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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

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