Item 9 Appendix A

Norfolk County Council

County Hall
Martineau Lane
Norwich
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NR1 2DH

Mr M Scott
Chief Executive
Norfolk and Suffolk NHS Foundation Trust

Letter sent by email

9 September 2016

Dear Mr Scott

Norfolk and Suffolk NHS Foundation Trust (NSFT) – unexpected deaths

Thank you for attending Norfolk Health Overview and Scrutiny Committee (NHOSC) yesterday and presenting NSFT's response to the Verita review of unexpected deaths carried out earlier this year.

There were some issues raised during the meeting that were not covered by the Verita review and, due to time constraints on the day, some questions that Members did not have the opportunity to ask or to explore as fully as they would have liked. The Chairman has asked me to write to you about these matters on the Committee's behalf.

Could you please respond on the following points by 30 September 2016:-

1. Please provide data comparing NSFT's current level of unexpected deaths with levels in Norfolk and Suffolk in previous years.

2. What affect did the radical redesign of NSFT's services under the Service Strategy 2012-2016 have on levels of unexpected deaths?

3. Are there trends in unexpected deaths that indicate concerns in specific localities or services?

4. Other than general mitigations (e.g. comparison with national average; unreliability of national data; the size of the trust in comparison with others) does NSFT have specific explanations for and analysis of the causes of the increase in unexpected deaths within the trust's area? e.g. to do with
    - specific localities;
    - service lines;
    - service changes;
    - withdrawal of the homeless and outreach service;
    - availability of staff and resources.

5. What is the trend in Coroner Reports to Prevent Future Deaths made in respect of NSFT in recent years and how does this compare with other mental health trusts in England?

6. Please provide assurance of public access to NSFT's information in respect of unexpected deaths in respect of:-
    (a) Statistics published on NSFT's website
    (b) Recording of the Board's analysis and action in response to unexpected deaths

7. We understand that concerns were first raised about the increase in deaths in the summer of 2013. What actions did the Board take during the two and a half years before they commissioned the Verita report?

8. The Verita report notes a comment that Lorenzo (the trust's new electronic patient record management system) would help with Root Cause Analysis (RCA) processes and risk assessments. Is there any data or evidence that this has been the case? Has Lorenzo been raised as an issue in any RCA since its implementation?

9. Please provide year-on-year data, pre and post radical redesign, of the numbers of people under the care of drug and alcohol services (not just the numbers referred but the numbers taken on by the service).

10. Please provide year-on-year data on the number of redundancies and the number of vacancies at NSFT by locality for the period of the 2012-2016 Service Strategy.

11. Regarding the Verita review:-
    (a) Who was involved in setting the terms of reference for the Verita review?
        i. Were staff with experience of unexpected deaths on their caseloads, staff representative bodies and bereaved family members involved?
        ii. Was the Campaign to Save Mental Health Services in Norfolk and Suffolk involved? (this was disputed at yesterday's meeting)
    (b) Did Verita raise concerns with NSFT about the limitations of the terms of reference?
    (c) Did families of service users raise concerns about the limitations of the terms of reference?
    (d) Were bereaved families whose family member died within the period being investigated notified that the review was taking place?
    (e) Were bereaved families whose family member died within the period being investigated explicitly invited to take part in the review?
    (f) How many NSFT staff in addition to the 11 listed in Appendix A to the Verita report were interviewed during the review?
        i. Please provide a breakdown of locality / professional background and band; and
        ii. How many of these staff had direct experience of an unexpected death of someone in their care?

(g) How many of the cases of unexpected death reviewed were:-

i. Of people under the care of the well-being service?
ii. Of people who had been formally discharged from services?
iii. For those who had been formally discharged, what were the lengths of time between discharge and death?

It is the NHOSC Chairman's intention that your response will be included within the Committee's published agenda papers for 13 October 2016. If it is not possible to respond by 30 September, could you please let me know the date by which you would be able to send the information.

Yours sincerely

Maureen Orr

Democratic Support and Scrutiny Team Manager