevention work but the trust and county council co-chair this multi-agency group. We cannot say, from the evidence we have seen, who was driving the work of the group and whether the group had the power to implement real change. The trust told us that it felt the group lacked coordination and that it is working on the trust internal strategy with a view to asking PHE to use it as a template for a county-wide strategies.

Finding

F16 The trust demonstrated multi-agency work in Norfolk in suicide prevention but lacked an overall strategy. Such strategy is PHE's responsibility and is out of the trust's direct control. Work on this is in its infancy and continues.

[49] Section 136 of the Mental Health Act provides police with the power to place members of the public in a safe place (typically a police station or hospital) if there are concerns in relation to the individual's mental health.

Suffolk multi-agency suicide prevention group

9.23 PHE is also responsible for leading the suicide multi-agency work in Suffolk. The lead psychologist for East Suffolk who is also the (non-medical) lead clinician for the area is the trust lead for the multi-agency work in Suffolk.

9.24 We spoke to the PHE lead for the Suffolk suicide work. She told us that the group did not have terms of reference yet. It reports to the health and wellbeing board.

9.25 The trust gave us a copy of the draft Suffolk *Strategy for suicide prevention 2015-2020* dated September 2015. Members of the steering group include Ipswich and East CCG, Public Health Suffolk, the trust, Suffolk constabulary, Healthwatch and the Samaritans.

Comment and analysis

The trust has provided input in relation to developing the Suffolk strategy, but it is not the primary author and as a result we have not commented on its content. Equally there are no terms of reference for the group so there is some doubt about whether it has a clear remit and objectives.

9.26 We met the lead clinician for East Suffolk who has been involved in developing the Suffolk strategy. She told us she had been meeting with PHE and the police to develop the strategy. Her role is to provide input in relation to mental health. She told us she aims to have a psychological basis to the strategy:

> "..[I'm] *trying to get a real psychological basis for the strategy. So there is a real rationale for why each of the other agencies that might be there are actually there. So what is it that each of us is trying to achieve across the whole map of potential suicide prevention, starting from birth to death... When is the earliest we can start psychologically helping children to be resilient, for example, so really starting looking at a whole community resilience model..."*

9.27 The group has met with the lead for an equivalent suicide prevention strategy in the North West of England and attended a suicide conference *Suicide bereavement: bridging*

the gap between what we know and what we do as part of this work. The lead clinician for East Suffolk added that she thought the Suffolk group was more focused on the development of strategy than the Norfolk group, but needed to grow, particularly in its multi-agency involvement. Members of the Suffolk group so far have been PHE, the trust, Healthwatch, police and trust court liaison team have been involved. The group is now taking steps to involve other agencies including those from the voluntary sector and the Samaritans.

Comment and analysis

The trust has made positive steps in relation to its suicide prevention work in Suffolk, particularly in terms of the involvement of the lead clinician for East Suffolk.

PHE is tasked with leading multi-agency suicide prevention work in the county. However the trust could take a more prominent role in this work particularly in light of the positive pilot work they are undertaking. We note examples of good work undertaken by the trust in this area such as a workshop in 2014 at Lynford Hall which sparked interest in the multi-agency groups.

9.28 The trust gave us minutes of the Suffolk suicide prevention meeting (January 2016) which includes a section on updates in relation to developing the draft strategy and a section on *Raising our ambition for a community approach to suicide in Suffolk*. For example:

> *"Reduce risk of suicide in high risk groups, identify and remove barriers... Tailor approaches to improve MH* [mental health] *specific groups... Provide better information and support to those bereaved/input from SOBs* [Survivors of Bereavement]*"*

9.29 The lead clinician for East Suffolk told us that the involvement of the coroner was a particular strength of the Norfolk group. The Suffolk coroner (described by the trust as supportive of the work) is invited to attend the Suffolk meeting but has been unable to do so:

"I think the link between the strategy and the coroner feels really important because of the suicide audits that they do and the information and the links into lots of information that would inform learning to prevent suicide"

The trust told us "...*although they have a much smaller group, they* [Suffolk] *are further ahead* [than Norfolk] *in terms of actually getting something on paper that looks like a multi-agency suicide prevention strategy"*

Finding

F17 The trust showed a strategic approach to developing its Suffolk suicide strategy (led by PHE).

Samaritans pilot

9.30 The trust has been working with the Samaritans in Suffolk[50] on a project that looks at engaging assertively to support people in crisis. The lead clinician for East Suffolk explained:

"…we are developing a piece of work with the Samaritans in Suffolk, which is something that they have developed in North Essex with the North Essex Trust. It is basically us referring people who've been asked if they want assertive contact from the Samaritans, taking on board that obviously they are a listening service for everybody. So it is not just suicide prevention. It can be anything. It can be carers, anyone who needs some psychological support, talking support. So we refer the person and then they do the work with them. We arrange a time for them to talk and then we leave it with them."

9.31 We were told that the work is in progress with a view to the service being available in August/September 2016 pilots. A dual organisation (the trust and the Samaritans) steering group has been formed and (at the time of writing) has planning meetings scheduled in April.

[50] This is a trust level project with the Samaritans. It is independent of the Suffolk multi-agency suicide prevention work.

Comment and analysis

We consistently heard positive comments about the work of the lead clinician for East Suffolk in developing the Suffolk suicide prevention strategy (including the learning from SI review group and Samaritans pilot). We note her own comments that many individuals including clinical team leaders and managers have been involved in the work she has led. The director of nursing told us she was seeking funding to expand the lead clinician's remit to include some work with the Norfolk group. We view this as a positive step in using someone who clearly has the experience and drive to take work forward and who would undoubtedly be of benefit in taking forward the trust-wide suicide strategy.

While PHE leads the multi-agency suicide prevention groups we recommend that the trust continues to take an active and increasingly prominent role in progressing the work of each group to ensure that both achieve similar outcomes and goals.

The trust has taken positive steps in relation to suicide prevention but the approach could be more cohesive. The work in Suffolk appears to be more developed. The trust has undertaken a number of positive actions in relation to suicide prevention – independent of the multi-agency suicide prevention group (e.g. Samaritans pilots and the SI review group in Suffolk) - that are likely to provide valuable information for developing practice and learning. Norfolk can demonstrate strong, broad multi-agency engagement as part of the multi-agency suicide prevention group, and independent pilot work with the police. The trust should have a mechanism in place across the counties to ensure that best practice and learning from each group (e.g. multi-agency working) and/or pilot is routinely shared. Any fundamental differences between the groups (e.g. Norfolk provides the Norfolk Recovery Partnership) should be taken into consideration by the trust leads for this work and reflected in the trust-wide suicide prevention strategy.

The lead clinician for East Suffolk told us that the SI review group was relatively small and that she felt development in the following areas would inform the trust's strategy and prioritisation of suicide prevention:

- ***research and evaluation of SI themes;***
- ***training for staff in relation to working with vulnerable groups;***

- ***staff engagement in reviewing service user experience/patient journeys; and***
- ***liaison with external agencies to improve clinical engagement.***

The trust suicide prevention work illustrates a slowly developing strategic approach to suicide prevention and learning but the work is relatively new and would benefit from more board leadership to prevent work from evolving separately and lacking cohesion. The trust board has a role in setting the principles for suicide prevention and leading the development and implementation of a new strategy.

Finding

F18 The trust lead clinician for East Suffolk played an instrumental and positive role in developing the Suffolk suicide prevention work.

Recommendation

R11 The trust should ensure that the intention to increase the funding of the lead clinician for East Suffolk to facilitate work in Norfolk is realised.

Findings

F19 The trust is engaged with PHE and system partners through the Norfolk and Suffolk multi-agency suicide prevention groups.

F20 The trust showed areas of good practice in multi-agency work with the police (Norfolk) and the Samaritans (Suffolk).

Recommendations

R12 The trust should ensure as a priority that multi-agency best practice and learning are shared between the two suicide prevention groups with a view to developing a uniform approach under its trust-wide suicide prevention strategy.

R13 The trust should as a priority develop a timeline of implementation of its suicide prevention work and strategy and undertake a follow-up review of progress made in **six to nine months.**

Appendix A List of interviewees

Trust staff

Michael Scott, chief executive

Jane Sayer, director of nursing and quality

Michelle Allott, deputy director of nursing and patient safety

Michael Lozano, patient safety and complaints lead

Alison Armstrong, director of operations in Suffolk

Debbie White, director of operations in Norfolk

Maeve Sykes, in-house solicitor

Gary Page, chair

Patient safety manager

Lead clinician for East Suffolk

RCA facilitator

Externals

Deputy chief nurse, Suffolk CCG

Quality and patient safety manager, South Norfolk CCG

Clive Lewis – MP, Norwich South

Therese Coffey – MP, Suffolk Coastal

Norman Lamb – MP, North Norfolk

A public health registrar on placement with Suffolk County Council

Jacqueline Lake, coroner for Norfolk

Patient experience and quality manager, nursing directorate, NHS England (East)

Representatives from the Campaign to Save Mental Health Services in Norfolk and Suffolk

Two families

Communities manager, the Havebury Housing Partnership

A GP based in Halesworth, Suffolk

A GP based in Great Yarmouth, Norfolk

Appendix B Documents reviewed

Policies

Norfolk and Suffolk NHS Foundation Trust, *Serious Incidents Requiring Investigation (SI/SIRI),* Version 01, 02, 03, 04, 05 and current

NHS England, *Procedure for identification and reporting of Serious Incidents for Specialist Mental Health Services directly commissioned by NHS England,* Schedule 6 Part D

NHS England, (27 March 2015), *Serious Incident Framework*

NHS England, (27 March 2015), *Revised Never Events Policy and Framework*

Norfolk and Suffolk NHS Foundation Trust, *Unexpected and Sudden Deaths (in-patient areas only),* Version 03

Norfolk and Suffolk NHS Foundation Trust, (April 2015), *Information Governance and Cyber Incident Investigations and Reporting,* Version 04

Norfolk and Suffolk NHS Foundation Trust, (December 2015), *Duty of Candour*, Version 02

Norfolk and Suffolk NHS Foundation Trust, (November 2015), *Infection, Prevention and Control Policy Review Table*

Norfolk and Suffolk NHS Foundation Trust, (October 2014), *Counter Fraud and Corruption Policy,* Version NSFT 5.0

Norfolk and Suffolk NHS Foundation Trust, (13 February 2014), *Procurement policy – 2013-2015,* Version 1

Norfolk and Suffolk NHS Foundation Trust, (March 2015), *Standing Financial Instructions,* Version 03

Norfolk and Suffolk NHS Foundation Trust, (19 December 2015), *Community Serious Incidents resulting in Death – Working Party Report*

Minutes

Norfolk and Suffolk NHS Foundation Trust, *Public board of director's meeting minutes* (2012 – 2015)

Norfolk and Suffolk NHS Foundation Trust, *Report for public board of director's - Patient Safety and Quality Reports*

Norfolk and Suffolk NHS Foundation Trust, *Service Governance sub Committee (SGsC), Patient Safety Update*, 2012 – 2016

Norfolk and Suffolk NHS Foundation Trust, *Service Governance sub Committee (SGsC), Complaints*, 2013 – 2016

Norfolk and Suffolk NHS Foundation Trust, *Minutes of the Preventing Death by Suicide Group meeting*

Norfolk and Suffolk NHS Foundation Trust, *Suffolk Suicide Prevention Strategy Meeting*

Norfolk and Suffolk NHS Foundation Trust SI Report Templates

3 Day Pre RCA Investigation Report

Serious Incident Requiring Investigation, Final Report

Serious Incident Requiring Investigation - Slips, Trips and Falls, Final Report

Review of 16 & 17 Year Old Admission

Review of High Risk Patient Absconsion No.

Root Cause Analysis - Report for Pressure Ulcers

Others

Norfolk and Suffolk NHS Foundation Trust, *Serious Incident (SI) Reporting User Guide*

West Norfolk CCG's independent investigation of community deaths

Norfolk and Suffolk NHS Foundation Trust, *East Suffolk SUIs Resulting in Death of the Service User – Draft Report*

Norfolk and Suffolk NHS Foundation Trust, Suicide Prevention Strategy 2013 – 2015

Norfolk and Suffolk NHS Foundation Trust, (April 2015), *Management supervision,* Version 04

Norfolk and Suffolk NHS Foundation Trust, (February 2015), *Clinical Supervision,* Version 03

Norfolk and Suffolk NHS Foundation Trust, (April 2015), *Quality of Clinical Supervision (Staff Survey) Audit of NSFT Policy*, Version 03

Norfolk and Suffolk NHS Foundation Trust, (December 2015), *Ligature and Suicide Risk: Environmental Assessment and Management,* Version 03

Norfolk Recovery Partnership, *Norfolk Recovery Partnership review of deaths 2015*

Norfolk Recovery Partnership, (August 2014), *Expert report*

Appendix C Full breakdown of sample

	Year 1	Year 2	Year 3	Year 4	Totals
Community	10	14	23	15	**62**
NRP	3	12	10	5	**30**
Wellbeing	5	2	3	3	**13**
Access and assessment	0	4	3	4	**11**
Acute	2	2	2	1	**7**
Inpatient	0	1	0	0	**1**
LD	1	0	0	0	**1**
Secure	1	0	0	0	**1**
Totals	**22**	**35**	**41**	**28**	**126**

Appendix D RCA assessment template

SI report reference number	Verita reviewer	Does the incident meet the trust SI criteria?	Are the terms of reference listed?	Are the terms of reference clear and appropriate?	Is the investigation carried out by a team or an individual?	Is there evidence that families have been given the opportunity to comment/contribute on the terms of reference?	Is there evidence that families were given the opportunity to contribute to the investigation process?	Is the trust lead for the work identifiable?	Are the interviewees listed?	Have appropriate individuals been interviewed?	Have relevant documents been reviewed and in instances where evidence couldn't be accessed, is a reason given and is this reason listed?
Is there a clear chronology of events?	Are relevant local benchmarks/good practice referenced?	Are relevant national benchmarks/good practice referenced?	Are the benchmarks/good practice applied to the investigation?	Is the analysis clear and rigorous, does it link to contributory factors?	Is the analysis clear and rigorous, does it link to RCA?	Is the analysis clear and linked to findings and (if any) recommendations?	Are the recommendations SMART?	Is there evidence that the report findings have been shared with families?	Is there evidence that staff have been supported across the investigation process?	Is there an action plan (if recommendations have been made)?	Does the action plan set out the recommendations from the investigation report?
Is there an action plan with lead individuals/teams identified to take forward recommendations?	Pre April 2015 – Has the SI been appropriately graded?	Was the investigation completed within the recommended timescale, and if not, a reason given? (Reference relevant column in spreadsheet submitted by the trust)	Is the report well written and easy to follow?	Is a locality manager, operations manager, service manager or lead clinician part of the investigation team (or their nominated deputy)?	Is there a theme related to dual diagnosis?	Is there a theme related to discharge?	Is there a theme related to continuity of care/care coordination?	What was the relevant service line?	When was the RCA produced (year)?	Was the death a suicide or death of undetermined intent (at the time of writing)?	How old was the service user when they died (if noted)?
What was the service user's gender?	In which locality did the death take	How did the service user die?	Overall and additional comments								

Appendix E List of data sources

Population served estimates

- Latest CQC reports or recent trust documentation (parameters 2014 -2016)

Suicides

- ONS's suicide registrations by local authority dataset (parameters 2013)
- ONS's suicide registrations in the UK dataset (parameters 1981 – 2013)

Demographics

- HSCIC's populations statistics database (parameters 2012 - 2014)

Unemployment

- ONS's regional labour market statistics (parameters 2012 - 2015)

Deprivation

- DCLG's index of multiple deprivation (parameters 2015)

Community mental health profiles

- PHE's community mental health profiles tool (parameters 2012 – 2014)

Risk profiles of services

- Services currently registered by the CQC as providing a substance misuse/drug and alcohol service
- PHE's outcomes framework data tool (parameters 2013-2014)

NRLS

- NRLS organisation patient safety reports (parameters October 2014 – March 2015)

Appendix F FOI data table

Serious Incidents FOI	Serious Incidents reported				Unexpected deaths			(NB New database and reporting categories from May 2015)	Suicide/Suspected Suicide			(NB New database and reporting categories from May 2015)
	2012/13	2013/14	2014/15	Apr 15 - Sep 15	2012/13	2013/14	2014/15	Apr 15 - Sep 15	2012/13	2013/14	2014/15	Apr 15 - Sep 15
2gether NHS Foundation Trust	60	44	47	21	4	2	3	8	17	22	20	10
5 Boroughs Partnership NHS Foundation Trust	50	73	98	49	38	36	43	27	0	12	23	25
Avon and Wiltshire Mental Health Partnership NHS Trust	94	117	107	59	36	41	41	28	0	0	1	18
Barnet, Enfield and Haringey Mental Health NHS Trust	71	110	134	37	10	17	20	16	30	23	19	16
Berkshire Healthcare NHS Foundation Trust	121	246	126	53	18	9	22	20	21	14	16	22
Birmingham and Solihull Mental Health NHS Foundation Trust	195	298	287	83	44	78	52	22	32	33	31	26
Black Country Partnership NHS Foundation Trust	63	36	56	26	15	11	15	7	10	3	5	6
Bradford District NHS Foundation Trust	35	108	288	53	3	3	1	6	15	17	22	3
Cambridgeshire and Peterborough NHS Foundation Trust	41	98	88	90	8	8	18	21	21	24	17	21
Camden and Islington NHS Foundation Trust	24	46	74	44	4	11	30	22	9	13	17	12
Central and North West London NHS Foundation Trust	106	114	166	112	9	8	13	21	33	31	34	22
Cheshire and Wirral Partnership NHS Foundation Trust	104	182	250	104	46	33	89	50	3	0	0	33
Cornwall Partnership NHS Foundation Trust	83	59	60	22	28	16	21	13	12	11	11	16
Coventry and Warwickshire Partnership NHS Trust	169	244	222	53	39	58	71	10	1	2	1	4
Cumbria Partnership NHS Foundation Trust	50	89	131	40	31	26	52	19	2	4	1	8
Derbyshire Healthcare NHS Foundation Trust	29	52	68	31	11	9	23	7	14	27	16	6
Devon Partnership NHS Trust	131	115	63	41	63	51	22	10	9	5	9	12
Dorset Healthcare University NHS Foundation Trust	95	116	138	54	11	27	28	20	19	9	11	20
Dudley and Walsall Mental Health Partnership NHS Trust	89	73	62	26	2	3	1	7	12	16	8	7
East London NHS Foundation Trust	84	78	135	40	14	9	5	15	13	11	18	14
Greater Manchester West Mental Health NHS Foundation Trust	66	57	81	35	18	27	33	19	1	5	13	14
Hertfordshire Partnership NHS Foundation Trust	13	39	60	28	6	24	31	14	0	0	0	7
Humber NHS Foundation Trust	25	52	65	17	17	15	28	10	3	12	5	10
Isle Of Wight NHS Trust	164	79	129	24	3	7	8	6	1	0	0	2
Kent and Medway NHS and Social Care Partnership Trust	97	119	114	99	6	20	47	43	15	37	37	22
Lancashire Care NHS Foundation Trust	163	210	232	67	70	69	62	30	0	0	0	17
Leeds and York Partnership NHS Foundation Trust	26	26	45	22	6	6	5	8	17	17	26	16
Leicestershire Partnership NHS Trust	275	203	181	60	13	11	12	13	24	25	25	18
Lincolnshire Partnership NHS Foundation Trust	80	86	92	53	13	14	13	29	24	30	26	26
Manchester Mental Health and Social Care Trust	91	51	71	52	52	35	30	21	8	3	11	7
Mersey Care NHS Trust	57	76	91	112	17	11	8	11	8	21	33	13
Norfolk and Suffolk NHS Foundation Trust	117	164	214	98	61	97	129	72	0	0	0	1
North East London NHS Foundation Trust	285	693	633	94	25	38	16	11	10	1	13	8
North Essex Partnership NHS Foundation Trust	44	51	79	27	18	31	51	17	15	1	2	9
North Staffordshire Combined Healthcare NHS Trust	67	77	65	27	18	36	18	18	21	11	15	10
Northamptonshire Healthcare NHS Foundation Trust	188	153	141	31	47	30	26	13	0	4	7	6
Northumberland, Tyne and Wear NHS Foundation Trust	138	191	127	50	82	120	99	35	0	0	0	2
Nottinghamshire Healthcare NHS Trust	199	197	184	87	37	37	35	21	24	25	25	15
Oxford Health NHS Foundation Trust	104	86	70	72	19	7	10	20	31	39	24	16
Oxleas NHS Foundation Trust	66	124	129	38	2	7	8	10	12	10	10	14
Pennine Care NHS Foundation Trust	417	295	311	151	37	68	54	40	0	2	1	20
Rotherham, Doncaster and South Humber Mental Health NHS Fou	77	96	89	26	23	23	21	17	20	21	20	8
Sheffield Health and Social Care NHS Foundation Trust	28	27	22	7	7	6	0	3	12	11	12	3
Solent NHS Trust		79	133	62		5	12	11		7	2	3
Somerset Partnership NHS Foundation Trust	93	99	88	34	18	31	8	14	0	0	15	9
South Essex Partnership University NHS Foundation Trust	344	278	601	204	21	9	34	16	0	0	1	10
South London and Maudsley NHS Foundation Trust		58	62	46		9	13	13		35	23	14
South Staffordshire and Shropshire Healthcare NHS Foundation Tr	100	96	94	50	45	38	33	28	8	23	38	21
South West London and St George's Mental Health NHS Trust	113	34	39	17	23	8	7	8	22	10	11	8
South West Yorkshire Partnership NHS Foundation Trust	45	98	105	41	12	12	16	24	27	17	42	24
Southern Health NHS Foundation Trust	370	439	494	135	43	47	31	30	0	2	21	25
Surrey and Borders Partnership NHS Foundation Trust	85	86	70	40	56	47	40	23	3	1	0	17
Sussex Partnership NHS Foundation Trust	66	202	202	125	48	109	82	45	1	0	0	38
Tavistock and Portman NHS Foundation Trust	1	1	0	1	0	0	0	1	1	1	0	1
Tees, Esk and Wear Valleys NHS Foundation Trust	95	81	64	52	76	56	59	46	0	1	0	28
West London Mental Health NHS Trust	119	118	104	89	7	15	12	18	13	13	13	16
Worcestershire Health and Care NHS Trust	162	226	258	138	32	39	52	25	1	1	0	15
TOTAL	**6074**	**7345**	**8139**	**3,349**	**1412**	**1620**	**1713**	**1,132**	**595**	**663**	**751**	**794**
CHANGE 2012/13 - 2014/15	**Serious Incidents: + 34%**				**SIs recorded as unexpected death: + 21%**				**SIs recorded as patient suicide/suspected suicide: + 26%**			

Appendix G Population served

Rank	Trust name	Population
1	Central and North West London NHS Foundation Trust	3,000,000
2	South Essex Partnership University NHS Foundation Trust	2,500,000
3	Hertfordshire Partnership University NHS Foundation Trust	2,100,000
4	Sussex Partnership NHS Foundation Trust	1,800,000
5	Kent and Medway NHS and Social Care Partnership Trust	1,700,000
6	Avon and Wiltshire Mental Health Partnership NHS Trust	1,600,000
7	Tees, Esk and Wear Valleys NHS Foundation Trust	1,600,000
8	Leeds and York Partnership NHS Foundation Trust	1,547,912
9	Lancashire Care NHS Foundation Trust	1,500,000
10	Norfolk and Suffolk NHS Foundation Trust	1,500,000
11	North East London NHS Foundation Trust	1,500,000
12	Solent NHS Trust	1,500,000
13	Northumberland, Tyne and Wear NHS Foundation Trust	1,400,000
14	Pennine Care NHS Foundation Trust	1,300,000
15	South London and Maudsley NHS Foundation Trust	1,300,000
16	Southern Health NHS Foundation Trust	1,300,000
17	Surrey and Borders Partnership NHS Foundation Trust	1,300,000
18	South West Yorkshire Partnership NHS Foundation Trust	1,250,000
19	East London NHS Foundation Trust	1,200,000
20	Oxford Health NHS Foundation Trust	1,200,000
21	Black Country Partnership NHS Foundation Trust	1,100,000
22	Cheshire and Wirral Partnership NHS Foundation Trust	1,024,000
23	Barnet, Enfield and Haringey Mental Health NHS Trust	1,000,000
24	Birmingham and Solihull Mental Health NHS Foundation Trust	1,000,000
25	Coventry and Warwickshire Partnership NHS Trust	1,000,000
26	Derbyshire Healthcare NHS Foundation Trust	1,000,000
27	Leicestershire Partnership NHS Trust	1,000,000
28	North Essex Partnership University NHS Foundation Trust	1,000,000
29	Nottinghamshire Healthcare NHS Trust	1,000,000
30	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	1,000,000
31	South West London and St George's Mental Health NHS Trust	1,000,000
32	5 Boroughs Partnership NHS Foundation Trust	938,000
33	Berkshire Healthcare NHS Foundation Trust	900,000
34	Cambridgeshire and Peterborough NHS Foundation Trust	900,000
35	Rotherham, Doncaster and South Humber NHS Foundation Trust	850,000
36	Mersey Care NHS Trust	840,000
37	Greater Manchester West Mental Health NHS Foundation Trust	800,000
38	Oxleas NHS Foundation Trust	800,000
39	2gether NHS Foundation Trust	761,000
40	Devon Partnership NHS Trust	746,400
41	Lincolnshire Partnership NHS Foundation Trust	719,000
42	Dorset Healthcare University NHS Foundation Trust	700,000
43	West London Mental Health NHS Trust	700,000
44	Northamptonshire Healthcare NHS Foundation Trust	629,000
45	Humber NHS Foundation Trust	600,000
46	Bradford District Care Trust	577,000
47	Dudley and Walsall Mental Health Partnership NHS Trust	560,000
48	Worcestershire Health and Care NHS Trust	560,000

49	Sheffield Health and Social Care NHS Foundation Trust	553,000
50	Somerset Partnership NHS Foundation Trust	550,000
51	Cornwall Partnership NHS Foundation Trust	532,300
52	Manchester Mental Health and Social Care Trust	503,000
53	Cumbria Partnership NHS Foundation Trust	500,000
54	North Staffordshire Combined Healthcare NHS Trust	464,000
55	Camden and Islington NHS Foundation Trust	420,000
56	Isle of Wight NHS Trust	140,000

Appendix H Definitions Indices of Deprivation

The Indices of Deprivation 2015 provide a set of relative measures of deprivation for small areas (Lower-layer Super Output Areas) across England, based on seven different domains of deprivation:

- Income Deprivation
- Employment Deprivation
- Education, Skills and Training Deprivation
- Health Deprivation and Disability
- Crime
- Barriers to Housing and Services
- Living Environment Deprivation

Each of these domains is based on a basket of indicators. As far as is possible, each indicator is based on data from the most recent time point available; in practice most indicators in the Indices of Deprivation 2015 relate to the tax year 2012/13. The Index of Multiple Deprivation 2015 combines information from the seven domains to produce an overall relative measure of deprivation. In addition, there are seven domain-level indices, and two supplementary indices: the Income Deprivation Affecting Children Index and the Income Deprivation Affecting Older People Index.

A range of summary measures are available for higher-level geographies including local authority districts and upper tier local authorities, local enterprise partnerships, and clinical commissioning groups. These are based on the geographic boundaries for these areas at the time of publication. The Index of Multiple Deprivation 2015, domain indices and the supplementary indices, together with the higher area summaries, are collectively referred to as the Indices of Deprivation 2015.

Index of Multiple Deprivation

The Index of Multiple Deprivation (IMD) combines information from the seven domains to produce an overall relative measure of deprivation. The domains are combined using the following weights:

- Income Deprivation (22.5%)
- Employment Deprivation (22.5%)
- Education, Skills and Training Deprivation (13.5%)
- Health Deprivation and Disability (13.5%)
- Crime (9.3%)
- Barriers to Housing and Services (9.3%)
- Living Environment Deprivation (9.3%)

The weights were derived from consideration of the academic literature on poverty and deprivation, as well as consideration of the levels of robustness of the indicators.

Income Deprivation Domain

The Income Deprivation Domain measures the proportion of the population experiencing deprivation relating to low income. The definition of low income used includes both those people that are out-of-work, and those that are in work but who have low earnings (and who satisfy the respective means tests).

Employment Deprivation Domain

The Employment Deprivation Domain measures the proportion of the working age population in an area involuntarily excluded from the labour market. This includes people who would like to work but are unable to do so due to unemployment, sickness or disability, or caring responsibilities.

Education, Skills and Training Deprivation Domain

The Education, Skills and Training Deprivation Domain measures the lack of attainment and skills in the local population. The indicators fall into two sub-domains: one relating to children and young people and one relating to adult skills.

Health Deprivation and Disability Domain

The Health Deprivation and Disability Domain measures the risk of premature death and the impairment of quality of life through poor physical or mental health. The domain measures morbidity, disability and premature mortality but not aspects of behaviour or environment that may be predictive of future health deprivation.

Crime Domain

The Crime Domain measures the risk of personal and material victimisation at local level.

Barriers to Housing and Services Domain

The Barriers to Housing and Services Domain measures the physical and financial accessibility of housing and local services. The indicators fall into two sub-domains: ‘geographical barriers’, which relate to the physical proximity of local services, and ‘wider barriers’ which includes issues relating to access to housing such as affordability and homelessness.

Living Environment Deprivation Domain

The Living Environment Deprivation Domain measures the quality of the local environment. The indicators fall into two sub-domains. The ‘indoors’ living environment measures the quality of housing; while the ‘outdoors’ living environment contains measures of air quality and road traffic accidents.

Income Deprivation Affecting Children Index

The Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0 to 15 living in income deprived families. This is one of two supplementary indices and is a sub-set of the Income Deprivation Domain.

Income Deprivation Affecting Older People Index

The Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of all those aged 60 or over who experience income deprivation. This is one of two supplementary indices and is a sub-set of the Income Deprivation Domain.

Appendix I Public Health England's Community Mental Health Profiles Tool Indicators

Depression: Quality outcomes framework (QOF) prevalence (18+)

Sourced from the HSCIC's Quality and Outcomes Framework (QOF) data, this indicator allows GPs and CCGs to compare the recorded prevalence of depression on their registers against national figures and compared against other regions. This data is presented as the percentage of patients aged 18 and over with depression, as recorded on practice disease registers.

Depression QOF incidence (18+)

The same HSCIC data source provides data on the rate of incidence, as a percentage, of patients aged 18 and over with depression recorded on practice disease registers for the first time.

Depression and anxiety prevalence (GP survey)

Using data source from NHS England's GP patient survey, this indicator examines the prevalence of depression among patients responding to the survey. The percentage of all respondents to the question "What is the state of your health today?" who answered "moderately anxious or depressed", "severely anxious or depressed" or "extremely anxious or depressed"

Mental health problem: QOF prevalence (all ages)

Public health England points to people with a serious mental illness having mortality rates 2-3 times higher than the wider population. The HSCIC's Quality and Outcomes Framework (QOF) data shows the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on general practice systems.

% reporting a long-term mental health problem

Public Health England's Community Mental Health Profiles tool includes an indicator, sourced from NHS England's GP patient survey that examines the percentage of patients reporting that they had a long-term mental health problem. According to this data the prevalence at a national level is 4.5%.

Patients with a diagnosis recorded

Sourced from the HSCIC's Mental Health Minimum Dataset, this indicator shows the percentage of people in contact with mental health services with a secondary care diagnoses recorded as a percentage of all people in contact with mental health services. A diagnosis can be useful in helping an individual understand their own condition and access appropriate support.

Patients assigned to a mental health cluster

Sourced from the HSCIC's Mental Health Minimum Dataset, this indicator shows the percentage of people in contact with mental health services assigned to a cluster (groups assigned for Payment by Results) as a percentage of all people in contact with mental health services

Patients with a comprehensive care plan documented in the records

This indicator reflects good professional practice and covers the percentage of patients on the mental health register who have comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate. The data is sourced from the HSCIC's Quality and Outcomes Framework.

Patients with severity of depression assessed

Sourced from the HSCIC's Quality and Outcomes Framework this data reflects the percentage of patients who have had an assessment of severity at the at the time of diagnosis using an assessment tool validated for use in primary care, as a proportion of patients with a new diagnosis of depression.

Antidepressant prescribing

Sourced from the NHS Business Services Authority this indicator reflects the total number of average daily quantities (ADQs) for all antidepressant prescribing per specific therapeutic group age-gender weightings-related prescribing units (STAR-PUs).

People with a mental illness in residential or nursing care

Sourced from the ONS's Referrals, Assessments and Packages of Care (RAP), this indicator shows the number of people in residential or nursing care aged 18-64 with primary client type "mental health" expressed as a rate per resident population aged 18-64.

Service users in hospital

Sourced from the HSCIC's Mental Health Minimum Dataset, this indicator reflects the number of people with an open hospital spell as a proportion of all people in contact with services

Detentions under the Mental Health Act

Sourced from the HSCIC's Mental Health Minimum Dataset, this indicator reflects the number of detentions under the Mental Health Act on admission to hospital as a rate per 100,000 of the 18+ population.

Attendances at A&E for a psychiatric disorder

Sourced from the HSCIC's Hospital Episode Statistics database, this indicator reflects the number of attendances to A&E units for a psychiatric disorder, expressed as a rate per 100,000 population.

Number of bed days

Sourced from the HSCIC's Mental Health Minimum Dataset, this indicator shows the number of bed days in secondary mental health care hospitals per 100,000 population.

People in contact with mental health services

Sourced from the HSCIC's Mental Health Minimum Dataset, this indicator reports on people with an open adult mental health care spell in NHS funded adult specialist mental health services reported as a rate per 100,000 population aged 18+.

Carers of mental health clients receiving assessments

Sourced from the ONS's Referrals, Assessments and Packages of Care (RAP), this number shows the number of adult carers of mental health patients aged 18-64 whose own needs were assessed during the year. This rate includes those who declined assessments and is expressed per 100,000 population aged 18+.

People on CPA

Sourced from the HSCIC's Mental Health Minimum Dataset this indicator shows the number of people on CPA expressed as a rate per 100,000 population.

% CPA adults in settled accommodation

Sourced from the HSCIC's Mental Health Minimum Dataset this indicator shows the percentage of people aged 18-69 with an open CPA episode whose most recent record of accommodation status in the previous 12 months showed they were in settled accommodation. This percentage is expressed as a proportion of all people aged 18-69 on CPA.

% CPA adults in employment

Sourced from the HSCIC's Mental Health Minimum Dataset this indicator shows people aged 18-69 with an open CPA episode at the end of the quarter whose most recent record of Employment Status in the previous 12 months showed they were employed expressed as a proportion of all people aged 18-69.

Emergency admissions for self-harm

Sourced from the HSCIC's Hospital Episode Statistics database this indicator covers the number of emergency admissions to hospital due to self-harm, expressed as an age-standardised rate per 100,000 population.

Suicide rate

Sourced from the ONS, this indicator reflects the age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population

Rate of recovery for IAPT treatment

Sourced from the HSCIS's Improving Access to Psychological Therapies Dataset, this indicator shows the number of people not at 'caseness' (i.e. who are moving to recovery) as a percentage of those who have completed IAPT treatment.

Appendix J Public Health England's Community Mental Health Profiles Tool

* aggregated from all known lower geography boundaries

Compared with benchmark: Lower | Similar | Higher | Not compared

Indicator	Period	England	East of England region	NHS Basildon And Brentwood C...	NHS Bedfordshire CCG	NHS Cambridgeshire and Peter...	NHS Castle Point And Rochfor...	NHS East And North Hertfords...	NHS Great Yarmouth And Waven...	NHS Herts Valleys CCG	NHS Ipswich And East Suffolk...	NHS Luton CCG	NHS Mid Essex CCG	NHS North East Essex CCG	NHS North Norfolk CCG	NHS Norwich CCG	NHS South Norfolk CCG	NHS Southend CCG	NHS Thurrock CCG	NHS West Essex CCG	NHS West Norfolk CCG	NHS West Suffolk CCG
Depression: QOF prevalence (18+)	2012/13	5.8	-	6.7	6.3	5.6	4.9	5.7	6.7	5.7	6.4	4.7	4.4	5.7	4.8	5.5	6.0	5.3	6.6	5.8	5.8	6.4
Depression: QOF incidence (18+)	2012/13	1.0	1.1*	1.6	1.1	1.0	1.2	1.1	1.2	1.0	1.0	1.1	0.7	1.1	0.8	1.2	1.2	1.3	1.8	1.0	1.0	1.0
Depression and anxiety prevalence (GP survey)	2012/13	12.0	10.8*	11.7	10.2	10.1	10.6	9.4	13.5	10.1	11.3	10.5	10.7	12.3	10.5	12.9	8.5	12.6	11.9	9.7	11.9	11.3
Mental health problem: QOF prevalence (all ages)	2012/13	0.84	0.77*	0.79	0.74	0.75	0.55	0.72	0.92	0.73	0.78	0.90	0.64	0.87	0.83	1.12	0.62	1.07	0.66	0.68	0.68	0.75
% reporting a long-term mental health problem	2012/13	4.5	-	3.5	3.8	4.4	3.4	3.6	4.6	3.2	4.2	2.9	3.8	4.4	4.3	6.7	4.2	5.0	3.9	3.6	5.2	4.6

Compared with benchmark: Lower | Similar | Higher | Not compared

Indicator	Period	England	East of England region	NHS Basildon And Brentwood C...	NHS Bedfordshire CCG	NHS Cambridgeshire and Peter...	NHS Castle Point And Rochfor...	NHS East And North Hertfords...	NHS Great Yarmouth And Waven...	NHS Herts Valleys CCG	NHS Ipswich And East Suffolk...	NHS Luton CCG	NHS Mid Essex CCG	NHS North East Essex CCG	NHS North Norfolk CCG	NHS Norwich CCG	NHS South Norfolk CCG	NHS Southend CCG	NHS Thurrock CCG	NHS West Essex CCG	NHS West Norfolk CCG	NHS West Suffolk CCG
Patients with a diagnosis recorded	2013/14 Q1	17.8	24.0*	4.9	30.3	27.1	7.4	24.1	25.9	22.7	32.5	29.9	28.7	38.1	18.3	15.7	18.9	6.0	11.7	36.3	4.9	40.1
Patients assigned to a mental health cluster	2013/14 Q1	69.0	67.1*	82.5	64.9	22.7	76.4	84.2	72.2	85.9	67.0	63.5	42.7	55.3	67.1	64.7	64.2	74.0	81.6	49.0	62.7	73.8
Patients with a comprehensive care plan	2012/13	87.3	-	89.6	90.6	88.4	86.3	88.7	85.4	90.6	81.3	85.8	91.0	86.8	86.7	89.4	87.9	92.2	88.8	85.7	85.1	85.4
Patients with severity of depression assessed	2012/13	90.6	89.4*	81.5	92.3	90.9	90.0	91.3	90.3	89.6	86.6	83.0	91.4	87.3	93.3	93.5	90.5	90.6	83.1	91.0	90.4	91.7
Antidepressant prescribing (ADQs/STAR-PU)	2012/13	6.0	6.2*	5.5	5.4	6.3	4.9	5.4	8.4	4.7	7.5	4.5	6.2	7.2	7.2	8.2	7.1	5.7	5.3	5.4	8.0	7.2
People with a mental illness in residential or nursing care per 100,000 population	2012/13	32.7	29.6*	28.6	13.6	19.9	28.6	22.4	41.5	22.4	19.9	31.1	28.6	28.6	66.4	66.4	66.4	33.2	30.2	28.6	66.4	19.9
Service users in hospital: % mental health service users who were inpatients in a psychiatric hospital	2013/14 Q3	2.4	2.6*	2.7	2.6	2.0	3.1	2.9	3.5	2.7	2.9	2.3	2.7	2.9	2.2	2.9	2.4	2.9	2.8	2.2	1.7	2.3
Detentions under the Mental Health Act per 100,000 population	2013/14 Q1	15.5	8.6*	11.3	0.0	7.8	10.1	1.4	15.2	3.2	8.0	1.3	15.0	24.2	10.1	12.0	7.5	15.3	18.3	9.7	7.9	6.9
Attendances at A&E for a psychiatric disorder per 100,000 population	2012/13	243.5	189.5*	370.9	105.9	360.4	82.5	9.8	11.7	18.8	306.6	437.7	202.0	192.2	89.3	186.7	132.2	23.5	297.7	55.9	413.4	350.3
Number of bed days per 100,000 population.	2013/14 Q1	4686	3341*	5104	4223	2816	4556	2243	3474	1297	2734	4591	4037	5864	2052	3449	1596	7049	6175	4165	1487	1917
People in contact with mental health services per 100,000 population	2013/14 Q1	2160	1411*	2125	2100	115	1691	1392	1563	1135	1178	2336	1951	1907	1264	1745	974	2445	1892	2014	1176	1163
Carers of mental health clients receiving of assessments	2012/13	68.5	117.8*	276.2	87.5	28.9	276.2	130.0	43.6	130.0	7.7	81.7	276.2	276.2	86.5	86.5	86.5	14.6	20.7	276.2	86.5	7.7

* aggregated from all known lower geography boundaries

Compared with benchmark: Lower | Similar | Higher | Not compared

Indicator	Period	England	East of England region	NHS Norwich CCG	NHS Great Yarmouth And Waven...	NHS Cambridgeshire and Peter...	NHS West Norfolk CCG	NHS North East Essex CCG	NHS North Norfolk CCG	NHS Southend CCG	NHS West Suffolk CCG	NHS South Norfolk CCG	NHS Ipswich And East Suffolk...	NHS West Essex CCG	NHS Bedfordshire CCG	NHS Luton CCG	NHS Mid Essex CCG	NHS Herts Valleys CCG	NHS Castle Point And Rochfor...	NHS East And North Hertfords...	NHS Basildon And Brentwood C...	NHS Thurrock CCG
People on Care Programme Approach per 100,000 population	2013/14 Q1	531	561*	422	347	17	184	1806	188	592	451	161	358	1895	355	399	1864	308	498	271	599	547
% CPA adults in settled accommodation	2013/14 Q1	61.0	72.7*	38.9	45.1	25.5	29.3	78.2	27.3	72.6	81.4	39.9	80.1	80.0	79.6	80.1	79.2	60.0	79.3	69.2	77.4	72.3
% CPA adults in employment	2013/14 Q1	7.0	10.9*	1.5	3.1	5.1	2.3	9.3	0.9	6.9	12.3	2.2	9.6	17.0	7.5	6.8	18.0	6.6	9.8	6.4	8.6	8.6
Emergency admissions for self harm per 100,000 population	2012/13	191.0	-	286.1	243.4	215.7	204.8	200.3	187.9	177.7	170.4	159.7	140.7	125.1	124.7	123.5	117.8	116.9	112.1	108.9	81.1	60.4
4.10 - Suicide rate	2010 - 12	8.5	7.9	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Hospital admissions for unintentional and deliberate injuries, ages 0-24 per 10,000 population	2012/13	116.0	100.0*	116.4	113.1	112.3	128.6	100.4	105.2	102.8	90.3	104.1	88.6	91.8	96.5	105.1	105.4	81.8	80.8	109.4	82.0	81.8
Rate of recovery for IAPT treatment	2012/13	45.9	51.6*	45.9	48.5	47.6	45.9	47.0	45.9	64.1	46.3	45.9	46.3	51.4	53.8	24.6	50.5	54.4	64.1	54.4	62.9	62.9

* aggregated from all known lower geography boundaries

Appendix K - The NHS England DCO team report

NHS England

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26/04/2016

Dear Jane,

INTERIM REPORT FOR NORFOLK AND SUFFOLK MENTAL HEALTH FOUNDATION TRUST REGARDING GOVERNANCE AUDIT UNDERTAKEN TO FOCUS ON REPORTING AND INVESTIGATION OF UNEXPECTED AND EXPECTED DEATHS

Aim of report:
This is an interim report to provide a timely update to Norfolk and Suffolk Mental Health Foundation Trust (NSFT) and to be viewed in conjunction with Verita's report. It is important to clarify that the trust participated in this audit on a voluntary basis and that this work was not driven by NHS England's local office in the East as a result of any concerns about the provider. It is also important to note that NSFT independently approached Verita and that there was no direction from NHS England for this to be done.

Rational for the audit undertaken:

- The Mazars report of Southern Health highlighted that it was possible for a trust to not be following guidance regarding investigating incidents and reporting these appropriately in line with the incident severity. An aim of the audit was to provide reassurance to the trust and commissioners that the MHTs in the East are appropriately investigating deaths of people with learning disabilities, older adults, and those with mental health problems.
- Additionally, a piece of work has been undertaken by the East local office focussing on the trends of suicides in the East MHTs to help inform discussions within the Quality Surveillance Group. Results of this audit are dependent on trusts reporting unexpected deaths in-line with the SI framework (i.e. a judgement of lower suicide serious incidents within one trust may be because there are fewer suicides, because the trust does not report suicides in line with the Serious Incident framework, or because the trust is unaware when a service user or recently discharged service user dies). Thus to better understand the trends of suicides in the East it was deemed beneficial to understand the reporting practices of the MHTs.

Avenues of focus within the audit:

1) Review of each MHT incident and Serious Incident policy to ascertain consistency with new NHS Serious Incident framework and duty of candour requirements
2) Review of governance arrangements for a provider deciding whether an incident should be raised as a Serious Incident
3) Review of compliance with the Serious Incident reporting framework by examination of a sample of deaths within the period of April 2015 to December 2015 from the following cohorts:
    a. Expected deaths under 65

Health and high quality care for all, now and for future generations

b. Expected deaths over 65
c. Unexpected deaths under 65
d. Unexpected deaths over 65

Methodology:
NSFT provided a list of all (known) deaths that occurred between April 2015 and Dec 2015 for service users actively engaged with their services (this included people who were referred and had yet to have their first appointment). Children and young people, and people involved in the drug and alcohol service were excluded from the audit.

The audit was undertaken by the author of this report, Dr Sarah Robinson. The author is a clinical psychologist who works in a patient quality and safety role at the local office of NHS England.

Conclusions:
The review of the policies associated with incident reporting and requirements of duty of candour highlighted that they require urgent updating to bring them in line with the new Serious Incident framework. Detailed feedback has been given to the patient safety team on where policies could be reviewed and updated. It should be noted that the trust manages to have an appropriate tone throughout the policy that embraces the NHS' attitude to learning from incidents not being about apportioning blame to specific staff members.

In total 38 case files were reviewed comprising 20 deaths from people over the age of 65 (18 deaths of people aged 18-64). A higher proportion of mental health deaths were reviewed than deaths for people with learning disabilities which reflects service needs of the population and the commissioning of learning disability services in Norfolk (another provider, HPFT, provides inpatient learning disability services in Norfolk).

Of the 38 case files reviewed (and thus deaths that had been examined within this audit), 17 were investigated as Serious Incidents and had Root Cause Analyses completed (or these investigations were still ongoing). The remaining 21 were identified as "expected deaths" where an investigation of the trust was not required. It is of the opinion of the author of the report that for all of these 21 deaths this was an appropriate decision to have been made and that there was no evidence that there was an act or omission occurring as part of the NHS funded care received from NSFT.

With regards to the Serious Incidents that were raised, it is of the opinion of the author that all were notified within the timescale expected (and any delays represented delays in the trust being made aware of the death) and that the investigations were completed in a timely manner. The style and degree of clarity within the investigation reports varied which is understandable given the different lead authors but all appeared to identify factors that were relevant for learning lessons and improving patient care. It should be noted that the reports were taken on face value and no independent review of the entire case file took place to examine the validity of the root cause analysis. However in terms of face validity, the reports were generally of a good quality. Duty of candour was well evidenced throughout.

Of the 17 cases reviewed, there was one (trust ref 116774) where it was questionable as to whether the full report should have been completed prior to the coroner giving an opinion on the cause of death as there could have been a possibility that a particular cause of death would have influenced the findings or in the very least required the trust to make a referral to the local authority to consider aspects of failure to safeguard an adult at risk. As it was the coroner concluded that the cause of death was "unascertained" and so would not have made a difference in this case.

The trust was able to provide an audit trail for the rationale for considering whether an incident should be explored and reported as a Serious Incident. An exploration of one

particular death as part of the audit (an older adult in a residential home, cause of death sepsis) highlighted that more inquisitiveness into examining the role that all NSFT staff have to ensure the safety of service users could have been helpful. Again in this particular instance, the NSFT staff member had not visited the resident in the days prior to the death but it is expected that this level of detail and thus rationale for not proceeding with an investigation is required by the provider.

The trust is planning how to strengthen this process to demonstrate further scrutiny to this process and to ensure that the trust is informed in a timely manner of deaths of community service users. It is of the opinion of the author that the trust is appropriately examining its own processes and understanding how to strengthen governance in this area. It is commendable that the trust was open, enthusiastic and proactive about engaging with both this audit and the commissioning of its own independent review.

Recommendations:

- Review incident reporting policies and consider how to embed an updated policy and understanding of the new serious incident framework as current staff training requirements does not require any update of the e-learning training package.
- NSFT may wish to consider the appropriateness of closing an investigation when the cause of death remains unknown and although there may not be implications for the trust regarding the cause of the death, understanding the cause of death could be important in ensuring safeguarding of vulnerable people in other settings where rigorous investigation of deaths is not contractually required. Alternatively, if it is felt due to timeliness that it is more appropriate that the investigation is completed prior to the coroner's verdict, it may be helpful for NSFT to consider a process of following-up and adding an addendum to the Serious Incident report.
- As part of the ongoing proactive developments of the trust to strengthen governance and transparency into the decision to investigate a death, the trust is encouraged to be interrogative when considering physical health deaths and whether NSFT staff had acted in line with expectations to escalate any concerns about the management of that person's physical health needs.

Summary:

This audit has provided reassurance that since April 2015 NSFT has reported deaths of its service users in line with the new NHS Serious Incident framework and has investigated these deaths in a timely and appropriate manner. The trust's policies do require an urgent review and it may be beneficial to consider how the new policy could be embedded into staff teams given that staff are not required to undertake any refresher training. In-line with other mental health trusts (and indeed providers across the health system) NSFT appear aware that there are developments that they need to make to strengthen their ability to provide assurance around reviews of the deaths of their service users and that they are appropriately informed of deaths that occur in the community.

Yours Sincerely,

Dr Sarah Robinson
Patient Experience and Quality Manager

Appendix L Indicator 2.18 of PHE outcomes tool

Compared with benchmark: Better Similar Worse

2.18 - Admission episodes for alcohol-related conditions - narrow definition (Persons) 2013/14

Directly standardised rate - per 100,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	333,014	645	643	647
East Midlands region	30,137	674	666	682
East of England region	33,647	582	576	588
London region	38,434	541	536	547
North East region	21,616	844	832	855
North West region	51,323	746	740	753
South East region	44,796	525	520	530
South West region	33,640	625	618	632
West Midlands region	37,631	697	690	704
Yorkshire and the Humber...	35,705	697	690	704

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

2.18 - Admission episodes for alcohol-related conditions - narrow definition (Persons) 2013/14

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Area	Count	Value	95% Lower CI	95% Upper CI
England	333,014	645	643	647
East of England region	33,647	582	576	588
Babergh	482	526	479	576
Basildon	888	532	498	569
Bedford	773	504	469	541
Braintree	815	563	525	603
Breckland	888	653	610	698
Brentwood	293	392	348	440
Broadland	796	597	556	641
Broxbourne	478	539	491	590
Cambridge	780	725	671	781
Castle Point	476	515	470	565
Central Bedfordshire	1,320	518	490	547
Chelmsford	974	590	554	629
Colchester	1,024	611	574	650
Dacorum	689	485	449	523
East Cambridgeshire	478	577	527	632
East Hertfordshire	592	444	408	481
Epping Forest	734	583	542	627
Fenland	667	677	626	731
Forest Heath	360	630	565	699
Great Yarmouth	580	591	544	642
Harlow	552	731	670	795
Hertsmere	527	543	497	592
Huntingdonshire	1,017	604	567	643
Ipswich	792	632	588	679
King's Lynn and West Norf...	1,129	744	701	790
Luton	1,267	724	683	766
Maldon	368	564	506	625
Mid Suffolk	572	563	517	611
North Hertfordshire	585	467	430	507
North Norfolk	752	660	611	712
Norwich	1,175	960	905	1,019
Peterborough	1,194	693	653	734
Rochford	381	444	400	491
South Cambridgeshire	840	568	530	608
South Norfolk	783	596	554	640
Southend-on-Sea	1,037	607	570	645
St Albans	583	442	406	480
St. Edmundsbury	706	641	594	690
Stevenage	400	506	457	559
Suffolk Coastal	703	535	495	577
Tendring	1,080	735	690	782
Three Rivers	480	566	516	619
Thurrock	730	520	482	560
Uttlesford	381	470	423	520
Watford	461	559	508	615
Waveney	628	524	483	567
Welwyn Hatfield	437	423	383	465

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

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