Norfolk and Suffolk NHS
NHS Foundation Trust

STAKEHOLDER BREIFING
Embargoed until 12pm May 26, 2016

CEO welcomes open and transparent report and pledges to implement recommendations

Independent experts asked to examine how numbers of local unexpected deaths compare with national levels have today declared that the number of suicides in Norfolk and Suffolk is not higher than the national average.

However, they suggest there remains more to be done to work with bereaved families and to implement recommendations they have made to Norfolk and Suffolk NHS FT (NSFT) around how lessons are learned from unexpected deaths and serious incidents.

In its 136-page report released today (**Thursday, May 26**), Verita - a leading agency for independent inquiries - state that the number of unexpected deaths recorded by NSFT is:

"…likely to be determined by the fact the Trust adopts an early SI (serious incident) reporting culture and reports incidents at a rate that is substantially higher than the national average for mental health trusts…" (Ref 3.40; P15)

"We conclude that the number of suicides in Norfolk and Suffolk is not higher than the national average…" (Ref 3.30; P14)

Verita was commissioned by NSFT in February to independently investigate whether the mental health trust is an outlier in terms of numbers, patterns or trends in unexpected deaths.

This came after the NSFT Board had concerns that the number of unexpected deaths it reports was increasing, and following the release of unstandardised national data in which it appeared the Trust had the highest rates of unexpected deaths among mental health Trusts in the country.

However, in its report Verita noted that there is a: *"… lack of national data on which to base analysis. This is outside of the Trust's control and is a national issue. National data about unexpected deaths in mental health trusts offers limited means for making meaningful comparison…" (Ref 3.25; P13)*

"*We would expect that trust's that serve larger populations record larger numbers of unexpected deaths. The fact that no correlation exists [between population size and deaths] suggests that the data are misleading…" (Ref 7.20; P73 Comment & analyses)*

Verita do go on to make recommendations on where things can be improved and they comment that: *"The Trust is well positioned to improve its systems and processes for managing unexpected deaths…" (Ref 3.55; P18)*

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In conjunction with the Verita investigation, the Trust took part in a review led by NHS England (Local Office), which looked at governance arrangements at health trusts for investigating deaths in the context of the new NHS Serious Incident framework.

In its report, also released today, NHS England (Local Office) said: *"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.... Duty of candour was well-evidenced throughout…"*

Michael Scott explained: "All of the recommendations made by Verita and NHS England are already, or will be, acted upon. We are far from complacent, and there would be no point in our commissioning this investigation if we turn a blind eye to where is indicates we need to do better. That is something we simply will not do.

"The safety of our service users and our services is paramount and one single avoidable death is one too many – that is why we commissioned this investigation. We wanted to ensure that our services are as safe as they can possibly be.

"We are reassured by Verita's findings, which reflect that we are a trust which is a high reporter of unexpected deaths and serious incidents, and one which reports early. It is recognised that organisations with high levels of reporting are generally safer organisations. It is where there is a culture of hiding, blame or deflection that things go very wrong.

"The lack of consistent national data which is not standardised, as mentioned by Verita, is a concern we share as we believe our Trust is unlikely to be a high outlier of unexpected deaths. If our numbers were extremely concerning, we are confident that our regulators would have stepped in.

"But it is not just our numbers. In commissioning this report we also wanted to know that we are acting correctly in trying to prevent unexpected deaths and that where there is a need for improvement or a lesson to be learned we take efficient action, and we ensure that learning is shared throughout our whole organisation.

"The stand out point for me is that we need to work even more closely with bereaved families, offering a consistent level of support and engagement. I give my own personal commitment, and that of our Board, that we will make this a priority.

"And we need to offer greater support and training to our staff on how to best document and investigate unexpected deaths and do that consistently in all of our services right across NSFT. We are now recruiting additional investigation managers to support this."

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Verita key findings:

The Verita report offers key recommendations about where NSFT needs to tighten up its processes following unexpected deaths, including:

- Improving internal investigation processes (1)
- Ensuring lessons are consistently learned and embedded across its services (1)
- Improving support and engagement with bereaved families (2)
- Better evidencing of Board discussion on unexpected deaths (3)

1: Improving internal investigation processes and ensuring lessons are consistently learned and embedded across its services

Verita reports that the Trust's Root Cause Analysis (RCA) process - used to internally investigate unexpected deaths and serious incidents - meet national requirements but the quality of reports could be more consistent and the analysis improved to aid the learning of lessons.

This, it said, was consistent with the national picture highlighted in the recent Department of Health (DH) *Healthcare Safety Investigation Branch Report*. *(Ref 3.4; P8)*

Verita says: *"Overall we found that the Trust's RCA investigation process meets Trust and national requirements.... but their analysis or wider exploration of service and care management problems could be improved….We found that the quality of reports were inconsistent…" (Ref 3.4; P8)*

In referring to the recent DH Report, Verita says: *"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…" (Ref 3.6; P9)*

Verita went on to say: "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. (Ref 6:49; P67 Comment & analyses)

NHS England's report states that of the sample of NSFT's Serious Incident reports it audited: *"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…. Duty of candour was well evidenced throughout…"*

2: Improving support and engagement with bereaved families

Verita also says that while the Trust's level of engagement with families has improved there are concerns about how NSFT engages with and supports bereaved families: *"We found that the Trust's level of engagement with families had improved after the introduction of duty of candour…" (Ref 3.8; P10)...*

"We have concerns about the Trust's current process of engaging with and supporting families [during RCA investigations]." … "The Trust responded by… appointment of two additional IIMs to

enable better family liaison, increase central investigation resource and improve quality of RCA reports…" (Ref 3.9; P10)

3: Better evidencing of Board discussion on unexpected deaths (3)

There was evidence of routine reports to the Board on unexpected deaths and more detailed action within the Executive Committee and Quality Governance Committees (QGC), which work well, but there is no evidence of more detailed discussion at the Board to ensure lessons are learned.

Verita said: *"Our opinion is that the Trust Board holds a monitoring role in relation to unexpected deaths… 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 lessons learned.*

"However, this work is conducted by the Executive Committee on a weekly basis and the Quality Governance Committee on a monthly basis.

"Both of these groups have executive representation and the latter non-executive representation (Ref 3.12; P11)…act [ing] as the forums for further exploration of issues/concerns and these vehicles now work well" (Ref 6.28; P60 Comment & analyses)

Verita recommends "…that there is more detailed discussion at Board meetings about unexpected deaths to ensure that learning is being applied across the Trust…" (Ref 3.12; P11)

ENDS

Background Notes

Scope of Verita Review
The Trust, working with Verita and other third parties including its regulators Monitor, agreed a clear set of terms of reference for the review to ensure it robustly examined several key areas, including:

- Comparing NSFT's rates of unexpected deaths with national trends
- Reviewing the Trust's internal investigation processes to examine if they are sufficiently rigorous for lessons to be learned, that there is consistency, sound challenge and families and carers offered the opportunity to contribute to the process of investigation
- Identifying potential themes, priorities for action and effective systems for monitoring and sharing learning
- An appraising of NSFT's suicide prevention strategy
- Examining how NSFT has progressed with national requirements for mortality review
- A review of Trust governance around investigating deaths set against guidance in the new NHS Serious Incidents Framework

Verita was not tasked with investigating individual cases, although investigators did speak to two families, a local Coroner, and examined documentation relating to 126 RCA reports and unexpected deaths which occurred between April 2012 and December 2015, in community and inpatient settings.

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Scope of NHS England (Local Office) Review
NHS England's audit focused on governance arrangements – including policy - for a provider deciding whether an incident should be raised as a SI, and reviewing compliance with the SI Framework by examining a sample of unexpected deaths at the trust which took place between April 2015 and December 2015.

Further information:

- To read the full report log on to the NSFT website after 12pm, 26.05.16 at www.nsft.nhs.uk/independentreview

- 'Unexpected deaths' is a term used to describe deaths where the cause could not be anticipated. It can subsequently be found to be the result of natural causes, a physical illness, suicide, an accident unrelated to the person's mental health condition, or be given an open or inconclusive verdict at inquest.

  It is a national requirement for mental health trusts to report unexpected deaths up to six months after the service user has been discharged; therefore some patients are no longer in the care of a trust at the time of their death.

  NSFT reports unexpected deaths before a Coroner's verdict is given and serious incidents (SIs) before an investigation is completed, and is therefore described as an 'early reporter'. Many deaths or SIs may subsequently be found to have no bearing on the mental health care provided.

- Verita is a leading independent consultancy for regulated organisations in the UK. Its work ranges from specialist support and advice on challenging operational and strategic matters, to reviews and investigations of complex, sensitive issues. Recent major assignments Verita has carried out include Savile oversight and lessons learned, work for Secretaries of State for Health and Education, Myles Bradbury and a recent appointment by the British Council to run their global complaints service.

  For further information about Verita please look at www.verita.net

- The statutory Duty of Candour (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.