Norfolk County Council

Norfolk Health Overview and Scrutiny Committee

Date: **14 September 2023**

Time: **10:00 am**

Venue: **Council Chamber, County Hall, Martineau Lane, Norwich**

Persons attending the meeting are requested to turn off mobile phones.

Members of the public or interested parties may, at the discretion of the Chair, speak for up to five minutes on a matter relating to the following agenda. A speaker will need to give written notice of their wish to speak to Committee Officer, Jonathan Hall (contact details below) by **no later than 5.00pm on 8 September 2023**. Speaking will be for the purpose of providing the committee with additional information or a different perspective on an item on the agenda, not for the purposes of seeking information from NHS or other organisations that should more properly be pursued through other channels. Relevant NHS or other organisations represented at the meeting will be given an opportunity to respond but will be under no obligation to do so.

Membership

MAIN MEMBER	**REPRESENTING**
Cllr Jeanette McMullen	Great Yarmouth Borough Council
Cllr Stuart Dark	Norfolk County Council
Cllr Lesley Bambridge	Norfolk County Council
Cllr Brenda Jones	Norfolk County Council
Cllr Pallavi Devulapalli	Borough Council of King's Lynn and West Norfolk
Cllr Julian Kirk	Norfolk County Council
Cllr Robert Kybird	Breckland District Council
Cllr Justin Cork	South Norfolk District Council
Cllr Peter Prinsley	Norwich City Council
Cllr Richard Price	Norfolk County Council
Cllr Adrian Tipple	Broadland District Council
Cllr Robert Savage	Norfolk County Council
Cllr Lucy Shires	Norfolk County Council
Cllr Jill Boyle	North Norfolk District Council
Cllr Fran Whymark	Norfolk County Council

CO-OPTED MEMBER (non voting)	**REPRESENTING**

Cllr Edward Back	Suffolk Health Scrutiny Committee
Cllr Edward Thompson	Suffolk Health Scrutiny Committee

For further details and general enquiries about this Agenda please contact the Committee Officer:
Maisie Coldman 01603 638001
or email committees@norfolk.gov.uk

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The Government has removed all COVID 19 restrictions and moved towards living with COVID-19, just as we live with other respiratory infections. However, to ensure that the meeting is safe we are asking everyone attending to practise good public health and safety behaviours (practising good hand and respiratory hygiene, including wearing face coverings in busy areas at times of high prevalence) and to stay at home when they need to (if they have tested positive for COVID 19; if they have symptoms of a respiratory infection; if they are a close contact of a positive COVID 19 case). This will help make the event safe for all those attending and limit the transmission of respiratory infections including COVID-19.

A g e n d a

1. To receive apologies and details of any substitute members attending

2. Minutes

To confirm the minutes of the meeting of the Norfolk Health Overview and Scrutiny Committee held on 6 July 2023. (Page 5)

3. Members to declare any Interests

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter.

If you have a **Disclosable Pecuniary Interest** in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter

In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with.

If you do not have a Disclosable Pecuniary Interest you may nevertheless have an **Other Interest** in a matter to be discussed if it affects, to a greater extent than others in your division

- Your wellbeing or financial position, or
- that of your family or close friends
- Any body -
    - Exercising functions of a public nature.
    - Directed to charitable purposes; or
    - One of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union);
      Of which you are in a position of general control or management.

If that is the case then you must declare such an interest but can speak and vote on the matter.

4. To receive any items of business which the Chair decides should be considered as a matter of urgency

5. Chair's announcements

6.	**10:10 – 11:00**	**Accident and Emergency (A&E) services in Norfolk and Waveney**	(Page 11)
7.	**11:10- 12:00**	**Norfolk and Suffolk NHS Foundation Trust (NSFT) Mortality Recording and Reporting review**	(Page 38)
8.	**12:00 – 12:05**	**Forward Work Programme**	(Page 255)

Tom McCabe
Chief Executive
County Hall

Martineau Lane
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Date Agenda Published: 06 September 2023

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Norfolk County Council

NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
Minutes of the meeting held at County Hall
on 6 July 2023.

Members Present:

Cllr Jeanette McMullen	Great Yarmouth Borough Council
Cllr Stuart Dark	Norfolk County Council
Cllr Brenda Jones	Norfolk County Council
Cllr Robert Kybird	Breckland District Council
Cllr Justin Cork (Vice-Chair)	South Norfolk District Council
Cllr Richard Price	Norfolk County Council
Cllr Lucy Shires	Norfolk County Council
Cllr Peter Prinsley	Norwich City Council
Cllr Jill Boyle	North Norfolk District Council
Cllr Julian Kirk	Norfolk County Council
Cllr Lesley Bambridge	Norfolk County Council

Substitute Members Present
Cllr Long substituted Cllr Whymark

Also Present:

Tricia D'Orsi	Executive Director of Nursing – Norfolk and Waveney Integrated Care Board (ICB)
Erika Denton	Medical Director - Norfolk and Norwich University Hospitals NHS Foundation Trust
Nancy Fontaine	Chief Nurse - Norfolk and Norwich University Hospitals NHS Foundation Trust
Chris Cobb	Chief Operating Officer - ICB
Nigel Kee	Chief Operating Officer - James Paget University Hospitals NHS Foundation Trust
Alice Webster	Chief Executive Officer - Queen Elizabeth Hospital NHS Foundation Trust
Kerry Broome	Deputy Chief Operating Officer - Queen Elizabeth Hospital NHS Foundation Trust
Diane Smith	Senior Programme Manager, Adult Mental Health - ICB
Rebecca Hulme	Director - Children, Young People and Maternity - ICB
Peter Randall	Democratic Support and Scrutiny Manager
Liz Chandler	Scrutiny & Research Officer
Maisie Coldman	Trainee Committee Officer

1. Apologies

1.1 Apologies for absence were received from Cllr Tipple and the Chair Cllr Whymark (substituted by Cllr Long), Vice-chair Cllr Cork chaired the meeting. Kings Lynn and West Norfolk Council had not yet appointed a representative to the committee.

2. Minutes

2.1 The minutes of the previous meeting held on the 1 June 2023 were agreed as an accurate record of the meeting.

3. Declarations of Interest

3.1 Cllr Bambridge declared 'an other' interest, they are a council appointed governor at the Queen Elizabeth Hospital.

4. Urgent Business

4.1 There were no items of urgent business.

5. Chairman's Announcements

5.1 There were no Chairman's announcements.

6. Outpatient and inpatient services in Norfolk

6.1 Chris Cobb, Chief Operating Officer of the ICB, provided the committee with a report overview that highlighted national targets for waiting times and their trajectory over the last three years. The committee heard that the Covid pandemic had impacted waiting times. The Norfolk and Norwich University Hospital (NNUH) became a Super Surge Centre for Intensive Care and Covid cases from March 2020 to June 2021, which took staff and resources away from routine activity, including appointments and treatment. Additionally, industrial action had impacted capacity, resulting in approximately 50% of appointments being cancelled on those days. NNUH joined the national Go Further Faster outpatient program to provide support and guidance from Getting it Right First Time (GIRFT) and the Royal Colleges to 14 specialties, intending to have no patients waiting over 52 weeks for their first appointment in these specialties on April 1, 2024.

6.2 Nigel Kee, Chief Operating Officer at James Paget University Hospitals (JPUH) NHS Foundation Trust, shared the collaborative work that had occurred across the acutes, including the use of mutual aid. They discussed waiting times at the James Paget University Hospital and noted that the increase in two-week wait referrals had increased the pressure on outpatient appointments being delivered in 14 days. Work had also been done with the intensive support team from NHS England to ensure that the data collected was robust and of high quality.

6.3 Alice Webster, Chief Executive Officer at Queen Elizabeth Hospital (QEH) NHS Foundation Trust, shared that diagnostic testing was a challenge. Last year, the trust was identified as the worst-performing NHS Provider in the country. Improvements had been made to put them on track for recovery to 95% by April 2025 per national planning guidance. Two new MRI scanners and an Endoscopy unit have been conceived as part of this work.

6.4 The committee received the annexed report (6) from Dr Liz Chandler, Scrutiny and Research Officer, on the joint reports from Norfolk and Norwich University Hospitals NHS Foundation Trust, James Paget University Hospitals Foundation Trust, and the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust regarding outpatient and inpatient services at Norfolk's three hospitals.

6.5 The following discussion points and clarifications were offered:

- A member shared anecdotal evidence of their experience in accessing treatment and questioned the knock-on impact of long waiting times on other specialities, such as pain management. It was acknowledged that the waitlist needs to be reduced. The QEH was in the process of developing a mechanism to adopt the Patient Initiated Follow-Up (PIFU), pioneered by NNUH, which would allow patients and their carers to initiate their appointments as and when they need them. This process was thought to offer clearer patient pathways and create additional capacity to reduce the waitlist. Patients and services would be informed of changes when they are implemented.

- It was clarified that cancer metrics are behind. The recent increase in demand for skin and breast cancer, coupled with days lost due to industrial action, have contributed to the most recent figures. The committee heard that this was not a reflection of poor performance or processes and that improvements are expected to be made over the summer and autumn periods of 2023.

- Norfolk has three of the five worst digitally mature hospitals in the country. Thus, the move to an Electronic Patient Record (EPR) system was a welcome improvement to the acute hospitals and was felt to be a tool that would improve the patient journey and experience. The EPR system would span across the acutes and would operate as one system that included all elements of the health care system. The procurement process was underway, and members were assured that while there was no NHS electronic system, the process of procurement has strict criteria for private companies, and data would not be used for private profit. Patients would also have access to interfacing that would allow them to prevent certain information from being shared. Concerning funding, this had been agreed upon nationally, but there was a risk that there would be a shortfall, and additional financial support might need to be sought from partnerships. Members of the committee felt that they may be able to help communicate the support and funding required once the funding gap was known.

- The ICB had been having conversations with the Public Health team to establish an assurance meeting to better understand what services are being commissioned concerning substance misuse and how these marry up to community needs.

- The issues faced are being addressed both in the short and long term. In the short term, the goal was to reduce the waiting list back to a national level in the next 3 to 5 years. The establishment of a single patient tracking list was to inform part of this work, this would give patients the option to travel to receive treatment where it was available. Following this, the hope was that there would be the capacity to see people much earlier, and that the offer across Norfolk would become more balanced. The Workforce Strategy sets out a long-term ambition in relation to staffing issues; however, the challenge remains turning strategy into increased staffing numbers.

- The development of a single Patient Tracking List (PTL) involved the creation of a computerised system that the acute trust could work with. This has been tested across different specialties and within the three acute hospitals. QEH had encountered difficulties, whilst these are solved, JPUH and NNUH can go

live with the pilot scheme with the ambition of having it rolled out fully by the end of the year.

- It was acknowledged that there was more that could be done to highlight careers within health and social care. Working with students to inform them of career options before they selected their options was thought to be a worthwhile avenue to explore. The development of the new apprentices and shortened education routes as part of the Workforce Strategy might offer an incentive early on.

- The acute trusts are regularly reviewing recruitment and retention. Members heard the scale of the issue to recruit in relation to nursing. In England, there are 47,000 vacancies for band 5 junior nurses, this was coupled with a reduction in interest in becoming a nurse. This raised concerns as the NNUH, for example, needs 120 newly qualified nurses annually, this would rise to between 140 – 160 in 2025 and to 200 in 2028. While the ambition was to recruit into vacancies, ensuring safe and operational staffing levels, achieved through agency and bank staff, was essential at times. The JPUH vacancy position was largely positive, this was attributed to the success of overseas recruitment and the quality of work that they have been able to offer. The Workforce Strategy outlines that international recruitment would reduce with the hoped update of apprenticeships a shortened education routes. In respect to the retention of staff, work was being done to support the wellbeing of staff; there was also a recruitment hub in Norfolk.

- A member shared anecdotal evidence and questioned if the struggles with car parking had an impact on retention rates. It was clarified that changes have been made to allow staff to purchase a car parking space. Additionally, there are an extra 1000 spaces at the NNUH. It was acknowledged that communication surrounding these changes could be improved.

- In response to a member question that asked for comments on the request for a pay increase, the speakers noted that wages are dictated by a national pay scale and that colleague's decisions to take part in industrial action or not are supported.

- Members of the committee were offered reassurance that communication, collaboration, and learning were occurring between trusts.

- Members of the committee requested that future reports have a standardised reporting system to make them easier to interpret.

6.6 The chair concluded the discussion:

- The chair noted that the EPR process would be included as part of the digital transformation strategy item later in the year. The committee would be able to explore the funding and implementation. Any actions agreed by the committee concerning the Electronic Paper Record system should occur at the meeting in November.

- A briefing noting an update regarding PIFU would be considered.

- Conversations surrounding the workforce issues (vacancy rates, recruitment, retention) were felt to be needed.

7. Eating disorder services in Norfolk and Waveney

7.1 Diane Smith, Senior Programme Manager, Adult Mental Health at the ICB, provided the committee with an overview of the report.

7.2 The committee received the annexed report (7) from Dr Liz Chandler, Scrutiny and Research Officer, on the report from Norfolk and Waveney Integrated Care Board (N&WICB) regarding eating disorder services in Norfolk and Waveney.

7.3 The following discussion points were discussed and noted:

- There was a desire to shift focus to early intervention, prevention, and building resilience into services. This had already been happening as part of the Family Hubs and Healthy Child Programme. The impact of deprivation and poverty needs to be understood so that improvements can be made in collaboration with partners. Members spoke of the importance of this given the rise in food insecurity and the risk that young children would adopt an unhealthy relationship with food.

- Intervention and initiatives in school settings were discussed as being key to early intervention. School staff were felt to be well placed to notice the signs of an eating disorder. There are mental health support teams in schools, but it was thought that more could be done to raise awareness of disordered eating and eating disorders among young people.

- It was clarified that eating disorders are more prevalent amongst girls and although boys are experiencing an increasing occurrence of eating disorders, this was often presented differently. The treatment offered to people with eating disorders remains the same regardless of the person's sex, it was personalised, and goal based for that specific person.

- Training was available to all and can be accessed through the Just One Norfolk Website.

- In the East of England, there are two eating disorder children units, one in Cambridge and another in the independent sector. Where possible, it was preferred to treat people in the community and thus, very few people are admitted to an in-person unit. The committee heard that the length of stay, and people requiring those beds, have reduced.

- It was clarified that the Dragonfly unit was still operating but, given the specialised nature of treatment required, doesn't treat patients with an eating disorder. The unit was a general adolescent psychiatric unit.

- Social media's influence was thought to affect the increase of disordered eating and eating disorders.

- There was no upper age limit to access adult services. Specific pathways had been established for people with severe and enduring needs.

- For many young people with an eating disorder, this would not impact their education as they were typically high achievers.

7.4 The chair concluded the discussion:

- The chair noted members' feelings of appreciation for the work and staff involved that had afforded improvements to take place, particularly regarding the decrease in in-patient beds being required.

- Members of the committee would receive a future update around the discussions to increase local capacity and eating disorder inpatient beds.

- Further exploration to understand the role of the NHOSC in encouraging partnership work between Norfolk County Council, Children Services, the ICB, and mental health trusts was required.

8. Forward Work Programme

8.1 The Committee received a report from Peter Randall, Democratic Support and Scrutiny Manager, which set out the current forward work programme and briefing details. The Committee agreed to the details for both briefings and future meetings.

8.2 The addition of the mortality review to the meeting in September prompted members to enquire if a joint Health Overview and Scrutiny Committee (JHOSC) meeting would be appropriate given that the data included Suffolk. It was clarified that JHOSCs are set up for specific issues, thus, there would need to be agreement from the Norfolk and Suffolk HOSCs to develop a JHOSC. If agreed, a meeting would likely take place at the end of the year at the earliest. An alternative would be for Norfolk and Suffolk HOSC to share their thoughts and learnings from the mortality review with each other. This would be taken away and discussed with the chair.

8.3 Members requested the possibility of a briefing note on the impact of food poverty on the health of the Norfolk population and also access to disabled facilities grants.

8.4 It was confirmed that dentistry was on the forward work programme for September. Although, members heard that given the limited amount of time that the ICB has had responsibility for dentistry, flexibility surrounding the update might be required.

8.5 Cllr Lucy Shires was appointed to the Norfolk and Norwich University Hospitals NHS Foundation Trust link role. Cllr Jeanette McMullen was appointed to be the substitute for the Norfolk and Suffolk NHS Foundation Trust link role.

Justin Cork Vice-Chair
Health and Overview Scrutiny Committee

The Chair thanked all attendees and closed the meeting at 12:16

Accident and Emergency (A&E) services in Norfolk and Waveney

Suggested approach from Liz Chandler, Scrutiny and Research Officer

Examination of Accident and Emergency (A&E) services at Norfolk's three acute NHS hospitals, namely: Norfolk and Norwich University Hospital (NNUH), James Paget University Hospital (JPUH) and Queen Elizabeth Hospital, King's Lynn (QEH). This item forms part of NHOSC's wider review of the patient pathway.

1.0 Purpose of today's meeting

1.1 To examine the report from Norfolk and Waveney Integrated Care Board (N&WICB) regarding Accident and Emergency (A&E) services at Norfolk and Norwich University Hospitals NHS Foundation Trust, James Paget University Hospitals Foundation Trust and the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. The report is attached at **Appendix A.**

1.2 Representatives of N&WICB will be in attendance to answer Members' questions.

2.0 Previous reports to NHOSC

2.1 A&E services have not been examined at a NHOSC meeting in the last five years, but the committee has received the following briefings:

- A briefing on the older person's emergency department at NNUH was provided in December 2017 with an update in January 2018.
- The Emergency Care Intensive Support Team (ECIST) was the subject of a briefing in September 2018.
- In October 2019, a briefing was received on A&E waiting times at NNUH.
- A situation briefing examining a rise in urgent and emergency activity in the previous six months was received in February 2022.

3.0 Background information

3.1 Delivery plan for recovering urgent and emergency care services

3.1.1 Following government pledges made in the Autumn Statement 2022, the Department of Health and Social Care and NHS England published their Delivery plan for recovering urgent and emergency care services in January 2023. This plan included a number of ambitions for improving urgent and emergency care including:

- Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.
- Ambulances getting to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

3.1.2 In order to meet these targets, the report committed to:

- Increase capacity, to help deal with increasing pressures on hospitals which see 19 in 20 beds currently occupied.
- Grow the workforce, as increasing capacity requires more staff who feel supported.
- Speed up discharge from hospitals, to help reduce the number of beds occupied by patients ready to be discharged.
- Expand new services in the community, as up to 20% of emergency admissions can be avoided with the right care in place.
- Help people access the right care first time, as NHS111 should be the first port of call and reduce the need for people to go to A&E.[1]

3.1.3 ICBs, working with local authorities and other partner organisations, are accountable for improving four-hour A&E waiting times and ambulance performance through the services that they commission.

3.2 BMA backlog data analysis

3.2.1 According to the British Medical Association's (BMA) analysis of monthly data released by NHS England, attendance at A&E attendance remains high. Nationally, there was a total of 2.22 million A&E attendances in June 2023, down slightly from 2.24 million in May 2023.

3.2.2 Waiting times throughout England also remain high, with only 73.3 percent of people attending A&E were seen within four hours, below the NHS target of 75 percent. In comparison to June 2022, the number of patients waiting more than 12 hours for an emergency admission was 1.20 times higher in June 2023 and 57 times higher than it was in June 2019.

3.3.3 The BMA blames the increase in waiting times on the backlog of care, chronic workforce shortages and discharge delays.

3.3 A&E attendances and emergency admissions

3.3.1 Every month, NHS England collects and publishes statistics for A&E attendances and emergency admissions from all trusts in the country.

The latest figures for N&WICB for June 2023 are as follows:

[1] Summary from Urgent and Emergency Care Recovery Plan | Healthwatch Westsussex.

3.3.2

A&E attendances and emergency admissions Norfolk and Waveney ICB June 2023	
Total A&E attendances	34,742
Less than four hours from arrival to admission, transfer or discharge	25,210
More than four hours from arrival to admission, transfer or discharge	9,532
Percentage of attendance within four hours	72.6 %
Total emergency admissions via A&E	6,129
Total emergency admissions	8,770
More than four hours from decision to admit to admission	3,086
More than12 hours from decision to admit to admission	855

View the full dataset here.

3.3.3 Annual figures for each individual acute trust in Norfolk are provided within N&WICB's report below.

3.4 NHS Patient Surveys

3.4.1 All eligible NHS Trusts in England participate in the Care Quality Commission's (CQC) NHS Patient Surveys, which seeks the views of patients on their recent health care experiences. As well as providing organisations with detailed patient feedback that can be used in future service delivery, the survey results are also used by the CQC to measure and monitor performance.

3.4.2 Patients are asked for feedback on nine different categories including Arrival at A&E, Waiting, Doctors and nurses, Care and treatment, Tests, Environment and facilities, Leaving A&E, Respect and dignity and Experience overall.

3.4.3 JPUH came within the top five highest scoring trusts in all categories, with QEH coming in the top five in three categories and NNUH in three categories. However, NNUH came in the five trusts with the lowest scores in one category (Doctors and nurses). All three trusts scored above the national average (7.4) in terms of Experience overall, with JPUH scoring 8.3, QEH 7.7 and NNUH 7.4.

3.5 NNUH's Older Person's Emergency Department

3.5.1 In April 2023, The Journal of Emergency Medicine published a report following its evaluation of the Older Person's Emergency Department (OPED) at NNUH. While the study showed that the OPED did not significantly lower the proportion of patients admitted to the hospital, it did demonstrate that patients seen in the OPED 'were more likely to meet the national 4-hour target and more likely to be discharged to their original place of residence.'

See also: Norfolk and Norwich University Hospitals NHS Foundation Trust.

3.6 Intensive support for N&WICB

3.6.1 In June 2023, the Eastern Daily Press reported that as part of the Delivery plan for recovering urgent and emergency care services, N&WICB had been offered 'intensive support' as hospitals had not been meeting A&E waiting time or ambulance response time targets.

4.0 Suggested approach

4.1 The committee may wish to discuss the following areas with representatives of N&WICB:

- Seek further details about N&WICB's local plan to deliver on performance ambitions of A&E.
- Question why JPUH and QEH are performing worse than NNUH in terms of patients waiting more than four hours to be seen after arriving at A&E?
- Question why the average wait to be seen at the QEH for patients with mental health conditions significantly increased in June 2023?
- Question why staff turnover at A&E is generally higher than 'all staff' turnover at NNUH and QEH than at JPUH? See also staff sickness levels.
- Request an update on hospital discharge and the extent to which delayed discharge is impacting on A&E.
- Request further information about how N&WICB is working to address the priorities identified as part of the Urgent and Emergency Care Recovery Plan.
- What can local authorities do to support N&WICB in addressing any issues relating to A&E provision?

5.0 Action

5.1 The committee may wish to consider whether to make comments or recommendations as a result of today's discussion.

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Item 6

Appendix A

Norfolk and Waveney
Integrated Care Board

Subject:	**Accident and Emergency (A&E) Services in Norfolk and Waveney**
Presented by:	**Mark Burgis – Director of Patients and Communities**
Prepared by:	**Ross Collett – Director of Urgent and Emergency Care**
Submitted to:	**Norfolk Health and Overview Scrutiny Committee (NHOSC)**
Date:	**14th September 2023**

Purpose of Paper:

To inform the Norfolk Health and Overview Scrutiny Committee (NHOSC) on current issues affecting Accident and Emergency (A&E) services in Norfolk and Waveney.

Report

What are the current issues affecting A&E services in Norfolk and Waveney?

We have three Emergency Departments (EDs) that operate across three hospitals: the Norfolk and Norwich University Hospitals NHS Foundation Trust which is a 1200 bed teaching hospital serving a population of approximately one million people in Norfolk and the surrounding areas; the James Paget University Hospitals NHS Foundation Trust which is a 500 bed hospital serving a population of approximately 250,000 people across Great Yarmouth, Lowestoft and Waveney as well as many visitors who come to East Anglia; The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust which is a 500 bed hospital serving a population of approximately 330,000 people across West and North Norfolk, in addition to parts of Breckland, Cambridgeshire and South Lincolnshire.

All three sites continue to see sustained high levels of demand through their Emergency Departments, although this will fluctuate to some degree month on month.

The principal issue that we have seen for a sustained period at all three sites are lengthy delays in handing over patients from ambulance crews to the EDs. These 'handover delays' can result in crews remaining at hospital, unable to clear, who are then unavailable to respond to further 999 calls requiring an ambulance dispatch. The causes of these handover delays are multifactorial but are a symptom of poor flow through the hospital meaning those patients requiring admission can be held up for extended periods of time whilst waiting for a bed to become available.

In addition to 'ambulance handover delays', a further issue that impacts our patients are the long waiting times in EDs for patients with a mental health condition. These patients can often

endure waits of several hours in our EDs before appropriate support, treatment or discharge takes place.

Figures for A&E attendances at the three acute trusts for the past 12 months broken down as follows:

- A&E attendances by number.
- Number/percentage of patients waiting more than 4 hours from time of arrival to be seen.
- Number/percentage of patients waiting more than 12 hours from time of arrival to be seen.
- Above figures compared with national average.
- Average wait from time of arrival for patients with mental health conditions to be seen.

Please see data in ***appendix A***

Updated figures for ambulance handover times at the three acute trusts (NHOSC received figures until January 2023 from EEAST at its meeting in March 2023):

Please see data in ***appendix B***

Update on the ambulance handover unit at JPUH and how this is working to reduce ambulance handover times:

This initiative was non-recurrently funded as part of Norfolk and Waveneys' 'winter' schemes which enable the JPUH to fund an externally staffed mobile unit that operated on site until March 23. Since March 23, the trust has continued to see sustained improvement in ambulance handover delays. This has been achieved through a senior leadership focus both operationally and clinically on reducing delays. Currently, JPUH is the best performing of our three sites in terms of reducing these.

As part of the Tier 1 national support process all three acute trusts have had visits from clinicians in both the Emergency Care Intensive Support Team (ECIST) and as part of the regional peer review process. The findings from both teams identify best practice as well as areas requiring improvement; these findings have been shared widely with ICB colleagues working with the trusts and with trust colleagues themselves.

To what extent are difficulties in accessing primary care services affecting A&E attendances? Figures for patients attending A&E due to difficulties in accessing NHS dental services (if available):

Please see figures for dental attendances in our EDs at ***appendix C.*** These figures will show attendances that are coded as dental, but we are unable to correlate this with access to primary care.

Norfolk and Waveney GP practices continue to offer more appointments than ever before. The latest data we have is for May 2023 and this showed the following:

	2023/24 (inc Covid)	2022/23 (inc Covid)	Var
April	538,689	511,490	27,199 ▲
May	605,552	582,858	22,694 ▲

PCN Total Covid 19 Vaccinations	
2023/24	2022/23
29,611	25,601
28,888	18,463

	2023/24 (excl Covid)	2022/23 (excl Covid)	Var
April	509,978	485,889	24,089 ▲
May	576,664	564,395	12,269 ▲

Face to face appointments, the ICB is at 77.9% versus a national average of 69.8%

39% of appointments are same day (compared to 44% nationally).

Comparing this year to pre-Covid (excluding vaccinations).

2023/24	2019/20	Var
509,978	498,491	11,487▲
576,664	516,802	59,862▲

Despite the ongoing workforce pressures, GP practices are continuing to see the equivalent of more than half of our Norfolk and Waveney population every month. The recently published GP Patient Survey data also shows that overall our practices satisfaction ratings are in line or higher than the national average. Within this there is a range, and we are working in partnership with practices experiencing resilience issues to support recovery.

Figures for patients attending A&E due to falls and what is being/can be done to improve this?

Please see data for 'falls' at ***appendix D***.

The ICS has established an ICS-wide Strategic Falls programme, led by the Director for Quality in Care. It is intended that once fully established the falls programme will report into the Older Person's Board, chaired by the ICB Medical Director. There are three workstreams and focuses areas in the programme:

- **Acute & Inpatient settings**
  - Leading on the design and implementation of standardisation of falls data in acute and inpatient settings, including a focus on standardising and capturing the measurement of falls and frailty.
  - Participating in the CLEAR East of England falls group which is currently interrogating falls data with the JPUH and QEH.
  - Developing a standardised approach to falls management in the acute sector
  - Capturing learning from the acute sector which can be used to inform other settings.

- **Community & prevention**
    - Proactively identifying individuals at high risk of falling, including links with the NCC's Proactive Interventions project, with pharmacy to identify individuals at risk of falling due to medications and use of ONS data.
    - Enabling an equitable approach to falls prevention, including self-referral into Falls Prevention services, use of GaitSmart and use of digital/technology to support prevention at home/in the community.
    - Enabling an equitable urgent community response for fallers ahead of Winter 2023-24, including a pathway for 'long-lie' fallers, support for the care sector, use of VCSE resources (where appropriate) and demand & capacity modelling.
    - Developing a public communications campaign, including self-help for falls prevention, help if you have experienced a fall or have a fear of falling, and access to strength and balance classes etc.

- **Care Sector**
    - Establishing a robust supporting framework for the care market sector to manage frailty and falls.
    - Analysing falls data from 111 (IC24) / 999 (EEAST) to identify and support care homes which appear as outliers.
    - Introducing digital technology/tools/algorithms to support care sector staff with decision making in response to a fall.
    - Education and training for all relevant staff to help reduce ambulance call outs and conveyance.
    - Enabling care sector staff to have access to proactive support from a senior clinician to assist with decision making via digital platforms, such as NHS mail and remote FEBRIS observation kits.

The ICS is developing an unscheduled care coordination hub which will provide a single point of access into the Norfolk and Waveney urgent care system. The initial contact to the hub will be with a senior clinician to enable a clinical conversation to take place and joint agreement of care planning. Where an alternative plan is agreed, the hub will take on the coordination of care services with direct links into community response teams which will facilitate more effective coordination of care while allowing ambulance crews to clear from the scene and attend other emergency calls. This will reduce ambulance crew job cycle time and release time back to respond to emergencies. Senior clinical review from community teams across the system will maximise the use of non-ED pathways to support patients with urgent needs to get the right care, in the right place, first time. The work includes identifying patients accessing 999 who may be more suitable for a community falls response and over a longer period of time will provide rich data on demand, capacity and any geographic service gaps.

How are patients who present at A&E with mental health issues assessed in terms of their risk of self-harm/suicide?

Upon arrival (via walk in or ambulance) at the point of triage, a mental health risk screen is completed where indicated. This is electronic within the ED EPR system and there is a paper option if the trust is in business continuity. The mental health risk screen will be indicated in situations either when the patient is presenting to ED specifically linked to their mental health needs or if this is less obvious but identified during the nursing triage process. The risk screen offers an outcome risk score to guide which area of the department the patient may be most safe to wait to be seen and will prompt a referral to the Mental Health Liaison Service to discuss the patient directly with the team. The ICB audits compliance at NNUH monthly and this is monitored via the ICB Mental Health Board monthly.
In addition, we have been working with NSFT and Public Health completing real time data analysis for attendances to ED for self-harm/ suicide intent. We have 1 WTE data analyst who

is funded into NSFT via public health who sits under NSFT patient safety team. If you need it, I can access data but that is probably not necessary.

This work is planned to roll out across JPUH and then QEH.

Update around the intensive support provided to N&WICB under NHS England's urgent and emergency care recovery plan:

Norfolk and Waveney ICB have been allocated to Tier 1 as part of the NHS England UEC Tiering Programme that supports the delivery of the national UEC Recovery Plan.

The entire system has recently undergone a diagnostic process with various teams as part of the national process.

The outcomes of this work have identified four initial priorities:

1. Improve front door and discharge processes to include:
    a. System wide unscheduled care coordination hub and review of front door processes to reduce 12 hour waiting times in ED.
    b. Review of simple discharges to include criteria led discharge and ward processes to reduce LOS.
2. Undertake an ICS wide frailty audit:
    a. Identify alternatives to admission for frail patients.
    b. Aim to reduce LOS in hospital for frail patients requiring admission.
3. Intermediate care:
    a. To review the model of intermediate care and processes
4. Resilience:
    a. Support the development of the System Control Centre, enabling better management and escalation of risk across the system.

The national team are working with the ICB/ICS to provide support in each of these areas to improve performance and outcomes for patients ahead of winter 23/24.

Information on the recent trial for staff in A&E at NNUH to wear body worn cameras for safety reasons.

Following a rise in the number of incidents involving aggression towards staff, ED have started to trial the use of body worn cameras (BWC) for designated clinical staff within the department.

The NNUH are hoping that the use of body worn cameras will be an aide to help protect staff dealing with members of public in situations where they are particularly vulnerable to abuse or where there is an ongoing need to capture images or speech for evidential purposes. The primary purpose of BWC, therefore, is as a preventative measure, and to support de-escalation of incidents. Secondarily, its purpose is to support reporting and evidence of specific incidents. Such as preventing and detecting crime, disorder, anti-social behaviour and the fear of crime by helping to provide a safer environment for those people who work for the trust, our patients, and visitors. You will note already that several trust security staff already operate BWCs.

Please be assured the following;

- That any use of body worn cameras is governed by internal policies and is conducted in accordance with the law.
- These cameras process video images and audio data of members of the public and people who come into contact with these staff members. BWC shall only be used after

a warning has been given and only when an offence is being committed or likely to be committed. Once an incident is over, BWV will be turned off.

- Recorded footage is secure and encrypted meaning that only authorised staff can access it. In the case of BWC, the operator will not be able to access the footage directly.
- The trust shall never continuously record using body worn cameras and will only utilise such technology where there is a legitimate need to do so.
- In the event that body worn cameras are in operation, trust operators shall take all reasonable steps to make sure those captured in such footage are made aware that recording it taking place.

The trial has been extended as until very recently no incidents have required the use of BWC, and unfortunately, there was not time to use it on the most recent violence and aggression incident in ED and it will not negate the need for (ideally) improved security staff presence in ED at all times.

During the trail phase NNUH only had one camera which was always situated with the lead nurse so when an incident is escalating, and they are alerted, they can respond and take the camera with them. During the RATS incident there was not enough time for the lead nurse to attend and activate the BWC as the event had escalated and deescalated quite quickly.

The NNUH has since ordered more cameras with one deployed in each area so that should an incident happen again, they will be able to capture the footage. In the area of the named incident, the team has also requested some CCTV to be installed to assist with prevention and evidence.

Figures relating to the A&E workforce at the three acute trusts broken down as follows:

- Staff turnover within A&E services in the past 12 months.
- Levels of staff sickness in the past 12 months.

Please see data at ***appendix E*** with supporting narrative

What are the key issues affecting recruitment and retention of staff in urgent and emergency care and how is N&WICB working to address these?

The issues affecting recruitment and retention of our total health and social care workforce in Norfolk & Waveney are multifactorial, but we see these being exacerbated in high pressure environments such as our Emergency Departments. The key issues can broadly be themed around burnout and loss of purpose (unable to deliver the excellent patient care our staff are trained to do), safety, leadership and culture. To improve conditions for our staff, we must take a multi-disciplinary and multi-agency approach to how we work as a system to address the whole care pathway considering how new ways of working will both reduce demand and increase flow as indicated earlier in this paper to reduce the demand on our ED departments.

Industrial action continues to have a significant impact on our NHS Providers – both at a strategic, operational and on the floor level. We have a well-planned and regionally commended approach to our planning and mitigations to ensure both safety for the public and to ensure the wellbeing of our staff in the lead up to, during and in recovery from industrial action. That being said, the impact of sustained periods of industrial action has reduced morale and we are seeing increased concern for patient safety by our staff resulting from delays in care. Our organisations have regular welfare checks, introduce increased supervision, bolster ED with additional staffing through the movement of other practitioners, and have visible leadership during each strike. We are very concerned about the impact of continued periods

of strike action which may continue into the winter months and are planning now as an ICS and with regional NSHE colleagues to manage the risk level.

As noted previously, a lens on improving the whole pathway will address workforce challenges impacting recruitment and retention for our ED workforce. A focus on increasing staffing levels and retaining staff, partnership working, and strategic leadership is needed with our social care, primary care, community and care home partners to reduce presentation at our EDs, increase flow of community bed provision and the availability of social care packages.

As an ICS we work closely with partners to address shared issues and emerging themes for our staff. In relation to UEC and ED staffing in particular, we have implemented the following programmes in line with the themes of burnout, safety, leadership and culture:

- A system wide mental health upskilling programme focussing on increasing awareness and training on de-escalation techniques. The aim is to provide a better experience for patients, increase safety for our staff, and better manage time and resources for patients which can have an impact on staffing availability in busy environments such as ED (ie HCAs are often required to supervise patients waiting for MH referrals or liaison teams from NSFT).
- The NHS national civility and respect programme to support staff by developing compassionate cultures is being embedded across our NHS partner organisations in N&W.
- We launched an ICS wide 'Stop the abuse' campaign in May this year to tackle bullying and harassment and urging people to be kind to staff. The campaign remains live and was launched in response to staff survey which highlighted the impact on staff of bullying and harassment on their wellbeing and satisfaction. Staff working at 'the front door' are more likely to experience poor behaviours which impacts on ability to provide care to patients and a safe working environment for our staff.
- Our virtual wards are expanding and alongside the ability to discharge patients to their homes sooner, working in a virtual ward can provide staff the opportunity to decompress and work in a less pressurised environment supporting their wellbeing and increasing their skill set.
- Systems leadership programmes promote time, space, and opportunity for our systems leaders to work together on complex issues.
- We have provided opportunities for senior leaders supporting the pandemic response and industrial action in ED to access bespoke trauma-based coaching.
- Each organisation supports staff resilience at an individual level. At an ICB level we are developing a collective resilience offer for teams/groups across the NHS organisations and working with pilot groups to test out what would be most helpful for them. The SRO for this workstream is Nancy Fontaine (NNUH, DON).

More broadly, our system wide retention programme focusses on whole workforce recommending the following approach for retaining staff:

1. **R**EDUCE abuse by the Public, bullying by staff, and racial discrimination.
2. **E**MBED & evaluate best practice initiatives at a trust level.
3. **T**AKE ADVANTAGE of the new NHS pension flexibilities + removal of the Lifetime Allowance.
4. **A**CCELERATE flexible working at a clinical level.
5. **I**NTERNATIONAL recruitment and retention.
6. **N**URTURE HCSWs, foundation practitioners, preceptees, & students with pastoral support & mentoring.

As we move into winter preparations, there will be a focused workforce workstream which bring partners together to plan for additional resilience during the winter months where we see

seasonal patterns of increased sickness levels for staff including flu and norovirus which enhances pressure on our organisations to manage demand from patients.

Our plan is in development, but will include:

- A focus on keeping our staff well and in work with our annual flu and COVID-19 boosters, and increased infection prevention and control processes to reduce spread of other seasonal diseases such as norovirus.
- Improving rest spaces for staff.
- Building additionality in workforce – focussing on additional temporary staffing support through bank and use of our reservist workforce to provide additional staff to critical areas including ED and discharge.
- Increasing bed capacity in the community – which requires support from multi-disciplinary and multi agencies including social services and our care homes.
- Winter wellness campaigns to the public signposting to appropriate services.
- We will also need to facilitate and lead system partners meetings across health and social care to promote collaborative working to improve flow.
- Enhanced rest and wellbeing initiatives for ED staff who will face challenging working environments which may cause moral injury ie patients waiting on ambulances for prolonged periods in winter months.

How the ICB and trusts are collaborating with partner organisations to improve A&E performance, in particular the work that the HWPs are doing in terms of frailty and falls and whether there was any crossover with them?

Each of our three acute systems is supported by a UEC Steering Group chaired by Directors and or Senior Clinicians. These groups bring together representatives from “Place” including primary care, social care, VCSE, the acutes and community. These groups have all signed up to and are committed to delivering against the ICB/ICS three key priorities for this operational year: reduce ambulance category 2 response times to an average of 30mins; implement a “step up” and step down” virtual ward across Norfolk and Waveney with 368 bed equivalent capacity; reduce long lengths of stay in our hospitals through the achievement of 92% occupancy at all three hospitals.

To deliver the improvements described above these groups come together to work on and support four key programmes of work: ED front door processes; discharge and long lengths of stay; unscheduled care coordination; virtual ward. Within each of these programmes there is a specific focus on those patients who are frail and frail and elderly and the pathways we have for falls and fallers; these include the work with social care and District Direct colleagues and so there is direct crossover with HWPs.

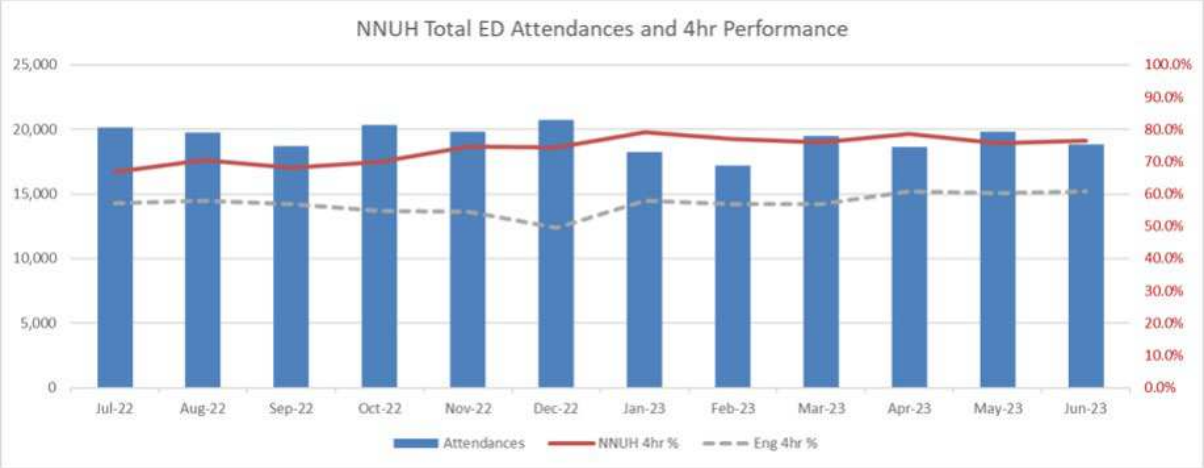
What support can local authorities/NHOSC give to improve the current issues facing urgent and emergency care in Norfolk and Waveney?

Our local authorities are already very engaged in the UEC work both at a “Place” / acute system level and they are represented at a senior level at the ICS Executive Management Team and attend the system Urgent and Emergency Care Board.

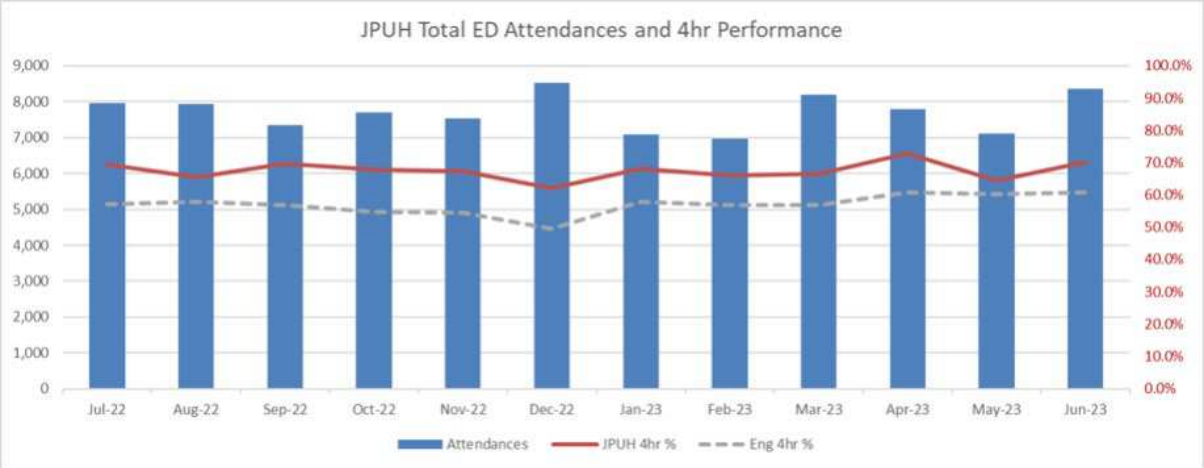
It would be helpful if NHOSC could support more engagement with members on the plans the ICB / ICS has to improve urgent and emergency care overall. This in turn will support wider public engagement in the ways in which our population can seek urgent or emergency care when they have a need in the most appropriate way. This will help us to use our precious clinical resources in the most effective way rather than our population seeing 999 and EDs as the default “go to” resource for support.

Appendix A - Figures for A&E attendances at the three acute trusts for the past 12 months

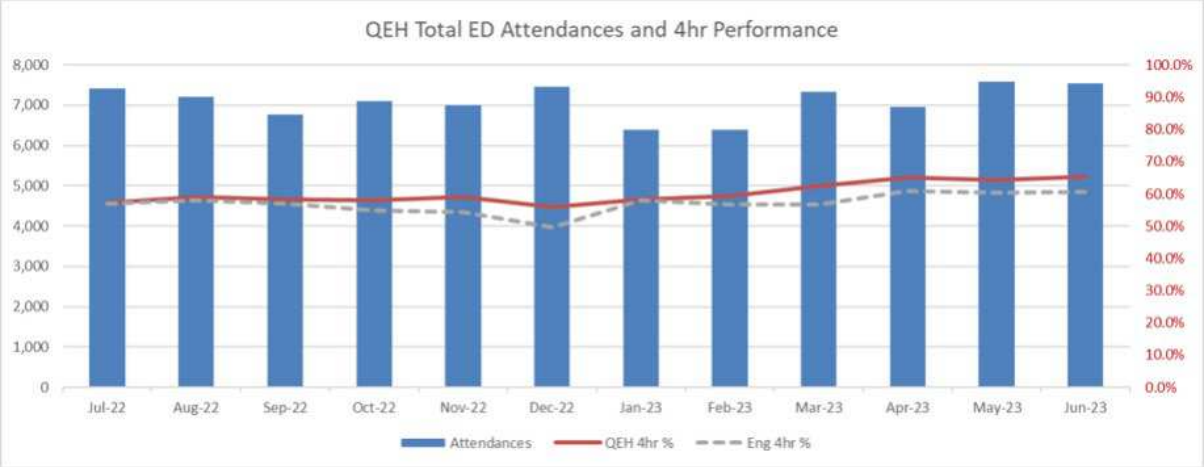
Number/percentage of patients waiting more than 4 hours from time of arrival to be seen.



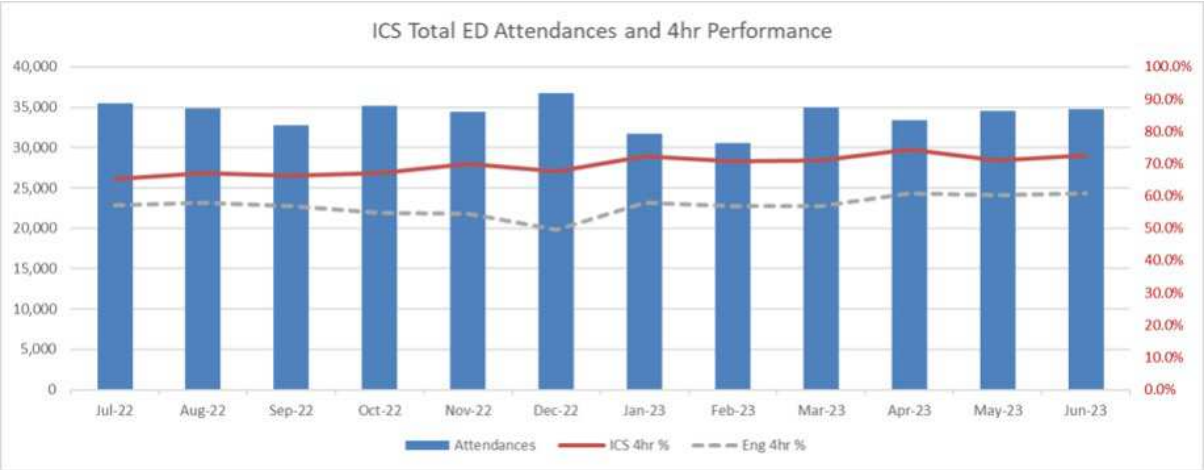
Provider	Metric	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
NNUH	Attendances	20,141	19,718	18,670	20,352	19,836	20,725	18,213	17,215	19,474	18,627	19,812	18,838
	4hr%	66.7%	70.5%	68.0%	69.9%	74.7%	74.3%	79.0%	76.9%	76.0%	78.7%	75.8%	76.5%
Eng	4hr%	57.0%	58.0%	56.9%	54.8%	54.5%	49.6%	58.0%	56.8%	56.8%	60.9%	60.4%	60.7%



Provider	Metric	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
JPUH	Attendances	7,951	7,944	7,344	7,693	7,541	8,533	7,092	6,973	8,187	7,796	7,119	8,352
	4hr%	69.4%	65.5%	69.8%	67.9%	67.4%	62.1%	68.2%	66.1%	66.6%	72.8%	64.4%	70.2%
Eng	4hr%	57.0%	58.0%	56.9%	54.8%	54.5%	49.6%	58.0%	56.8%	56.8%	60.9%	60.4%	60.7%

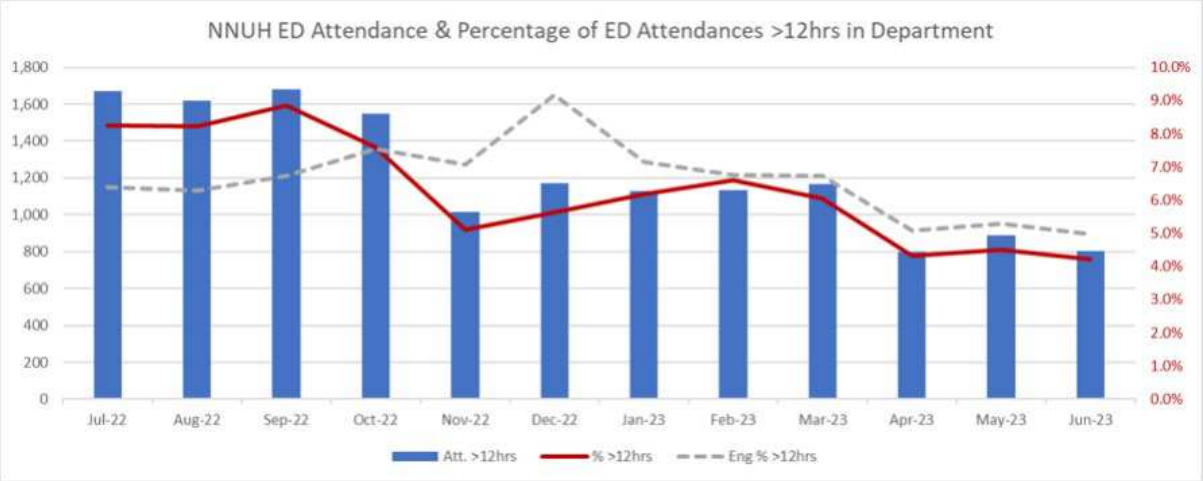


Provider	Metric	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
QEH	Attendances	7,412	7,212	6,773	7,110	7,007	7,450	6,399	6,401	7,341	6,953	7,584	7,552
	4hr%	57.3%	59.1%	58.3%	58.1%	59.1%	55.8%	58.3%	59.3%	62.4%	65.0%	64.4%	65.4%
Eng	4hr%	57.0%	58.0%	56.9%	54.8%	54.5%	49.6%	58.0%	56.8%	56.8%	60.9%	60.4%	60.7%

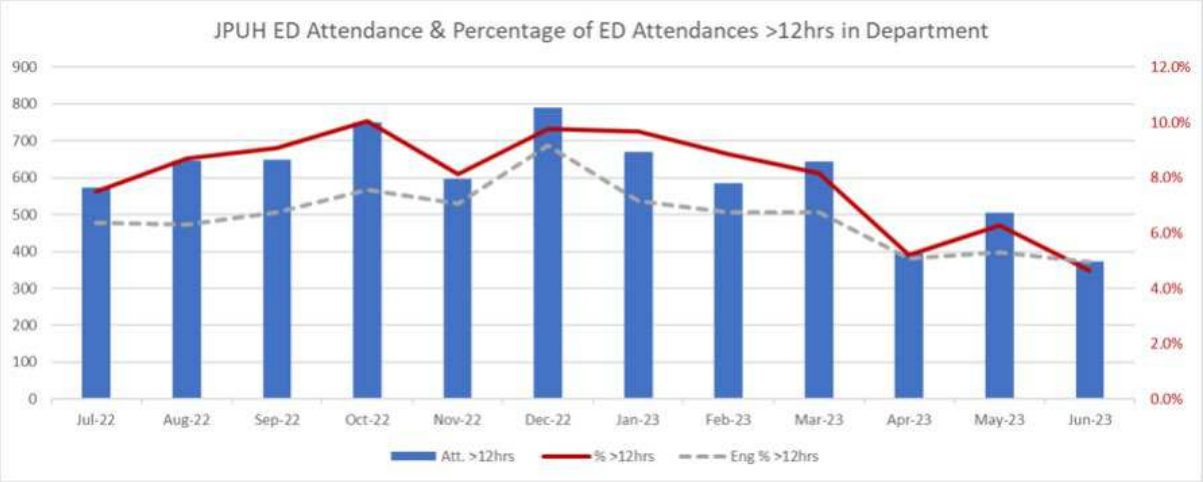


Provider	Metric	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
ICS	Attendances	35,504	34,874	32,787	35,155	34,384	36,708	31,704	30,589	35,002	33,376	34,515	34,742
	4hr%	65.3%	67.0%	66.4%	67.1%	69.9%	67.7%	72.4%	70.8%	70.9%	74.5%	70.9%	72.6%
Eng	4hr%	57.0%	58.0%	56.9%	54.8%	54.5%	49.6%	58.0%	56.8%	56.8%	60.9%	60.4%	60.7%

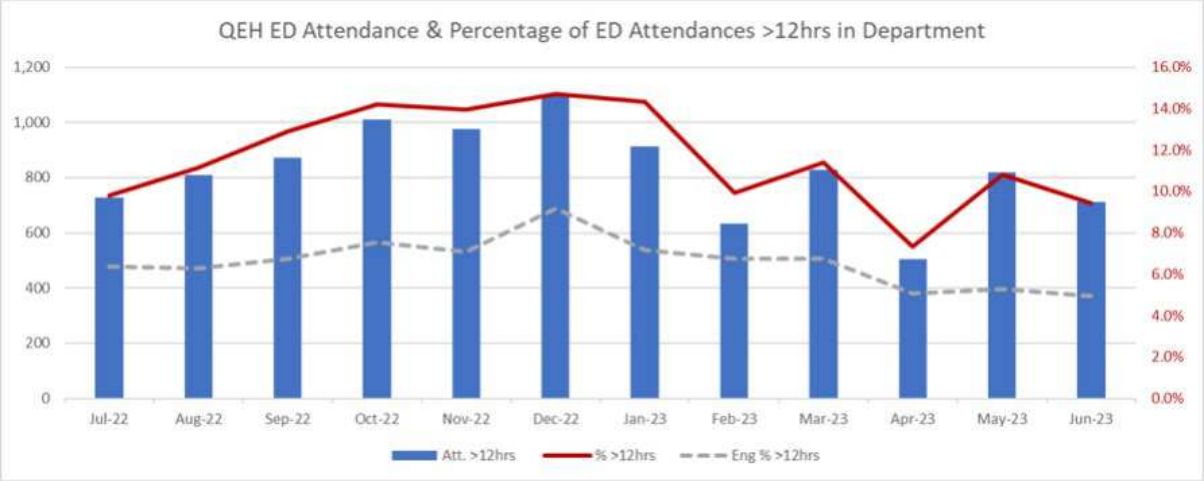
Number/percentage of patients waiting more than 12 hours from time of arrival to be seen.



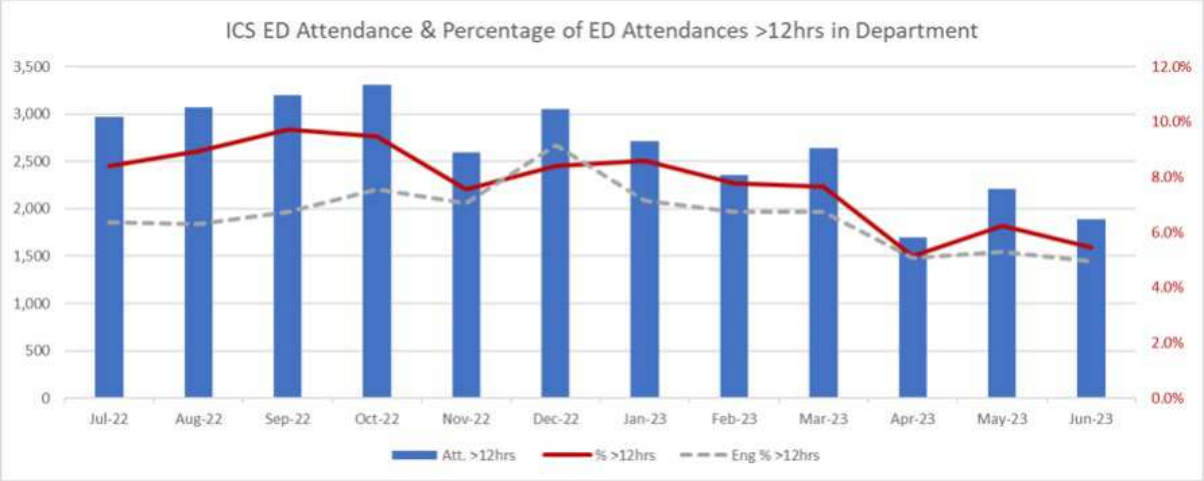
Provider	Metric	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
NNUH	Att. >12hrs	1,671	1,620	1,681	1,549	1,016	1,171	1,127	1,132	1,165	799	890	805
	% >12hrs	8.3%	8.2%	8.8%	7.6%	5.1%	5.6%	6.2%	6.6%	6.0%	4.3%	4.5%	4.2%
Eng	% >12hrs	6.4%	6.3%	6.7%	7.6%	7.1%	9.2%	7.2%	6.7%	6.7%	5.1%	5.3%	5.0%



Provider	Metric	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
JPUH	Att. >12hrs	573	646	649	749	598	791	671	586	644	394	506	372
	% >12hrs	7.5%	8.7%	9.1%	10.1%	8.1%	9.8%	9.7%	8.9%	8.2%	5.2%	6.3%	4.7%
Eng	% >12hrs	6.4%	6.3%	6.7%	7.6%	7.1%	9.2%	7.2%	6.7%	6.7%	5.1%	5.3%	5.0%



Provider	Metric	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
QEH	Att. >12hrs	727	808	873	1,010	976	1,095	912	634	829	504	818	712
	% >12hrs	9.8%	11.2%	12.9%	14.2%	14.0%	14.7%	14.3%	9.9%	11.4%	7.3%	10.8%	9.4%
Eng	% >12hrs	6.4%	6.3%	6.7%	7.6%	7.1%	9.2%	7.2%	6.7%	6.7%	5.1%	5.3%	5.0%

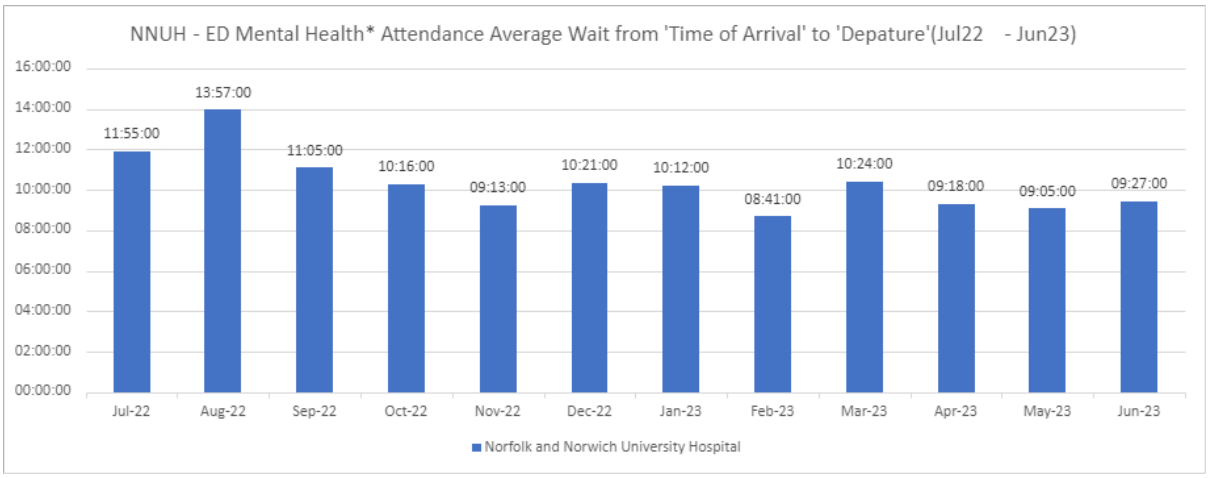


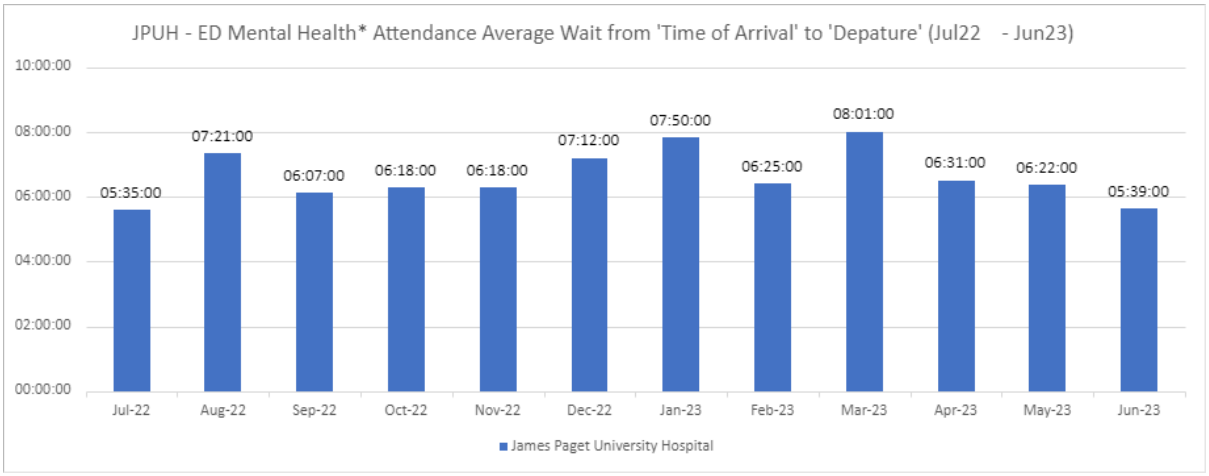
Provider	Metric	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
ICS	Att. >12hrs	2,971	3,074	3,203	3,308	2,590	3,057	2,710	2,352	2,638	1,697	2,214	1,889
	% >12hrs	8.4%	8.9%	9.7%	9.5%	7.6%	8.4%	8.6%	7.8%	7.7%	5.1%	6.2%	5.4%
Eng	% >12hrs	6.4%	6.3%	6.7%	7.6%	7.1%	9.2%	7.2%	6.7%	6.7%	5.1%	5.3%	5.0%

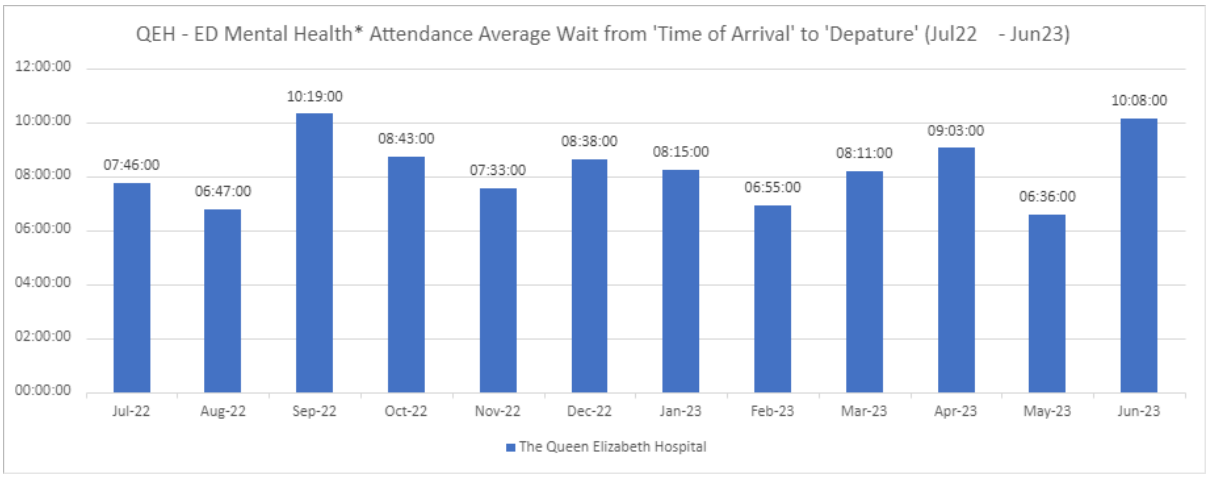
Average wait from time of arrival for patients with mental health conditions to be seen.

Provider	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
James Paget University Hospital	05:35:00	07:21:00	06:07:00	06:18:00	06:18:00	07:12:00	07:50:00	06:25:00	08:01:00	06:31:00	06:22:00	05:39:00
Norfolk and Norwich University Hospital	11:55:00	13:57:00	11:05:00	10:16:00	09:13:00	10:21:00	10:12:00	08:41:00	10:24:00	09:18:00	09:05:00	09:27:00
The Queen Elizabeth Hospital	07:46:00	06:47:00	10:19:00	08:43:00	07:33:00	08:38:00	08:15:00	06:55:00	08:11:00	09:03:00	06:36:00	10:08:00

***time shown in HH:MM**


NNUH - ED Mental Health* Attendance Average Wait from 'Time of Arrival' to 'Depature'(Jul22 - Jun23)
16:00:00
14:00:00
12:00:00
10:00:00
08:00:00
06:00:00
04:00:00
02:00:00
00:00:00
11:55:00
13:57:00
11:05:00
10:16:00
09:13:00
10:21:00
10:12:00
08:41:00
10:24:00
09:18:00
09:05:00
09:27:00
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Norfolk and Norwich University Hospital

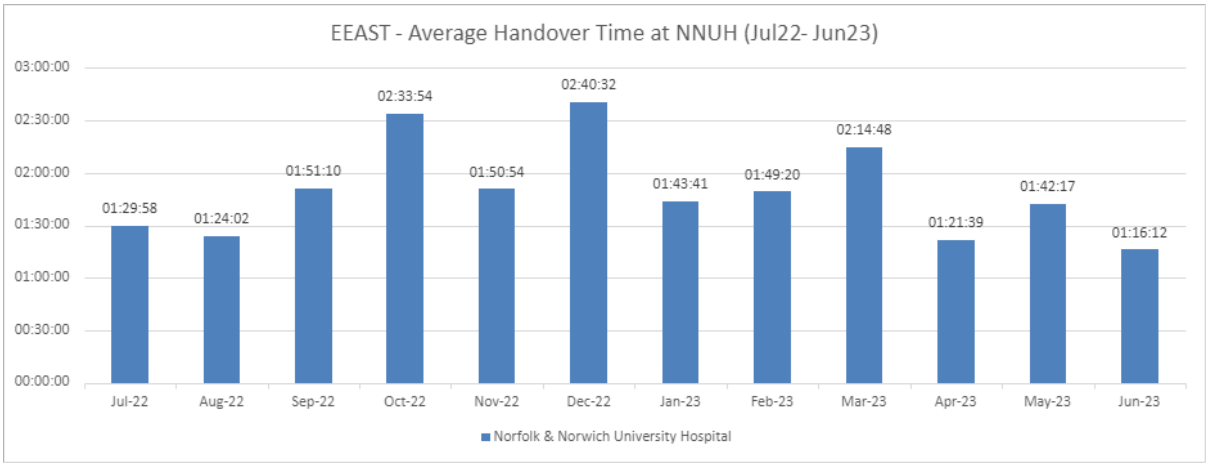

JPUH - ED Mental Health* Attendance Average Wait from 'Time of Arrival' to 'Depature' (Jul22 - Jun23)
10:00:00
08:00:00
06:00:00
04:00:00
02:00:00
00:00:00
05:35:00
07:21:00
06:07:00
06:18:00
06:18:00
07:12:00
07:50:00
06:25:00
08:01:00
06:31:00
06:22:00
05:39:00
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
James Paget University Hospital

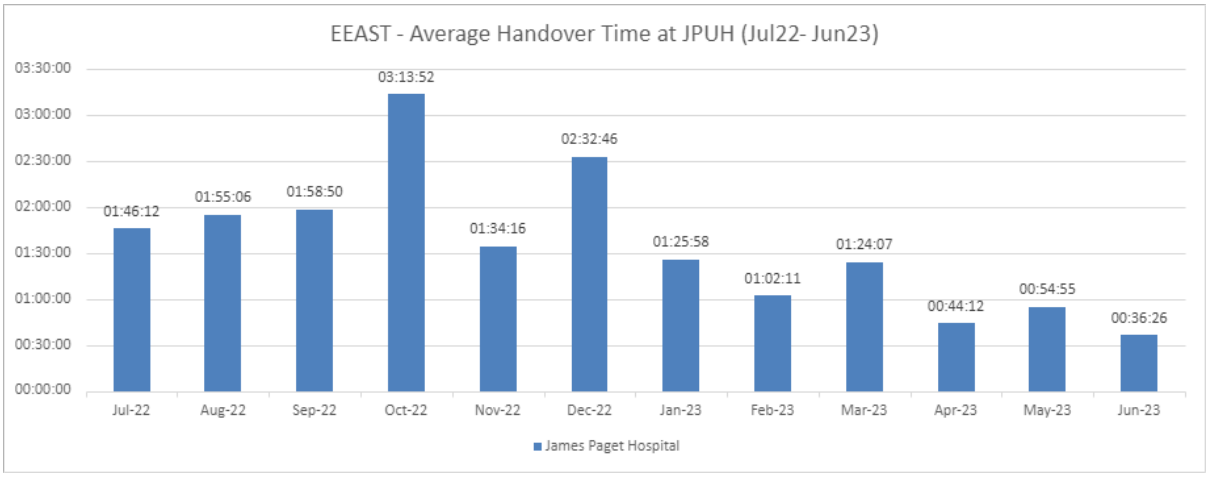

QEH - ED Mental Health* Attendance Average Wait from 'Time of Arrival' to 'Depature' (Jul22 - Jun23)
12:00:00
10:00:00
08:00:00
06:00:00
04:00:00
02:00:00
00:00:00
07:46:00
06:47:00
10:19:00
08:43:00
07:33:00
08:38:00
08:15:00
06:55:00
08:11:00
09:03:00
06:36:00
10:08:00
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
The Queen Elizabeth Hospital

Appendix B - Updated figures for ambulance handover times at the three acute trusts (NHOSC received figures until January 2023 from EEAST at its meeting in March 2023)

Average Handover Time

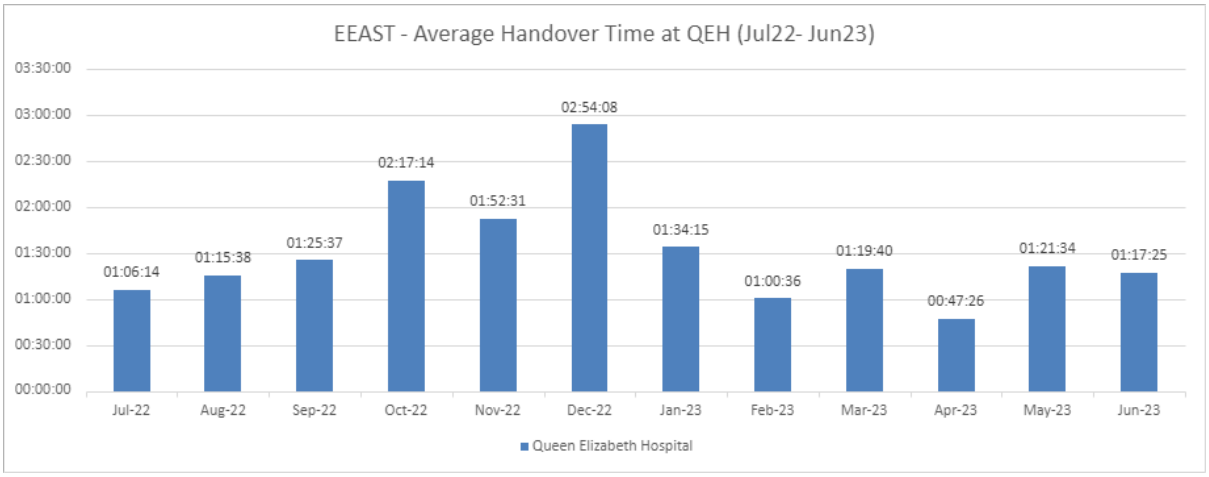
Provider	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
James Paget Hospital	01:46:12	01:55:06	01:58:50	03:13:52	01:34:16	02:32:46	01:25:58	01:02:11	01:24:07	00:44:12	00:54:55	00:36:26
Norfolk & Norwich University Hospital	01:29:58	01:24:02	01:51:10	02:33:54	01:50:54	02:40:32	01:43:41	01:49:20	02:14:48	01:21:39	01:42:17	01:16:12
Queen Elizabeth Hospital	01:06:14	01:15:38	01:25:37	02:17:14	01:52:31	02:54:08	01:34:15	01:00:36	01:19:40	00:47:26	01:21:34	01:17:25

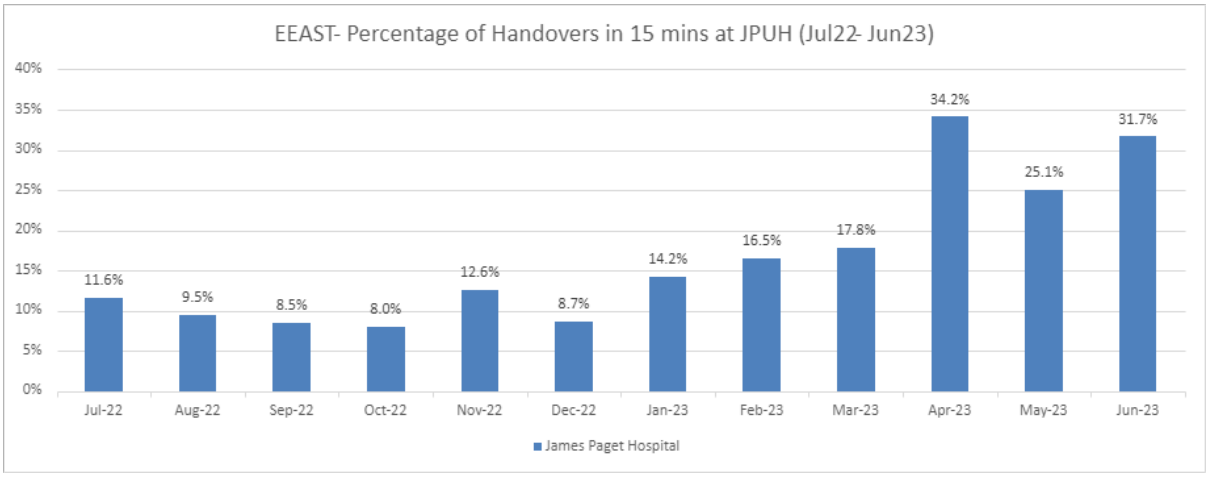


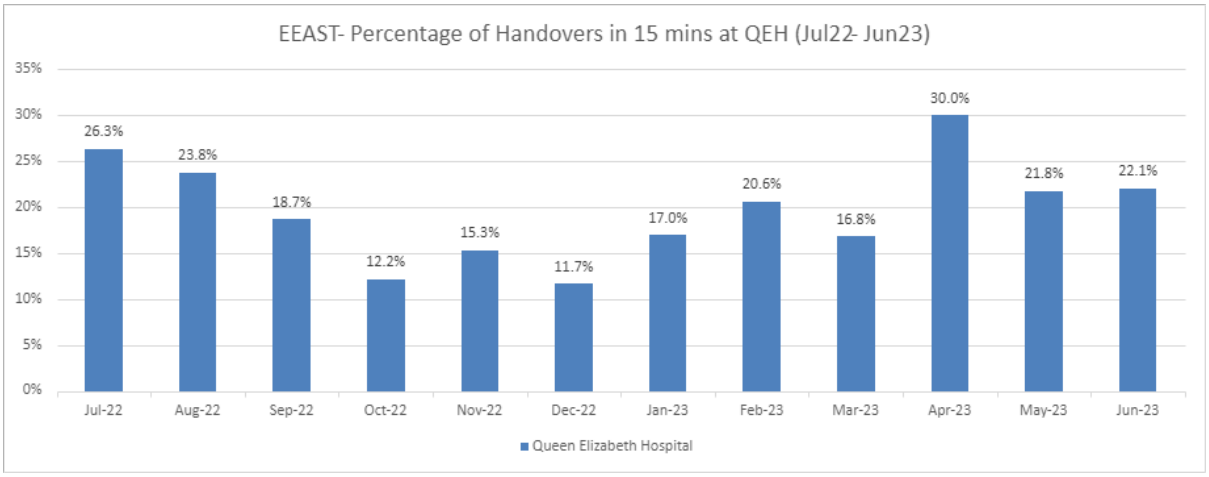


% of Handovers in 15 Minutes

Provider	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
James Paget Hospital	11.6%	9.5%	8.5%	8.0%	12.6%	8.7%	14.2%	16.5%	17.8%	34.2%	25.1%	31.7%
Norfolk & Norwich University Hospital	13.8%	16.1%	9.8%	6.2%	17.9%	14.4%	22.5%	18.5%	11.2%	22.2%	17.2%	27.2%
Queen Elizabeth Hospital	26.3%	23.8%	18.7%	12.2%	15.3%	11.7%	17.0%	20.6%	16.8%	30.0%	21.8%	22.1%

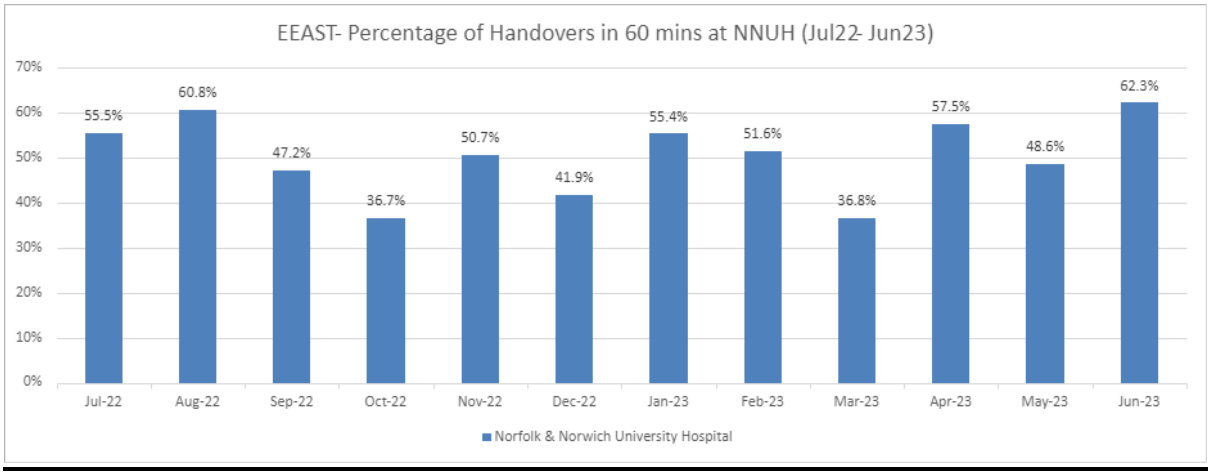


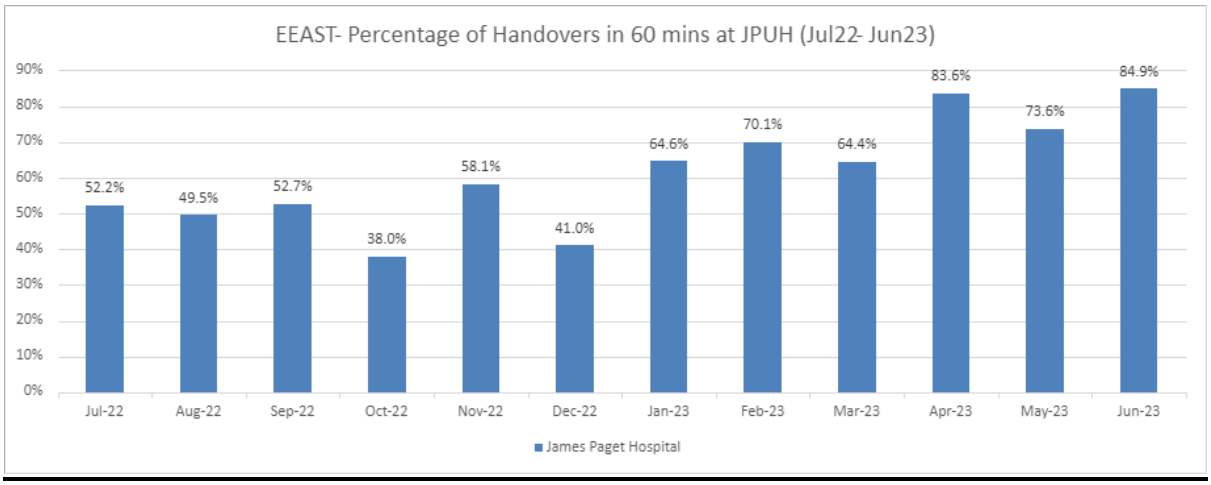


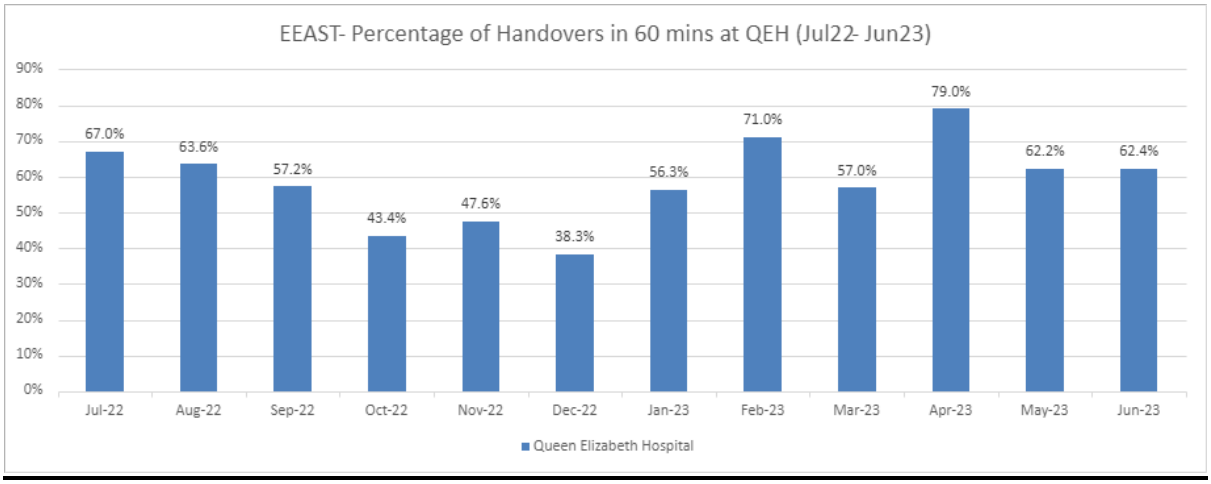


% of Handovers in 60 Minutes

Provider	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
James Paget Hospital	52.2%	49.5%	52.7%	38.0%	58.1%	41.0%	64.6%	70.1%	64.4%	83.6%	73.6%	84.9%
Norfolk & Norwich University Hospital	55.5%	60.8%	47.2%	36.7%	50.7%	41.9%	55.4%	51.6%	36.8%	57.5%	48.6%	62.3%
Queen Elizabeth Hospital	67.0%	63.6%	57.2%	43.4%	47.6%	38.3%	56.3%	71.0%	57.0%	79.0%	62.2%	62.4%

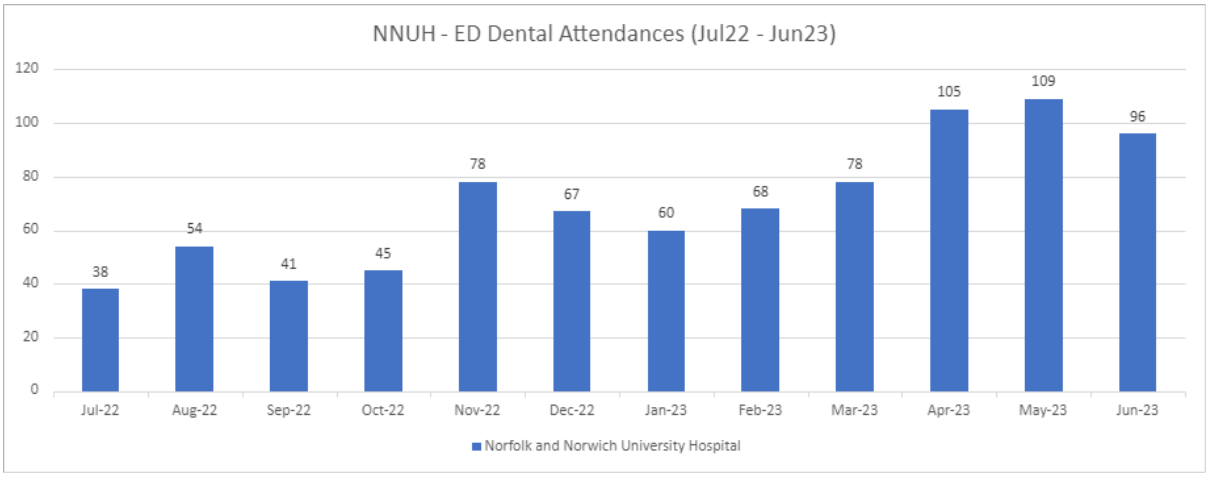

EEAST- Percentage of Handovers in 60 mins at NNUH (Jul22- Jun23)
70%
60%
50%
40%
30%
20%
10%
0%
55.5%
60.8%
47.2%
36.7%
50.7%
41.9%
55.4%
51.6%
36.8%
57.5%
48.6%
62.3%
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Norfolk & Norwich University Hospital

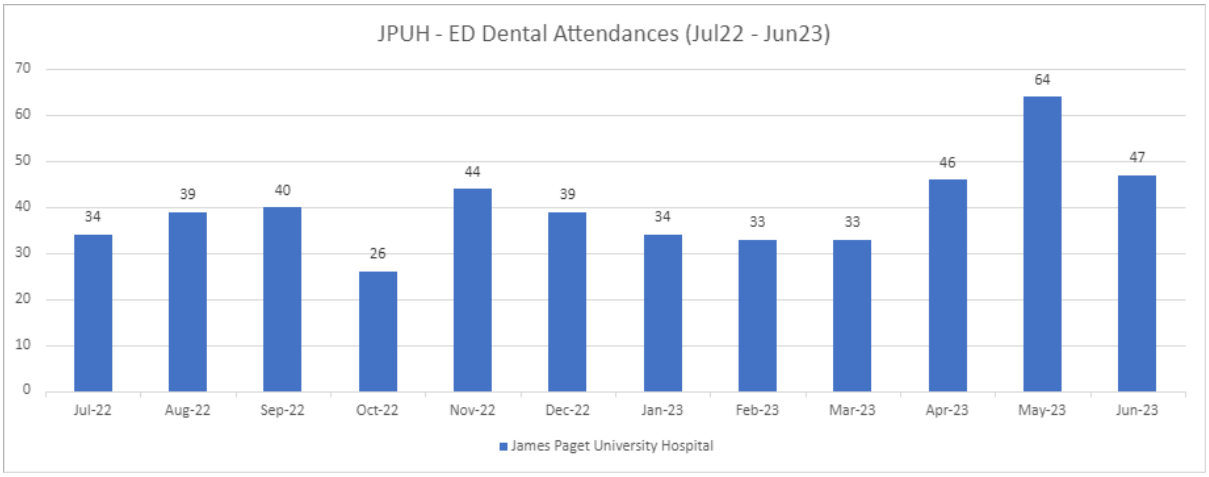

EEAST- Percentage of Handovers in 60 mins at JPUH (Jul22- Jun23)
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
52.2%
49.5%
52.7%
38.0%
58.1%
41.0%
64.6%
70.1%
64.4%
83.6%
73.6%
84.9%
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
James Paget Hospital

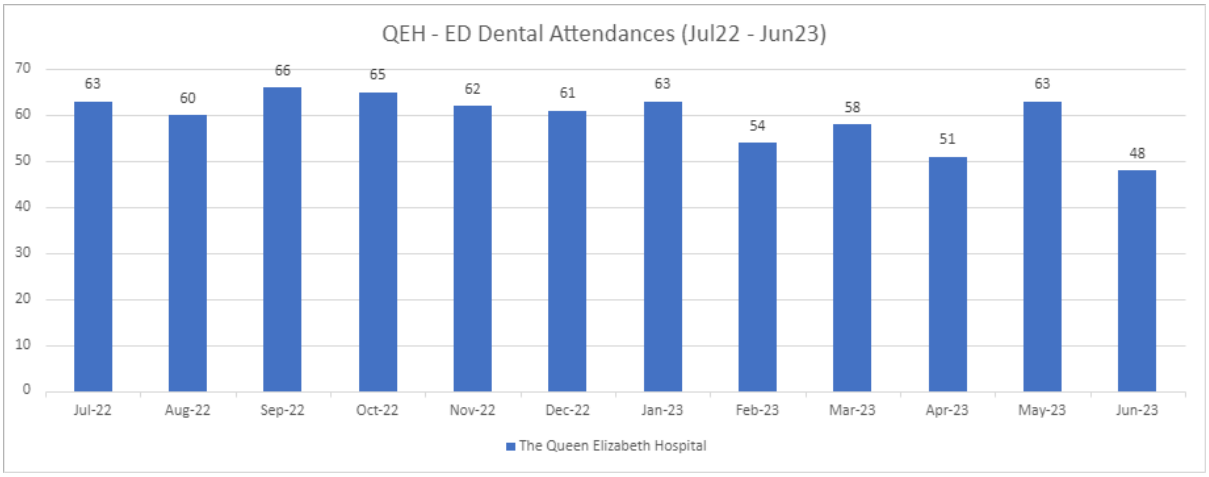

EEAST- Percentage of Handovers in 60 mins at QEH (Jul22- Jun23)
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
67.0%
63.6%
57.2%
43.4%
47.6%
38.3%
56.3%
71.0%
57.0%
79.0%
62.2%
62.4%
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Queen Elizabeth Hospital

Appendix C - Figures for Dental Attendances in Our EDs

Provider	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
James Paget University Hospital	34	39	40	26	44	39	34	33	33	46	64	47
Norfolk and Norwich University Hospital	38	54	41	45	78	67	60	68	78	105	109	96
The Queen Elizabeth Hospital	63	60	66	65	62	61	63	54	58	51	63	48

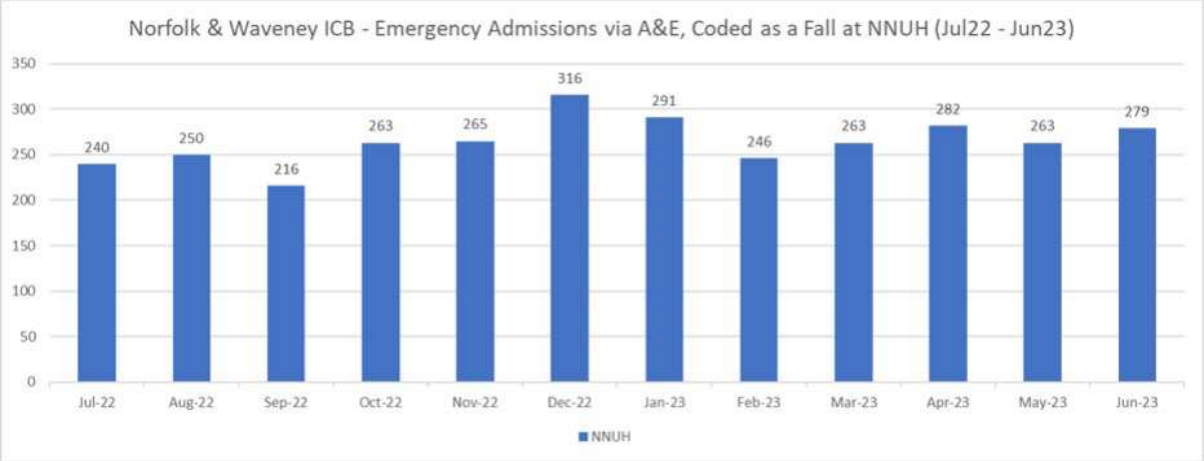


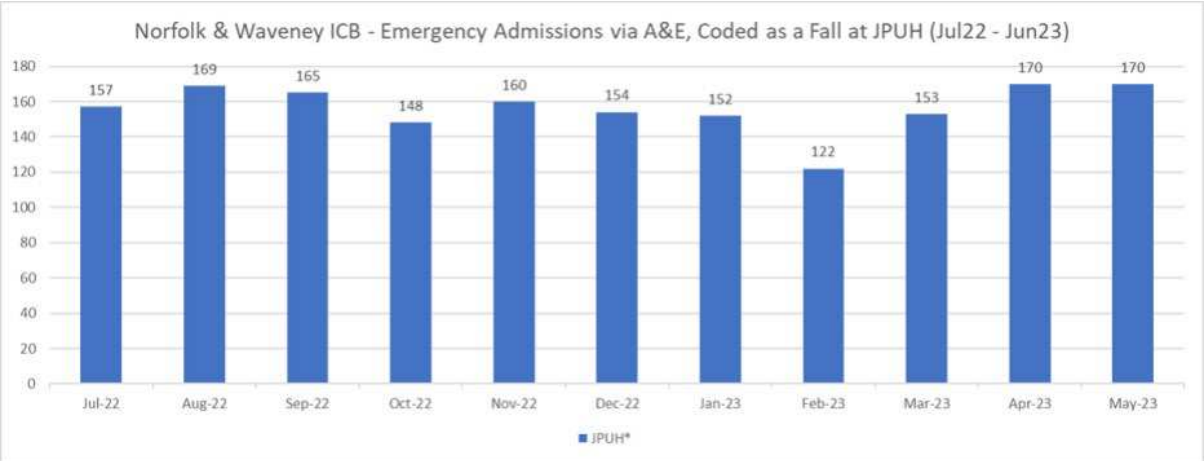


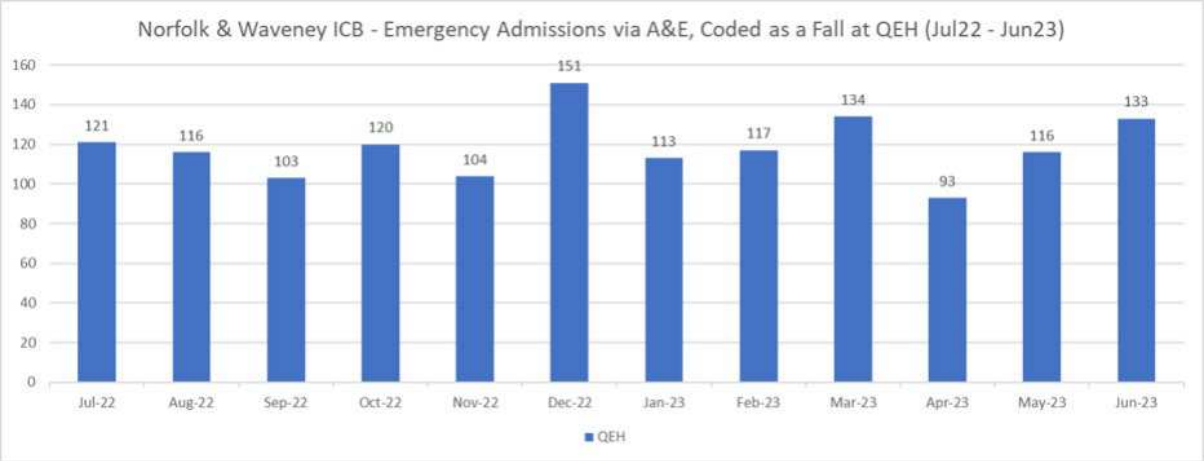


*ED Dental Attendance is based on the 'ECDS Primary Diagnosis Desc' field including 'Dental' or 'Tooth' in the description.

Appendix D – Falls Data



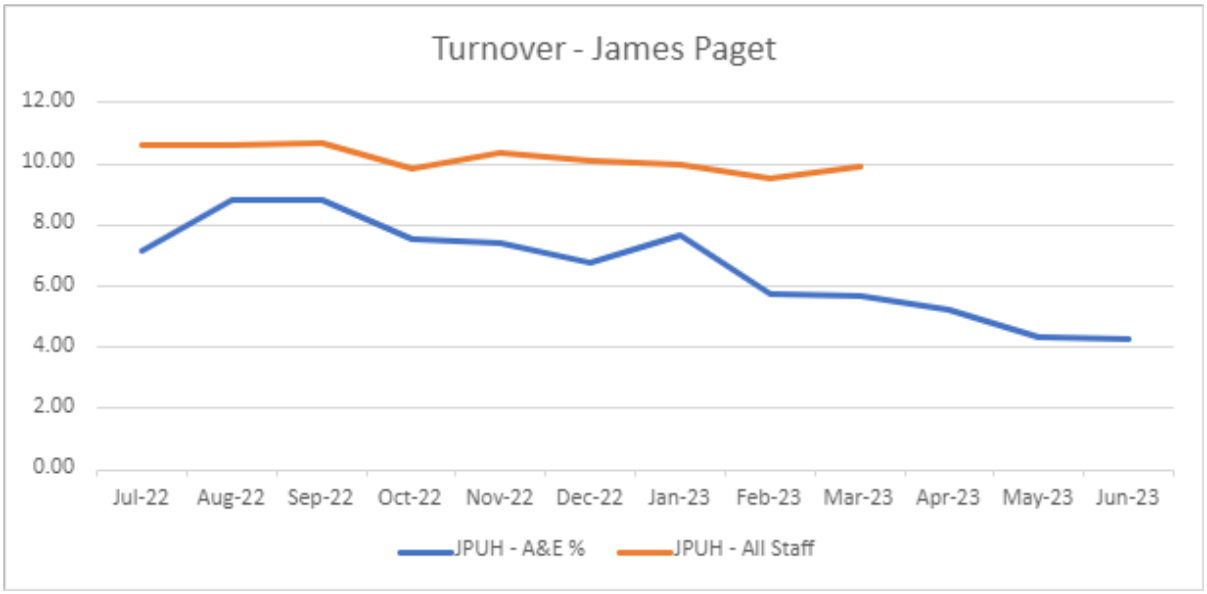


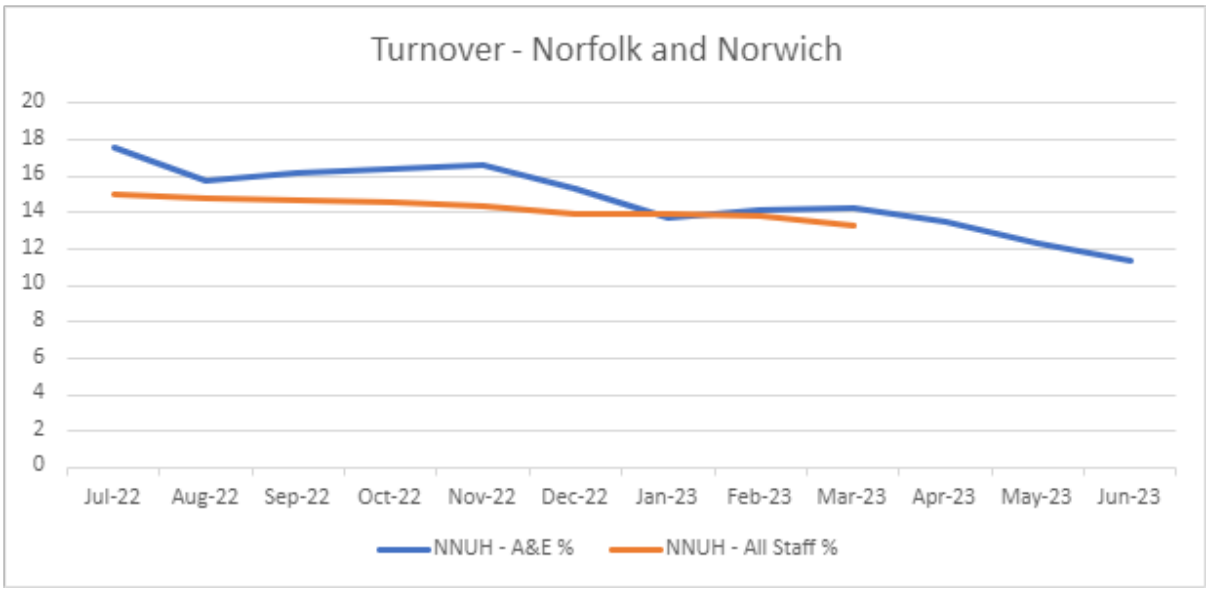


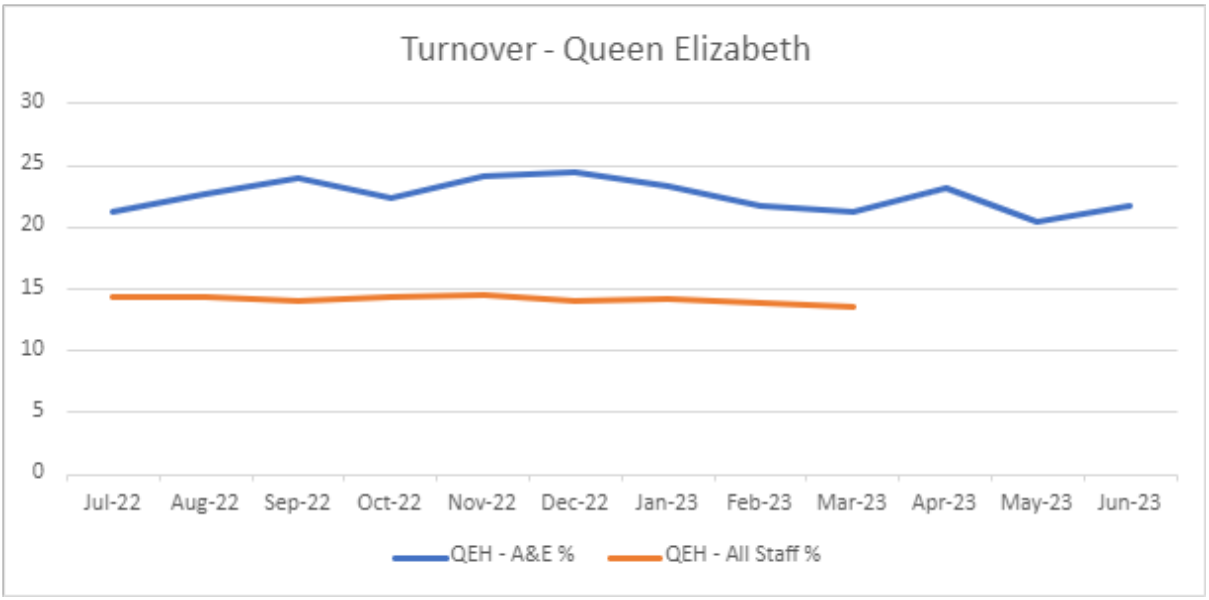
Appendix E - Figures relating to the A&E Workforce

Staff turnover within A&E services in the past 12 months

Month	JPUH - A&E %	JPUH - All Staff	NNUH - A&E %	NNUH - All Staff %	QEH - A&E %	QEH - All Staff %
Jul-22	7.15	10.60	17.6	15.02	21.26	14.4
Aug-22	8.80	10.65	15.8	14.79	22.68	14.44
Sep-22	8.84	10.67	16.2	14.70	23.94	14.02
Oct-22	7.53	9.83	16.4	14.58	22.45	14.4
Nov-22	7.42	10.38	16.6	14.36	24.22	14.53
Dec-22	6.77	10.10	15.3	13.90	24.48	14.1
Jan-23	7.68	10.00	13.7	13.91	23.32	14.21
Feb-23	5.72	9.50	14.1	13.80	21.68	13.93
Mar-23	5.71	9.90	14.3	13.31	21.28	13.55
Apr-23	5.24		13.5		23.19	
May-23	4.36		12.3		20.51	
Jun-23	4.26		11.4		21.66	







Turnover Rates

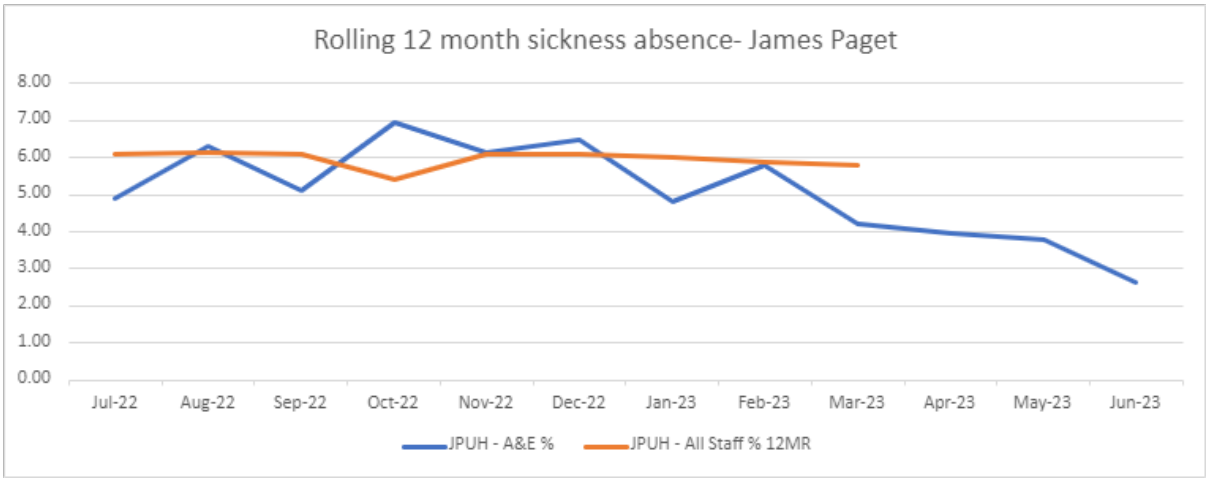
Data has been supplied by each trust for the purposes of this report.

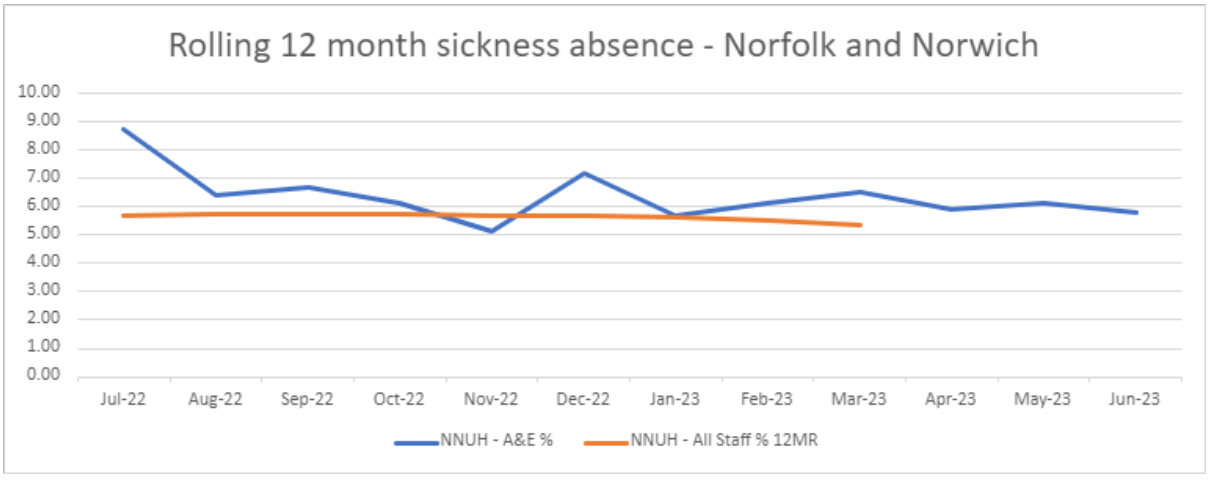
Turnover rates have improved within the A&E teams at both JPUH and NNUH. The June 2023 turnover rate for A&E at JPUH was 4.26%, the lowest in the comparison period v 11.4% at NNUH, again the lowest rate in the 12 month review period.

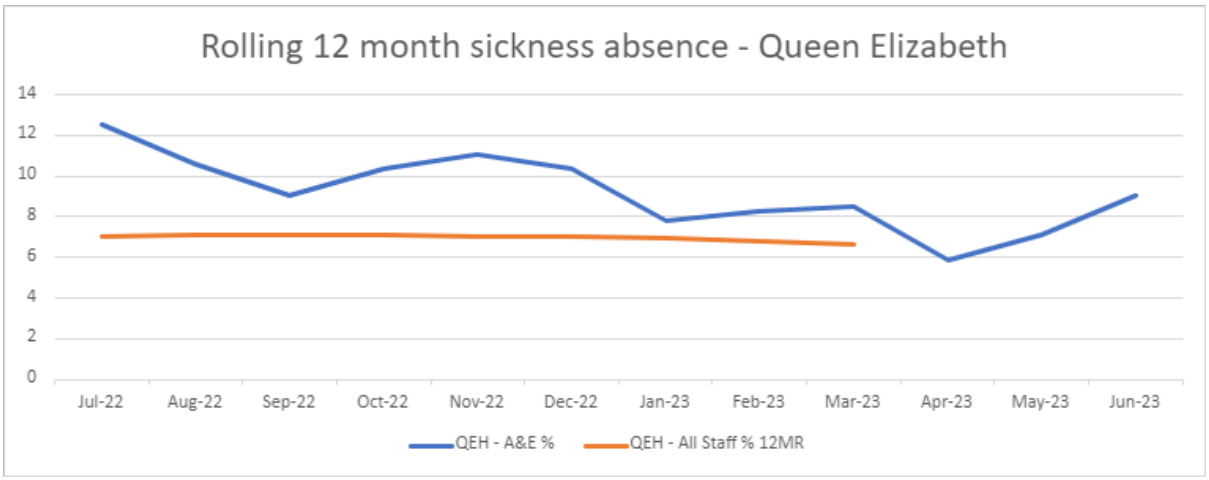
The QEKL turnover rates within A&E were 21.7% in June 2023, with rates being above 20% throughout the comparison period. High levels of turnover are likely to result in increased additional staff use, lower morale and high recruitment costs.

Levels of staff sickness in the past 12 months.

Month	JPUH - A&E %	JPUH - All Staff % 12MR	NNUH - A&E %	NNUH - All Staff % 12MR	QEH - A&E %	QEH - All Staff % 12MR
Jul-22	4.89	6.10	8.70	5.69	12.56	7.01
Aug-22	6.30	6.13	6.40	5.72	10.58	7.13
Sep-22	5.13	6.08	6.70	5.73	9.03	7.08
Oct-22	6.94	5.39	6.10	5.71	10.39	7.07
Nov-22	6.15	6.11	5.10	5.67	11.04	7.00
Dec-22	6.46	6.10	7.20	5.70	10.32	7.03
Jan-23	4.83	6.00	5.70	5.61	7.83	6.91
Feb-23	5.80	5.90	6.10	5.50	8.23	6.81
Mar-23	4.20	5.80	6.50	5.35	8.53	6.62
Apr-23	3.94		5.90		5.84	
May-23	3.77		6.10		7.07	
Jun-23	2.63		5.80		9.06	







Sickness Absence Rates

Data has been supplied by each trust for the purposes of this report.

All three trusts have a trend over the review period of improved absence rates in their A&E units. It is not clear from the data provided that sickness has yet returned to a more usual, seasonal patterns seen pre covid.

The rate of improvement is most marked at JPUH, from a peak of 6.94% in Oct 2022 to the current 2.63% absence rate.

Absence rates at QEKL have an overall improved trend but from 12.56% in July 2022 to 9.06% in June 2023, very likely resulting in significant levels of additional staff use.

Ongoing high rates of absence at NNUH and JPUH is a concern with action needed to support staff to return to work.

Norfolk and Suffolk NHS Foundation Trust (NSFT) Mortality Recording and Reporting review

Suggested approach from Liz Chandler, Scrutiny and Research Officer

Examination of the report from Norfolk and Suffolk NHS Foundation Trust (NSFT) regarding the findings and recommendations of the Grant Thornton Mortality Recording and Reporting review, as well as NSFT's actions in response to those recommendations.

1.0 Purpose of today's meeting

1.1 To examine the report from Norfolk and Suffolk NHS Foundation Trust (NSFT) regarding the findings and recommendations of the Grant Thornton Mortality Recording and Reporting review, as well as NSFT's actions in response to those recommendations. The report is attached at **Appendix A.**

1.2 Representatives from NSFT will be in attendance to answer Members' questions.

1.3 In late August 2023, NSFT were the subject of a BBC Newsnight investigation, challenging the manner in which the drafting process for the mortality review was conducted, alongside a number of other articles and reports. Officers from NSFT have been invited by the Chair of the committee to provide a verbal statement to address claims set out in the national and local press, which has been accepted.

2.0 Previous reports to NHOSC

2.1 Over the past five years, NSFT has attended the following NHOSC meetings:

- In December 2017, NSFT attended NHOSC with a report regarding the impact of the Care Quality Commission (CQC) inspection which took place in July 2017 (published October 2017).
- NSFT returned to NHOSC in April 2018 with an update on its improvement plan following the meeting in December 2017 and responses to recommendations made by the committee at that meeting.
- In January 2019, NSFT presented a report to NHOSC following the CQC inspection in September 2018 (published November 2018).
- A progress report on the 2018 CQC inspection was provided by NSFT at the NHOSC meeting in July 2019.
- In September 2020, NSFT returned to NHOSC following another CQC inspection in October – November 2019 (report published January

2020). At this meeting, Members also examined the CQC's focussed inspection of specialist community mental health services for children and young people which took place in February 2020 (report published May 2020).

- The use of out of area placements was the subject of a report by NSFT at the NHOSC meeting November 2021.
- In September 2022, NHOSC examined NSFT's improvement plan following the CQC inspection in November-December 2021 (published February 2021). This was re-examined by NHOSC in November 2022.
- Also in September 2022, NSFT attended a Joint HOSC (JHOSC) with Suffolk HOSC regarding the redesignation of Psychiatric Intensive Care Units in Norfolk and Suffolk.

2.2 The most recent editions of the NHOSC Briefings to contain reports from NSFT are as follows:

- In October 2020, NSFT provided information regarding staff training to avoid physical restraint or seclusion of patients, support for schools, accessibility of mental health services, waiting lists and the next CQC inspection.
- A report on the CQC inspection in November-December 2021 (published February 2021) was included in the March 2021 Briefing.
- For the August 2021 Briefing, NSFT provided an update on progress with CQC requirements, information on discharge from acute mental health beds to hotel/B&B accommodation and information on conveyance of patients to out of area placements.
- Intensive care beds were the subject of a report in the October 2021 Briefing.
- In the December 2021 edition, NSFT provided information on waiting times for mental health services, commissioned capacity of services compared with demand and pauses to admissions.
- A situation briefing on mental health services was included in the February 2022 edition.
- An overview from NSFT of the range of community health services it provides was provided in the April 2023 Briefing.

3.0 Background information

3.1 Grant Thornton Mortality Recording and Reporting review

3.1.1 The Norfolk and Suffolk Foundation Trust's Mortality Recording and Reporting report was published in June 2023. Independent company Grant Thornton was commissioned by Norfolk and Waveney and Suffolk and North East Essex Integrated Care Boards to review the collection, processing and reporting of data related to patient deaths at NSFT. The full report is attached at **Appendix B.**

3.1.2 The report was not intended to ascertain levels of mortality within NSFT or investigate the circumstances of individual deaths, but to review the processes used by NSFT to collect and report mortality data.

3.1.3 Grant Thornton found a number of shortfalls in NSFT's recording and reporting of mortality data. It consequently includes a number of recommendations for improvements, together with an action plan by NSFT outlining how it will address those recommendations.

3.1.4 At the meeting of NHOSC on 8 September 2022, NSFT stated that it had agreed to an independent review of its mortality data. While the number of deaths at NSFT was known, there was confusion about how this data had been collected and recorded. It was hoped that the review would end this confusion.

3.1.5 NSFT has subsequently published an overview of its mortality data for the past five years which is available here.

3.2 Forever Gone: Losing Count of Patient Deaths report

3.2.1 In response to the Grant Thornton review, the independent Forever Gone: Losing Count of Patient Deaths report by Caroline Aldridge, Anne Humphrys and Emma Corlett was published in July 2023. The report is attached at **Appendix C**.

3.2.2 The report provides detailed analysis of the findings of the Grant Thornton review and provides a number of suggestions for actions including a Statutory Public Inquiry into mortality at NSFT.

3.2.3 At a meeting of N&WICB on 18 July 2023, Chair Patricia Hewitt apologised for the failings in care and admitted that they should have listened to campaigners earlier. See: Eastern Daily Press.

3.2.4 Following a discussion of the report at NSFT's board meeting on 27 July 2023, NSFT Chair Zoe Billingham admitted that the trust had lost count of people who had died due to failings in care at the trust. Ms Billingham, together with NSFT Chief Executive Stuart Richardson, apologised to bereaved families. See: Eastern Daily Press.

4.0 Suggested approach

4.1 The committee may wish to discuss the following areas with representatives from the three acute trusts:

- Request an update on actions completed and actions to complete in response to the recommendations in the Grant Thornton report.
- To what extent does NSFT feel the Grant Thornton report fulfilled the objectives that NSFT said it would at NHOSC's meeting on 8 September 2022?
- Will bereaved families be involved in agreeing the terms of reference of the follow-up audit expected in April 2024?
- Request further information about the work being undertaken with Healthwatch Norfolk and Healthwatch Suffolk.

- What is Norfolk and Waveney ICB (N&WICB) doing to support NSFT to address some of the recommendations in Grant Thornton's report?
- What can local authorities do to support NSFT in addressing any issues raised by the Grant Thornton review?

5.0 Action

5.1 The committee may wish to consider whether to make comments or recommendations as a result of today's discussion.

IN TRAN communication for all	If you need this report in large print, audio, Braille, alternative format or in a different language please contact Customer Services on 0344 800 8020 or Text Relay on 18001 0344 800 8020 (textphone) and we will do our best to help.

Item 7

Appendix A

Norfolk and Suffolk NHS Foundation Trust

Norfolk Health Overview and Scrutiny Committee update – 14 September 2023

This paper provides an update to Norfolk Health Overview and Scrutiny Committee (HOSC) as to the findings and recommendations of an independently commissioned report into the processes Norfolk and Suffolk NHS Foundation Trust (NSFT) uses to collect and report data relating to mortality.

In also provides an update about our independent Guardian Service which allows colleagues to raise concerns anonymously if they wish.

Section 1: Independent report into the processes the Trust uses to collect and report data relating to mortality

Executive Summary

Our thoughts and heartfelt sympathies are with those family and friends who have lost their loved ones and who have been upset by the publication of the independent review on how the Trust processes mortality data.

We are truly sorry for failings in care that have led to the death of a loved one and are very aware of the anguish of those who are bereaved. We are deeply committed to working with them as we continue to learn lessons from the past and make improvements at NSFT.

We want to ensure that people living with mental health conditions, as well as their wider family, friends and carers, have access to high quality mental health services. Ensuring timely and accurate reporting on mortality is an important part of achieving this wider goal.

In the context of our ongoing work to improve learning from deaths this update presents the findings and recommendations from Grant Thornton UK LLP's independent audit of the processes we use to collect and report data relating to mortality.

We requested this work, and it was commissioned by NHS Norfolk and Waveney and NHS Suffolk and North East Essex integrated care boards (ICBs), with endorsement from NHS England regional team, to provide an independent view as part of our continued commitment to improve.

We fully accept all the recommendations made as part of the report and are grateful to our local ICBs for commissioning this review on our behalf and to the team who carried it out.

Introduction

The expectations in relation to reporting, monitoring and Board oversight of mortality incidents are set out in NHS England's National Quality Board's 'Learning from Deaths' guidance (March 2017), and builds on the recommendations made by the Mazars investigation into Southern Health (Dec 2015), the CQC report 'Learning, Candour and Accountability publication' (Dec 2016) and the Learning Disabilities Mortality Review (LeDeR) which is managed by NHS England.

The Learning from Deaths framework (LfD) places particular responsibility on Trust Boards to ensure their Trust has robust systems for recognising, reporting and reviewing or investigating deaths where appropriate. The LfD states *'the aim of this process is to ensure that all deaths of people under the Trusts' care are reviewed at the appropriate level and organisational learning occurs'*.

Over the past year, we have undertaken significant work to improve learning from deaths – of which effective management of mortality data is a part – in line with national guidance and best practice.

This work is led by Chief Medical Officer, Dr Alex Lewis as Executive responsible officer and is summarised in Appendix 1. It includes work to invest in independent external expertise and scrutiny; in engagement, training and development of staff; in strengthened governance and processing of information; and in collaborative working with ICB partners, service users and carers and wider stakeholders.

In brief, the work and improvements underway across NSFT include:

- ensuring we have standardised reporting across NSFT for mortality, from our clinicians to our Board so that meaningful comparisons can be drawn over time
- developing data sharing agreements with our partners so that all organisations in our care systems can better understand and learn from deaths, to help address inequalities in our communities' health
- upgrading the technology and systems our clinicians need to automatically update service user records with information from outside the Trust, for example the information shared by their GP. This will mean we have systems that talk to each other and provide robust and meaningful data on which to base decisions
- embedding a new Learning from Deaths Committee chaired by the Trust's Medical Director for Quality with oversight from the Trust Board.

We requested an external review of mortality data processes to provide independent scrutiny of the Trust's management of mortality data recording and reporting. Reflecting our ongoing commitment to improve, learning from deaths is an explicit part of our Improvement Programme, setting long term plans to evidence sustained improvement for our service users and carers, our staff and partners.

Grant Thornton review of mortality data processes

Last year, we asked NHS Norfolk and Waveney and NHS Suffolk and North East Essex ICBs to commission an independent review to assess mortality reporting at NSFT between April 2019 and October 2022.

In September 2022, Grant Thornton UK LLP were commissioned to undertake the review, following a procurement process. The review was commissioned for a specific purpose – to provide an independent audit of the processes used by NSFT to collect and report data relating to mortality.

It was not designed to investigate the circumstances of individual deaths or to compare the levels of mortality reported by or related to NSFT with other NHS trusts in the UK.

Grant Thornton produced a draft of the report which was shared with NSFT and the ICBs in February 2023 to check for factual accuracy. The Grant Thornton report was then published on 28 June 2023. A copy of the report can be read here:

https://improvinglivesnw.org.uk/independent-review-published-on-mortality-reporting-and-recording-at-the-norfolk-and-suffolk-nhs-foundation-trust/.

We are working with ICB partners and wider stakeholders in response to the findings and the report includes immediate actions which are already underway. Attached to this report as Appendix 2 are Grant Thornton's recommendations and the Trust's corresponding action plan.

We and the ICBs all recognise the importance of delivering the improvements recommended by this report and are committed to working collaboratively.

The Grant Thornton report will also be important to address any learning that could be relevant for other trusts across the country.

We recognise the contents of the report have been exceptionally difficult for service users, families and carers. Together with the ICBs, we offer sincere condolences to all those affected by this report and issues related to it.

A listening service has been commissioned by the ICBs through Just B to support affected individuals. Just B is an independent charity based in North Yorkshire that has no connection with services across Norfolk and Suffolk, including NSFT. More information about the service and how to access it can be found here:

Just B support line set up to listen to people in Norfolk and Suffolk - Norfolk & Waveney Integrated Care System (ICS (improvinglivesnw.org.uk)

For those without access to the internet, the number is **01423 856799** and it is available from **8am to 8pm, any day** of the week.

Conclusions of the Grant Thornton report

The Grant Thornton report concluded the following:

- We have strong governance in our approach to inpatient deaths and any on site incidents are followed up.
- We need to bring that same rigour to improve the processes around the reporting of all mortality, and the understanding of all deaths for current patients, or patients who die within six months of being discharged from our care, particularly for deaths in the community.

- The process of categorising and grouping expected and unexpected deaths and the decision making involved was unclear and inconsistent.
- Such issues have led to questions of clarity within public facing documents and reduced clinical insight into the mortality information reported. This results in a lack of confidence from external stakeholders – including regulators and the public – in the data, and in our understanding of it.
- We are often reliant on other NHS providers, such as GPs and hospitals, for cause of death information for community patients and more needs to be done by these other providers for us to access this information. In resolving these issues, we are committed to taking forward the actions we are able to complete, and to work with partner organisations to identify additional information.
- To implement the necessary changes, we will need to be supported by both ICBs and the other healthcare organisations within the health system to make this information available.

Following publication of the Grant Thornton report, we published data on the numbers of deaths that occurred while service users were under our care (or that happened within six months of discharge) that we were confident in reporting.

The data covers the past five years and can be read on our website – www.nsft.nhs.uk.

We continue to work with ICB executives to ensure visibility and validity of data reporting, including for those unexpected deaths for which a cause of death is not available.

We are committed to working with ICB partners, service users and carers, families or bereaved relatives, as well as Healthwatch Norfolk and Healthwatch Suffolk to coproduce the action plan that will address the issues raised.

Verita report

NHS England released data in January 2016 about the number of unexpected deaths reported by mental health trusts in England, including NSFT. Between April 2012 and September 2015 this data identified NSFT as reporting the most ‘unexpected’ deaths of all mental health trusts in England. It is important to note that an ‘unexpected’ death does not mean that there were any shortcomings in someone’s care or treatment.

In February 2016 NSFT commissioned Verita to undertake an independent review of unexpected deaths reported by the trust between April 2012 and December 2015.

We accepted all the recommendations of the Verita report, which also identified similar issues relating to national data sets as the Grant Thornton report, and took a number of actions.

In April 2021, we gained accreditation with the Royal College of Psychiatrists’ Serious Incident Review Accreditation Network in recognition of the steps we now take to carry out high quality patient safety investigations which fully involve families and staff.

The Serious Incident Review Accreditation Network was awarded after the college looked in detail at a number of standards in place at the trust, including governance structures, how learning is shared following a patient safety incident and how we involve staff, service users, carers and families in investigations.

An independent response to the Grant Thornton report

We thank Caroline Aldridge, Anne Humphrys, and Emma Corlett for their detailed and thorough response to the Grant Thornton report 'Forever Gone: Losing Count of Patient Deaths'. This has been shared with the ICBs, members of our Board, as well as the Healthcare Safety Investigations Branch. It can be downloaded from www.learningsocialworker.com.

We are grateful too to Healthwatch Suffolk and Healthwatch Norfolk for agreeing to participate in a systemwide programme of co-production where we know patient, service user and carer voices need to be heard more strongly, and to fulfil a challenge role across the system to ensure accountability.

We are committed to supporting and working with those affected by the issues raised in both reports.

Next steps

At our most recent Trust Board meeting (July 2023) we agreed to the following in response to the Grant Thornton report:

- To reiterate our sincere condolences to the families and loved ones of all patients who have died.
- To receive and note the report by Grant Thornton and the immediate actions we have already taken, with partners, contained within the report.
- To commit to work in mutually meaningful coproduction with NHS Norfolk and Waveney and Suffolk and North East Essex ICBs, service users and carers, their families and communities, and bereaved relatives to make the recommended improvements, and any further improvements that may arise because of this work, and to ensure that the Trust uses the right processes to accurately record and learn from deaths.
- To commit to work together with NHS Norfolk and Waveney and Suffolk and North East Essex ICBs, service users and carers, their families and communities, and bereaved relatives to better understand the deaths of patients under the care of the Trust (or within six months of discharge), both retrospectively and in the future.
- To review and co-produce with the ICBs and service users, carers, their families, and bereaved relatives, Healthwatch Suffolk and Healthwatch Norfolk an action plan that considers the concerns raised since publication of the Grant Thornton report.
- To note that assurance of completion of the action plan will be provided through the NSFT Oversight and Assurance Group chaired by NHS England and reported to SNEE ICB and Norfolk and Waveney ICB through the Quality Committees.

- To agree in principle to a follow up audit of mortality data recording processes in the Trust in April 2024, following completion of the action plan.

Section 2: our ongoing commitment to supporting our people to speak up, and how we listen and respond

At the request of HOSC members, the following information provides an update about our independent Guardian Service.

As members of HOSC will be aware, NSFT introduced a new, independent Guardian Service in September 2022 as a priority area of focus to support our work to transform our culture.

It's also fundamental to the commitment we have to providing consistently excellent, safe care because we recognise that includes listening and changing things to improve people's experience of using our service and working with us.

Ensuring all colleagues can quickly and anonymously report concerns about clinical safety or things they see or experience in the workplace supports our determination to both improve our services for patients, service users and their loved ones, and take a zero-tolerance approach to all forms of discrimination.

As such, the overarching objective for launching the new service was to strengthen the ways in which colleagues could speak up and to create the right environment for staff to speak up, feel heard, and supported.

We have undertaken a six-month evaluation of the service, which has been reported in public to our Board. The full paper is attached as Appendix 3 for HOSC members' information.

Key findings of the evaluation include:

- There has been significant use of the service since it was introduced, supported by a Trust-wide campaign to ensure staff are aware of, and encouraged, to report concerns
- The three most common themes for reports related to concerns about internal systems and processes, for example recruitment; behaviours not in line with organisational values and concerns raised in relation to line management
- Since the new service was launched in September 2022, no staff member has reported that they suffered a detriment as a result of speaking up.

Improvements introduced as a result of the service

We recognise there is still much work to do to improve our culture and that this will take time.

However, we are making progress and have introduced a number of improvements and changes to how we work to ensure that we are acting on what people tell us through the Guardian Service, including:

- Launching a new recruitment panel to support fair, open and transparent recruitment – the panel, for example, approves adverts, salaries and interview panel members to ensure fairness.
- Introducing face-to-face training for recruiting managers which addresses how to spot and prevent bias.
- Investing in additional medical cover for some services following concerns raised.
- Initiating HR investigations to address specific concerns raised by staff members.

In addition:

- Monthly meetings between the Guardian Service and Trust senior leaders, including the CEO and Deputy CEO and non-executive directors look at the concerns raised (confidentiality is always maintained) to explore themes, outcomes of cases, learning and what service changes might need to happen
- NSFT's Guardian conducts regular walkabouts, visiting sites and offices to speak to staff directly– since November 2022, 55 visits both in person and via Teams have been made
- The Trust Guardian also holds briefings with teams and attends meetings both in person and online to encourage a culture of speaking up for all staff and managers
- The Guardian regularly attends meetings with various staff networks and attends corporate induction to speak to new starters to make sure people are aware of the service and encouraged to report concerns.

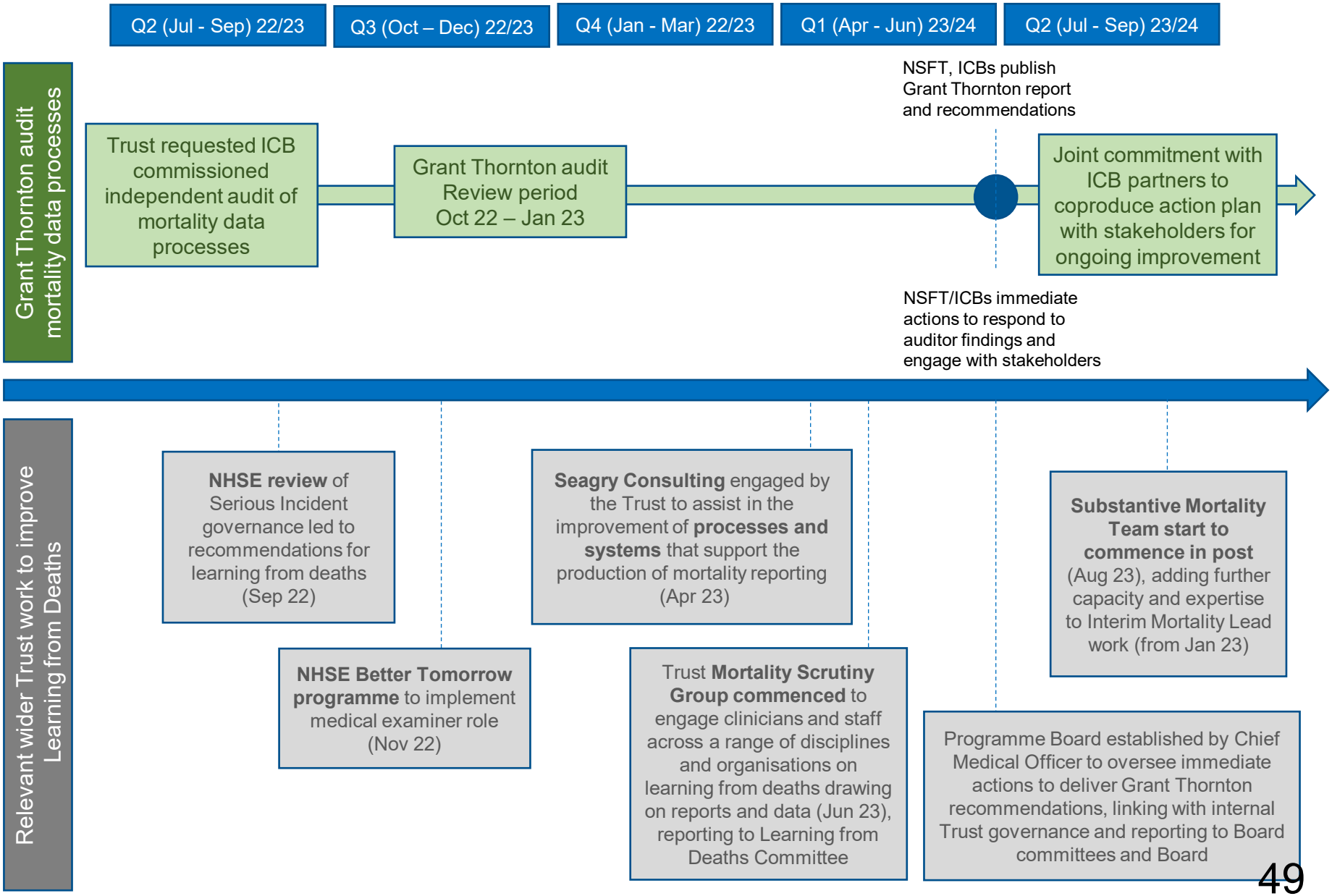
We are committed to using the learning from the first six months of this new service to inform the development of our wider people and culture strategy, the development of which is currently underway.

Appendix 1: Trust work on Learning From Deaths

Appendix 2: Status update on actions following Grant Thornton report July 2023

Appendix 3: Freedom to Speak Up Guardian Service Report

Appendix 1: Grant Thornton audit in context of wider Trust work



Ref	Recommendation	Priority	Actions	Status
Theme 1: Data – focusing on the technical data management to be completed by business intelligence and related teams				
1	Improve the mortality data pathway to automate and digitise the production of mortality reporting, removing manual processes for transferring and transforming the data, and introducing an audit trail where user interaction is required. The data pathway covers data entry by clinical and service staff, clinical system configuration for capturing and codifying data, export process from clinical systems, data management within data warehouse (or through manual intervention), rules and categorisations applied to support reporting, the presentation of reporting outputs, and the process for validating these outputs.	**High**	1. Seagry Consultancy and NSFT to review the technology, solutions and processes used to capture, collate and report mortality data. Interoperability, system upgrade requirement as and when required should be included as part of this review.	**Complete**
			2. Seagry Consultancy will produce a list of actions with assigned owners to support improvement, processes and tools to assist NSFT in mortality reporting.	**Complete**
			3. A single overarching Standard Operating Procedure (SOP) will be implemented following this work. This will include the formal change management process required when reporting requirements change. The SOP will include inputting of data, extracting of data, validating of data and reporting of data within a given timeframe.	**In progress** Planned completion by Aug 23
			4. An audit trail will be incorporated into the process as described in action 1.	
			Additional commentary: • Sharepoint (web based collaborative platform) is being introduced to draw data from NHS Spine and Information Warehouse (providing information on patient demographics and health conditions) for use by the mortality and patient safety teams. It will be used by both teams to input case decisions at each stage of the learning from deaths process – removing manual processes and improving accuracy and consistency of recording • Full alignment with ICT Change Management process will ensure changes are appropriately approved and there is an audit trail in a Sharepoint change log of any historical changes • A Power BI mortality dashboard will be available for the Mortality and Patient Safety Teams and clinical teams to enable Trust-wide and local analysis	
2	Develop standard operating procedures (SOPs) for each stage of the data recording process, and ensure these are kept up to date	**Medium**	1. An overarching SOP will be developed which will detail each stage of the mortality data pathway	**In progress** Planned completion by Nov 23
			2. The SOP will include roles and responsibilities within the process	
			3. The SOP will describe the formal change management process when mortality reporting requirements change	
			4. The Learning from Deaths policy will incorporate the requirements of the SOPs	

Status update on actions in response to Grant Thornton audit on mortality recording and reporting – July 2023

Ref	Recommendation	Priority	Actions	Status
			Additional commentary: • SOPs are in place for Medical Records, Datix, Patient Safety and IT Teams. The overarching Mortality SOP is to be completed by end of July following publication of Grant Thornton report. This will include an overarching flowchart to ensure the process is clear to all	
3	Develop reporting tools or method of measuring incomplete data fields to feed back into the organisation, and support training. Develop reporting tools or method of measuring incomplete data fields to feed back into the organisation, and support training. (cont.)	**Medium**	1. Reporting tool to be developed to measure the data fields missing on clinical record system such as demographics. All data fields must be made as mandatory as much as technically possible to eliminate missing data and avoid human errors 2. To be reported and included in the Care Group Quality and Performance metrics and scrutinised in the Trust's Quality and Performance meeting. **Additional commentary:** • IT data quality dashboard in place which records completeness of fields, such as ethnicity and gender. This is available on the Trust intranet and shared with the ICB. The report is shared within the Data Quality Group. • Work to be undertaken with clinical teams to emphasise the importance of recording patient demographics	**In progress** Planned completion by Nov 23
4	Use the Spine as the definitive reference source of identifying deaths and update this information on a weekly basis.	**High**	1. Develop a system that utilises NHS Spine's automatic update to Lorenzo to reduce the need for manual downloads 2. This action is included as part of recommendation 1 3. A weekly report will be generated to validate any reporting of Death to Trust against the Spine. This assurance check will be included as part of SOP **Additional commentary:** • Sharepoint agreed as the system to utilise Spine updates and Lorenzo information • Weekly report downloaded from Spine • Robotic Process Automation in the process of being implemented to enable Spine data download occurs on a daily basis	**Complete** **Complete** **Complete**

Ref	Recommendation	Priority	Actions	Status
Theme 2: Reporting – focusing on the process of producing internal and external reports, dashboards, and related documentation				
5	Agree a standardised reporting structure for board reports, to include thematic analysis and consistent presentations of figures, axis and scales. Clearly define the Trust's methodology for mortality recording and reporting within Board reports . Any changes should be clearly documented and the impact upon historically reported figures should be described to provide continuity.	**High**	1. The proposed standardised reporting structure for mortality will be presented through the Committee structure and agreed by the Board 2. The Learning from Deaths quarterly Board report will include thematic analysis of key metrics such as age, diagnosis, cause of death and deprivation indices. **Additional commentary:** • Review of 'Mental Health Learning from Deaths' Board papers that are publically available to establish a standard that adheres to the National Quality (NHSE) requirements for mortality reporting • Joint work to be undertaken with ICBs to agree a set of future reporting • Learning from Deaths report to be presented to September Trust Board	**In progress** Planned completion by Aug 23
6	Align the internal dashboard with external reporting to ensure that volumes on the internal dashboard clearly reconcile to numbers within Board reports.	**High**	1. The Trust are working with Seagry Consultancy to agree the Mortality data pathway. Part of this work will include further development of Mortality Dashboard. 2. This will be underpinned by the work completed as part of recommendations 1 and 5. 3. The ability for Care Groups to drill down within the dashboard will be enhanced so they are able to interrogate their and other Care Groups data. 4. The improved dashboard will be supported by the Patient Safety Team and Mortality Team attending Care Group Governance meetings. 5. The newly developed dashboard will be available on the Trust's intranet. **Additional commentary:** • Sharepoint will generate Power BI mortality dashboard, enabling a single set of data to be used by the Trust for all reporting	**In progress** Planned completion by Aug 23
7	Work with public health and, when in post, medical examiner to identify key themes in the data and identify and implement timely targeted interventions	**Medium**	1. The Norfolk and Waveney ICB have implemented a bi-monthly Learning from Deaths forum. This includes Public Health and Medical Examiners. NSFT are a member of this forum with data shared as part of this meeting. 2. Learning and themes from NSFT Mortality reviews will be shared with the ICB so wider system learning can be considered. 3. Development of Care Group reports and attendance of Mortality Team and Patient Safety Team to local governance meetings to share learning and implement targeted interventions.	**Complete** **Ongoing** **In progress**

Status update on actions in response to Grant Thornton audit on mortality recording and reporting – July 2023

Ref	Recommendation	Priority	Actions	Status
			4. Within the Learning from Deaths committee, the Mortality team will share local, regional and national data and learning to guide where improvements need to focus.	Planned completion by Nov 23
			5. Ensure that NSFT are part of the membership of the Learning from Deaths forum in Suffolk and North East Essex ICB when commenced.	
			6. NSFT will continue to attend regional and national forums.	**Ongoing**
			7. NSFT to be members of the Norfolk and Waveney ICB LeDeR forum.	**Complete**
			Additional commentary: • NSFT are members and are participating within ICB Learning from Deaths. • ICBs Quality Leads are members of the Mortality Scrutiny Group and the NSFT Learning from Deaths Committee	
8	Use clinical input to update the cause of death groupings which are presented as part of the dashboard, and used in Board reports, so that it is clear where the Trust is awaiting data (pending), or the Trust feels this data will not be accessible, or will remain unknown.	**High**	1. Review the data collected in the Trust Mortality dashboard to include all patient demographics, cause of death, diagnosis, medication etc.. to enable the drilling down both locally and strategically of key metrics. This will include 2 'unknown' cause of death categorisations 'awaiting cause of death' and cause of death not available'.	Planned completion by Aug 23
			2. The Mortality process, criteria and screening will describe this requirement as part of the overarching SOP (Recommendation 2).	
			Additional commentary: • Data will be available in full once the new system of Sharepoint is implemented. • New Clinical Team Leader appointed who will lead on clinical decision making for case selection criteria (i.e. which cases need to be subject to a Structured Judgement Review) and supervise the clinical classification of the cause of death recorded on Sharepoint • The Mortality process, criteria and screening has been accepted by the Quality Committee and to be included in the SOP	

Ref	Recommendation	Priority	Actions	Status
Theme 3: Clinical Engagement – focusing on engaging with clinical service staff in the use and production of mortality data				
9	Establish a process of validation and use of mortality reporting and analysis at service level, aligned to corporate reporting	**High**	1. New Mortality Data Pathway as per Recommendations 1, 3, 5 and 6 will detail the process for capturing, collating, validating and reporting mortality data.	Planned completion by Aug 23
			2. Care Groups and Trust committees will be able to utilise the revised Mortality dashboard to drill down into individual Care Groups as well as maintain oversight from a Trust perspective.	
			3. The mortality data will be centrally produced, therefore the data will be consistent from 'Ward to Board'.	
			4. The dashboard will be available without patient details on the Trust intranet for all staff to review.	
			Additional commentary: • Links to recommendations 1,3, 5 and 6. • Power BI dashboard in development to be used for reporting and for Care Groups and Committee use, allowing data interrogation	
10	Review the process of retaining patients on caseloads, and subsequent discharge from caseloads, to ensure it results in consistent data across the services	**Low**	1. The guidance which details the process for administration staff to follow describing the steps to be taken when discharging a patient from the service will be shared with all Business Managers to action.	**Complete**
			2. Further guidance will be developed for administration staff as to the process to follow when a person on the team's caseload is found to be deceased.	Planned completion by Feb 24
			3. Caseload Reviews should be carried at a minimum 6 monthly with the involvement of Medical, Nursing, Therapies and Local Manager input and should be embedded in local teams standard practice.	
			Additional commentary: • Guidance in place for staff to assist in discharging patients from electronic systems. This guidance will be reviewed in line with this recommendation. Additional action for clinical teams to ensure timely discharge	
11.	Create supporting training programme for all staff who input data into systems that have an impact upon mortality data. Ensure that the implications and impacts of incorrect or incomplete data entry are understood by staff.	**Medium**	1. Implement training programmes focusing on the importance of mortality reporting dependent on the role the member of staff fulfils.	Planned completion by Nov 23
			2. To be supported by learning bulletins which highlight the importance of accurate mortality data reporting and how this can assist in improving clinical care.	

Ref	Recommendation	Priority	Actions	Status
			Additional commentary: • Clinical Team Leader and Interim Mortality Lead to facilitate learning events to improve staff's knowledge of mortality, increase staff awareness of inputting demographics and feedback learning for improvement • The SOPs will in addition provide clear guidance for staff as to the expectations of their roles within this process	

Ref	Recommendation	Priority	Actions	Status
Theme 4: Partnership working – Trust and ICB partners working to facilitate joint working and knowledge sharing				
12	Establish links with primary care networks to explore opportunities to improve the completes of the Trust's mortality data (including cause of death), supported and enabled by the ICB	**Medium**	1. In order to inform the ICB where their assistance can be best be focused, the Trust will complete an audit of the available cause of death data. 2. NSFT will develop a standardised process led by the Mortality Team for contacting GPs, Coroners, Medical Examiners and clinical data systems to obtain the cause of death wherever possible. 3. This recommendation will be shared with the ICBs through the dissemination of this report and to be added as an agenda items on ICB Learning from Deaths Forums where/when in place.	Planned completion by Nov 23
			Additional commentary: • The aim of this work is to improve the current and established relationships with local Acute hospitals, Bereavement offices, Medical Examiner and GP Practice Managers through direct liaison with the key leads • To support ICBs to assist the Trust in gaining information from partners on an individual's cause of death the Trust will undertake an audit to identify particular points where there are gaps in data, for example with a particular partner or provider of care • The Mortality Team will review all current IT systems to establish where it is feasible to have the direct access to the cause of death. This includes access to the Registry of Deaths once the appropriate Information Sharing Agreements are in place	
13	Explore opportunities for formal data sharing agreements between the Trust and primary and secondary care in the region	**Medium**	1. Establish formal data sharing agreements between the Trust, Primary and Secondary care within the region.	Planned completion by Nov 23
			Additional commentary: • Data sharing agreements in place with Acute Hospitals • The Trust are currently exploring the potential for a broader Information Sharing Agreement (ISA) for the purpose of Mortality Reviews, which would apply regionally, e.g. access to Registry of Deaths	

Ref	Recommendation	Priority	Actions	Status
Theme 5: Governance – focusing on the oversight and controls over mortality data production and reporting				
14	Update the Trust's Learning from Deaths policy to ensure the Trust's governance addresses the issues in this report and explicitly reference community deaths. Ensure the governance in relation to all mortality is clearly understood by clinical and corporate staff involved in the production and reporting of mortality information.	**High**	1. Following confirmation of the revised mortality data pathway, the Learning from Deaths policy will be reviewed and updated to include the SOP referenced in Recommendation 2. This will include the nationally defined focus of mortality being both community and inpatient deaths. 2. The Learning from Deaths policy will be supported by a 'policy on a page' which will be available to all staff. 3. The circulation of information and learning bulletins 'Learning from Deaths Matters' will be published and disseminated throughout the Trust. 4. This will be supported by learning events. **Additional commentary:** • Policy review has been commenced following the publication of the Grant Thornton Report	Planned completion by Aug 23
15	Establish a clear improvement plan to address the issues identified in this report, and report progress to a board committee	**High**	1. The improvement plan will be monitored through the Learning from Deaths and Incidents committee and reported quarterly to the Quality Committee. **Additional commentary:** • Chief Medical Officer as Executive Lead has established and is chairing Programme Board to oversee this improvement plan and actions set out in this document • Process in place to enable reporting to Quality Committee and Board	Planned completion by Aug 23
16	Introduce a process of assurance over mortality reporting: Introduce a clear audit trail and series of checks to ensure adherence with SOPs, and report outcomes to executive leads on a regular basis Introduce or commission patient level data reviews to provide assurance over the accuracy of data recording. Link to the clinical validation process established under recommendation 9	**High**	1. An audit process will be developed and implemented every 6 months. The audit will test the comprehensiveness of the mortality data pathway with the findings reported to the Learning from Deaths and Incidents Committee. 2. External verification will be sought by an external consultancy team who are experienced in data within the NHS. **Additional commentary:** • Sharepoint list will have built in audit trail of who accessed the records • Sharepoint will have a defined list of who can edit the data contained within the list • Sharepoint will automatically be updated once automation is in place • Overarching process map/flowchart to be developed • Power BI dashboard will be developed from Sharepoint list • Clinical decisions will be recorded on Sharepoint	Planned completion by Aug 23

Report to:	Board of Directors
Meeting date:	27th July 2023
Title of report:	Freedom to Speak Up Guardian Service Report
Purpose of paper:	This paper provides an update on the guardian service and introduces the report on the six months review of the service.
Author:	Ade Adetukasi, Associate Director of Employee Experience & OD Kym Gillingham, Freedom To Speak Up Guardian
Director:	Cath Byford, Deputy Chief Executive/Chief People Officer
Link to Trust Strategy	Inspirational people; Enabling our staff to thrive The paper is linked to the Improvement Plan Culture Pillar.
Legislation/Compliance	Public Interest Disclosure Act 2010 Freedom to Speak Up national guidance
Link to BAF Risk/s	Board Assurance Framework (BAF) risk 1.1 and 3.2

Executive summary

The purpose of this paper is to provide an update on the guardian service and to introduce the report on the six months review of the service. The introduction of a new Freedom To Speak Up service (FTSU) is one of the foundational and priority initiatives under our culture reset programme launched in September 2022. The overarching objective for launching the new service is to strengthen our FTSU infrastructure and to create the right environment for staff to speak up, feel heard, and supported.

Review of the new service provided by Guardian Service Limited.

One of the core Freedom To Speak Up principles set out by the National Guardian Office is that "Speaking up arrangements' effectiveness will be monitored, and opportunities to improve taken". To evaluate the new service, a review of the service commenced in May 2023 and this paper introduces the Guardian Service report on the review. The report sets out the progress and development of the service and identify learning from the themes arising from the cases received by the guardian. See the full report below.

Key highlights from the review

- There is high usage of the service. By the end of March 2023, there had been over 100 cases (the expected annual average for NHS trusts "in normal times") logged. See appendix 1 below for details of the monthly usage of the service.
- The successful implementation and promotion of the service contributed to the high usage.
- The 3 most common themes for new cases were System and Process, Behaviour and Management.

- East/West Suffolk is the care group with the highest number of concerns raised.
- The majority of staff who use the service chose to speak to The Guardian Service because they believe that the organisation would not take action or were fearful of reprisal.
- Since the new service was launched in November 2022, no staff member has reported that they suffered a detriment because of speaking up.
- The report recommends further line management training for managers, including completion of Freedom To Speak Up training modules.
- The report identifies key learning and improvements for the trust to action and also makes recommendations for further developing the FTSU function.
- Following discussions with the Guardian Service as part of the review, we have been offered 25% discount on charges for the excess above the contracted 100 cases threshold. This is specifically for the period Nov 22 – May 23 and amounts to £5680 in cost savings. In addition, a new threshold of 50 cases has been put in place for the period June – Nov 23.

Next Steps

1. As part of the process of developing our long term culture strategy, **learning, evidence and recommendations from the review of the service will be used in further developing a speak up culture in the trust.** Learning and evidence from the report are currently being analysed for actions as part of the diagnostic and thematic analysis work been carried out by the Culture and Leadership Pillar of the improvement programme.

2. **An options appraisal on the future of the FTSU service will be presented to the Executive Team for consideration in August.** Our current contract with the Guardian Service ends in November 2023. Some of the options to be explored in the appraisal includes:

a) A one-year extension to the current contract with the Guardian Service, with renegotiated terms and conditions to address cost and threshold concerns.

b) A longer term (3 – 5 years) extension to the current contract with Guardian Service, also with renegotiated terms

c) Procurement of a new longer term FTSU provider through a competitive tendering process to allow for other external FTSU providers to compete to ensure value for money.

d) Rebuilding and investing in a new in-house FTSU service based on learning from the current Guardian Service model.

Norfolk and Suffolk
NHS Foundation Trust

The Guardian Service
Here to listen

Interim Report
November 2022- 31 March 2023

Prepared by: Kimberley Gillingham

Guardian
The Guardian Service Ltd.

Date: 10th May 2023

Contents

1. Executive summary

The Guardian Service Limited began providing the Freedom to Speak Up Service for Norfolk & Suffolk NHS Foundation Trust on the 14th November 2022. Between the period of 14th November 2022 and 31st March 2023, 133 concerns were raised by staff members.

The efforts by the Trust to help promote the roll out of The Guardian Service as well as colleagues sharing positive experiences and results of using the service contributed to the increased usage of this channel for speaking up.

The majority of staff chose to speak to The Guardian Service because they felt that the trust would not take any action or were fearful of reprisal if they spoke up via other internal channels.

Concerns received are recorded by GSL against specific themes which are Management Issues, System & Process, Bullying & Harassment, Discrimination & Inequality, Behaviour & Relationship and Patient Safety/Quality and Worker Safety.

The top 3 job groups raising concerns were Nursing and Midwifery (40), Additional Clinical Services (32) and Administrative and Clerical (19).

The 3 most common themes for new cases were System & Process (35), Behaviour (27) and Management (23).

The total of cases raised that were specifically relating to Patient Safety was 16. However, it is important to note that there were cases recorded under other themes that had the potential to indirectly impact on the quality of patient care and safety.

East and West Suffolk were the care group with the highest number of concerns. This should not be viewed negatively, but as encouragement that staff are comfortable to speak up.

The majority of staff chose to speak to The Guardian Service because they believed that the organisation would not take action or were fearful of reprisal.

No staff member reported that they suffered a detriment because of speaking up.

There are a number of recommendations detailed at the end of this report that the Trust is asked to consider. These relate to management training and the completion of Freedom to Speak Up in Healthcare modules.

2. Background to Freedom to Speak Up

Following the Francis Inquiry[1] 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

3. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the Norfolk & Suffolk NHS Foundation Trust as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Norfolk & Suffolk NHS Foundation Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in Norfolk & Suffolk NHS Foundation Trust (NSFT) on the 14th November 2022.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the organisational induction programme.

4. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not NSFT employees and are external to the Trust.

5. Categorisation of Calls and Agreed Escalation Timescales

The following timescales have been agreed and form part of the Service Level Agreement.

Call Type	Description	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours

[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours
White	No discernible risk to organisation.	No organisational response required

For this date period, all escalated cases were responded to within the agreed RAG protocols.

Open cases are continually monitored and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

Escalated cases are cases which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. There are circumstances where cases are escalated at a later date by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

6. Purpose of the paper

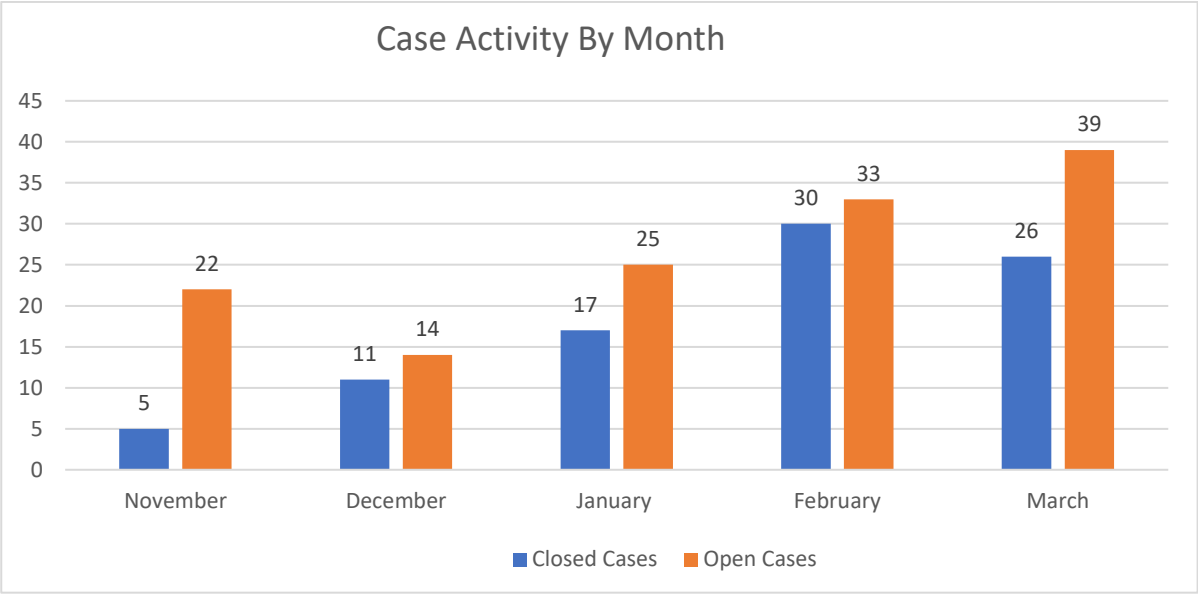
The purpose of this paper is to detail the progress and development of the Speak Up service within NSFT and to identify learning from the themes arising from the cases received by the Freedom to Speak Up Guardians.

This report provides an overview of themes and issues raised through the Guardian Service from 14th November 2022 to 31st March 2023. The report also sets out some learning points and makes recommendations for consideration.

The report follows the guidance from the NGO on the content FTSU Guardians should include when reporting to their Board which include: Assessment of cases, Action taken to improve speaking-up culture and Recommendations.

7. Number of concerns raised

From 14th November 2022 – 1st March 2023, 133 concerns were raised to The Guardian Service.



Since the service went live within Norfolk & Suffolk Foundation Trust, monthly calls received have been fairly high compared to other similar sized Mental Health Trusts.

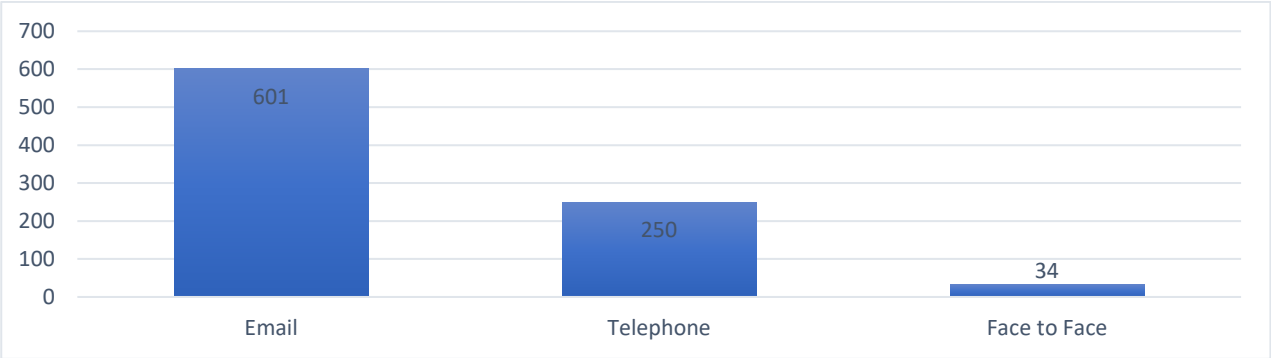
By the 31st March 2023, 44 cases remained open and 89 have been closed.

Open cases are continually monitored and regular contact is maintained by the Guardian. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the Associate Director of Employee Experience and OD at regular monthly meetings.

Escalated cases are cases which are referred to the most appropriate person in the trust, at the request of the employee, who has the ability to take action. The Guardian always encourages the staff member to escalate to their manager in the first instance, however this may not always be the most appropriate action for them. If this is the case, the Guardian can support them to escalate higher.

As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. In a few cases, contact with the Guardian is not maintained.

The number of emails, telephone calls (including text messages) and face to face visits engaged by the Guardians in responding to concerns are as follows:



There are often multiple contact points for every concern raised, therefore the numbers do not directly correlate with the number of concerns raised.

8. Confidentiality

The way in which cases are managed by The Guardian Service with respect to confidentiality and escalation routes is recorded cumulatively. A breakdown of this data covering the period of 14th November 2022 to 31st March 2023 is provided below;

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	74	55.64%
Permission to escalate with names	33	24.81%
Permission to escalate anonymously	26	19.55%
Total	**133**	

Within this reporting period, over 50% of staff members asked for their concern to be kept confidential with The Guardian Service with just over 19% giving their permission to escalate their concern anonymously. The data would appear to show that there is a general 'fear' of Speaking Up within the Trust.

9. Themes

Concerns raised are broken down into the following categories;

Theme	Total
A Patient and Service User Safety / Quality	16
B Management Issue	23
C System Process	35
D Bullying and Harassment	19
E Discrimination / Inequality	6
F Behavioural / Relationship	27
G Other (Describe)	2
H Worker Safety	5
Total Concerns	**133**

10. Assessment of Themes

System & Process

This was the highest reported concern with 35 concerns raised in relation to this theme. Examples as described by staff:

- Process issues with call handling and duty rotas
- Unfairness highlighted on a number of occasions with regard to the recruitment policy not being adhered to by managers
- Staff being investigated regarding a complaint and not being given any details by the Trust
- Concern regarding processes of the reception staff within teams
- Concern regarding the time taken for a grievance to be fully investigated

Behavioural / Relationship

27 concerns were reported in relation to this theme. Examples as described by staff:

- Staff being spoken to in a disrespectful manner by colleagues
- Lack of communication with regard to changes of job roles
- Increasing workload causing low moral
- Behaviour within secure units creating a closed culture
- Invasion of privacy with regard to staff searches within Secure Unit

Management Issue

23 concerns were raised in relation to this theme. Examples as described by staff:

- Insensitivity towards staff concerns and issues including mental health issues
- A belief that staff are not listened to when they raise concerns
- Breakdown of trust between staff and managers
- Some Managers consistently fail to demonstrate that they are/have listened to their staff - not acknowledging emails, avoiding contact, not offering supervision
- A belief that staff are not consulted regarding changes and that their input and work is not respected or valued
- Concerns over confidentiality when matters are discussed between worker and manager
- Managers not consulting with HR/following correct policies with regard to Performance Management or Flexible Working Applications

Bullying and Harassment

19 concerns were raised in relation to this theme. Examples as described by staff:

- Inappropriate language, including name calling, comments intended to belittle
- Aggressive communication and shouting/swearing
- Talking openly about other staff members, lack of confidentiality
- Being actively excluded from the team
- Repeated reminders of errors and providing feedback in a manner that is not constructive

Patient Safety / Quality

16 concerns were raised in relation to this theme. Examples of concerns described by staff:

- Concern regarding an incident whereby staff members were assaulted by a Service User.
- Concern regarding a Ward at having significant staff shortages.
- Concern regarding patient safety within a Ward due to Safeguarding Concerns.

The above red concerns have been resolved.

Discrimination / Inequality

6 concerns were raised in relation to this theme. Examples concerns described by staff:

- Racist comments
- Staff feeling they have not been treated fairly after Speaking up regarding bullying concerns
- Concern that some staff member(s) have been treated poorly after refusing to be vaccinated against Covid-19

Worker Safety

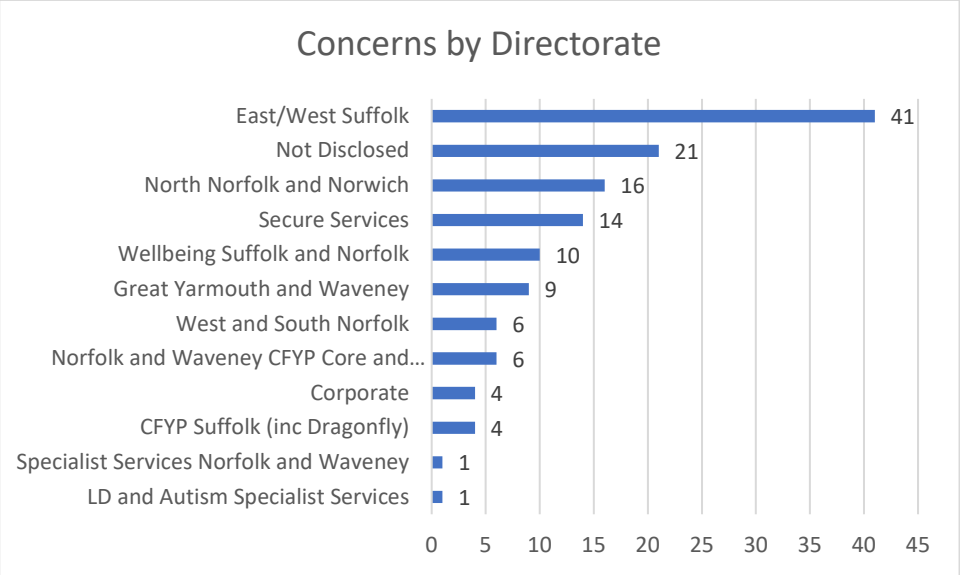
5 concerns were raised in relation to this theme.

The cases recorded under this theme included the following example concerns described by staff:

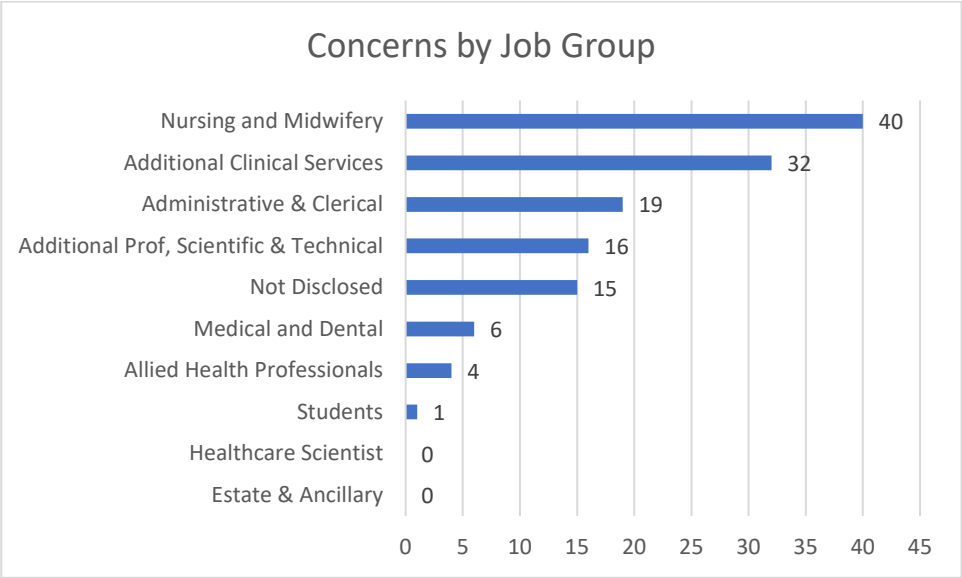
- Staff being assaulted by Service Users
- Staff members not having PMA training prior to working on wards

11. Statistical Graphs

Concerns raised by Directorate

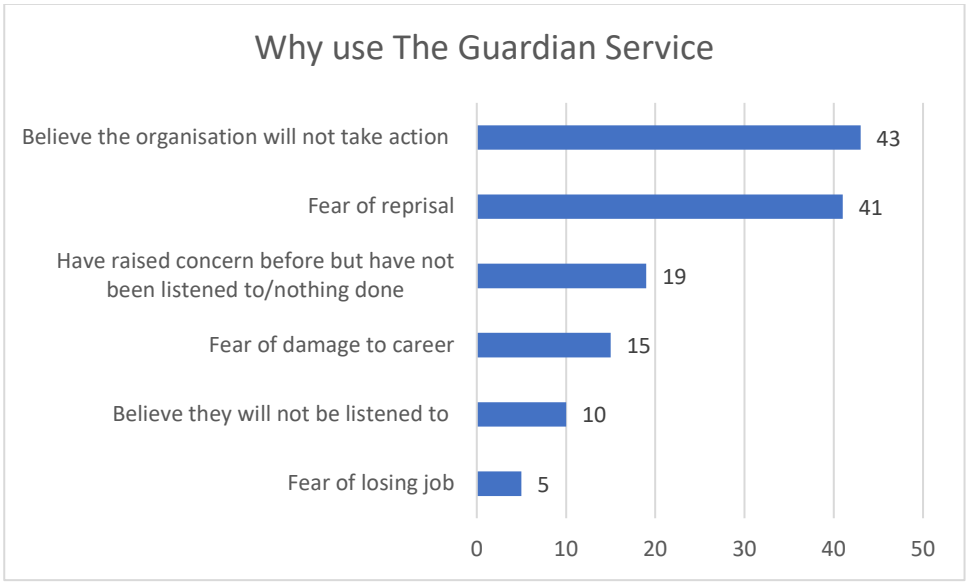


Concerns raised by Job Group



12. Why do staff use The Guardian Service?

Staff who make contact with The Guardian Service are routinely asked why they chose this route to raise a concern. The responses provided are demonstrated in the chart below;



13. Detriment

Although, there has been no report of detriment suffered as a result of speaking up through the Guardian Service channel, staff have reported previous instances of detriment that they feel has occurred as a

result of speaking up directly to their manager or colleague. The Guardian Service encourages staff to speak up whilst maintaining that they will not suffer any detriment.

A number of callers were so fearful that this would happen they decided to withhold their name from the Guardian and were fearful about any details being shared with the Trust that would identify them or took the decision not to pursue their concern.

Detriment is a major concern associated with speaking up and has a huge influence on FTSU culture. The FTSU Guardian will not close cases without approval of the staff member. The staff member is encouraged to keep the lines of communication open throughout their case and following closure and any perceived detriments should be advised to the Guardian.

14. Action taken to improve the Freedom to Speak Up Culture

- Monthly meetings with the Associate Director of Employee Experience & OD, to discuss the monthly activity reports which includes themes and outcome of cases. No individual can be identified by the discussion of themes therefore maintaining staff confidentiality.

- Bi Monthly meetings with the NED to discuss the monthly activity reports which includes themes and outcome of cases. No individual can be identified by the discussion of themes therefore maintaining staff confidentiality.

- Monthly meetings held with CEO and Deputy CEO to discuss emerging themes and learning points.

- The Guardian conducts walkabouts, visiting sites, and offices to speak to staff about The Guardian Service distribute promotional materials at different locations. The Guardians hold briefings with teams and attend meetings both in person and via Teams to talk about the service and encourage a culture of speaking up for all staff and managers.

- The Guardian regularly attends meetings with various Networks such as the International Employee Network, the BME Network and the Ability Network to provide a visible presence to staff. The Guardian also attends various staff Inductions both virtually and in person to present the role of The Guardian Service. 55 visits both in person and via Teams have been conducted by The Guardian since November 2022 with ongoing plans to visit a number of sites throughout 2023.

- The Guardian attends the Eastern regional meetings, workshops, events and conferences organised by the NGO. This, in addition to the NGO Bulletins, enables Guardians to keep abreast of developments in the field which in turn support the effective handling of concerns.

- The Guardian's role is complex, and the landscape is constantly evolving. To ensure best practice, the Guardian completes annual refresher training provided by the NGO to support learning and

development needs on changes. The NGO also provides regular updates to the Freedom to Speak Up landscape.

- The Guardian is a Mental Health First Aider. This is valuable when liaising with staff who may be experiencing poor mental health. The skills learned enable the Guardian to signpost a person to appropriate support.

- The Guardian listens and supports staff to enable them to raise their own concerns. Exploring ideas and options for using existing tools, such as facilitated meetings, peer facilitation, formulating e-mails to managers, verbal communication and preparation for staff attending facilitated or one to one meetings. All of which can help an individual bring about a resolution, without instigating formal grievance procedures.

15. Learning and Improvements

- There are cases where staff did not wish to escalate issues through GSL. Reasons for this are more complex than they appear as each person has different reasons for speaking to a Guardian. Staff conversations with the Guardians indicate work could be undertaken by the organisation to try and understand why employees feel they cannot escalate an issue internally and what the organisation could do to remove barriers to speaking up.

- Staff choose to speak up through a Guardian because they have raised concerns before but are not listened to and many believe the organisation will not take action. Confidence can be restored through promoting positive staff experiences of speaking up at work through all available speaking up available routes within NSFT.

- There are staff at all levels in the organisation who are struggling (due to, for example, low staffing levels, poor relationships with colleagues and managers), consideration could be given to how NSFT recognises this in their staff and how they are supported. Poor communication is the biggest barrier to finding out if staff are okay. With a little bit of encouragement and support, a staff member will speak up as evidenced in numbers of staff who have spoken up after a conversation with the Guardian Service.

16. Comments & Recommendations

- Management Training - People management training for all who have supervisory, team or individual leadership roles or responsibilities. It is apparent that there are some leaders within the trust that have had limited support in preparing them to be people-managers.

- Civility & Psychological Safety training & strategy – How staff treat each other at work does have an impact on engagement, teamwork, safety, staff wellbeing and patient care. The NHS's People Plan sets out a commitment to support trusts in creating a positive workplace culture. There are toolkits available on the NHS website that can be used to help in this regard.

Psychological safety is a crucial ingredient for a healthy, open and engaging work environment. Staff who feel psychologically safe enough to engage in conversation with colleagues/leaders, are more likely to speak up about their concerns, and present ideas that can contribute to a healthier work environment. It is therefore important that people-leaders understand what can impact both positively and negatively on psychological safety along with a trust-shared strategy to manage psychological safety appropriately.

- Resources for Investigations – Some staff have been surprised in how long it takes for the Trust to address some concerns. Particularly when these concerns have been raised by multiple complainants or where the concern is of a more complex nature. The timeliness, rigour and the methods chosen to investigate has shown to be important influential factors on FTSU culture. It is therefore recommended that the investigative resources are reviewed and enhanced where possible to enable appropriate investigations to be conducted in a timely manner.

- I have seen a significant number of concerns raised that related to the recruitment practices within NSFT. These outline recruitment policies not being adhered to correctly, with further allegations of favouritism and/or nepotism. These issues have been recognized by the Trust and with the appointment of our new HR Director, alongside with a Director of Culture, it is hoped measure being put into place will help ensure all staff & managers have a full & concise understanding of the Trust's recruitment policies. Hopefully these new measures will address some of the issues, and reduce the number of concerns raised in this area.

  - The FTSU Guardian encourages the Trust to embed Speaking up further by making it mandatory for all staff to complete the 'Freedom to Speak Up in Healthcare' modules - *Speak Up*, *Listen Up* and *Follow Up*, introduced by the NGO.
    1. Speak Up covers what speaking up is and why it matters. It helps staff understand how they can speak up and what to expect.
    2. Listen Up focuses on listening to concerns and understanding the barriers to speaking up. It helps Managers to understand what speaking up is and how they should respond when someone speaks up to them.
    3. Follow Up was developed for senior leaders throughout healthcare – including executive and non-executive directors, lay members and governors. The module aims to promote a consistent and effective Freedom to Speak Up culture across the system, which enables workers to speak up and be confident they will be listened to and action taken.

  - NHS England has published updated Freedom to Speak up guidance and reflection tool and FTSU Policy. These address the thinking and language around healthy speaking up cultures for primary care and NHS trusts. By 31*st* January 2024 trust boards should evidence:

1. Local FTSU policy reflecting the updated national template.
2. Assessment of their organisation's FTSU arrangements against revised guidance .
3. Assurance of progress aligned with the FTSU improvement plan.

17. Staff Feedback

Positive comments that staff have fed back to the Guardians have included:

‘That’s great, thanks for all this Kym, really appreciate it.’

‘Many thanks for the feedback and everything you are doing Kim.’

‘Thanks again for taking time to listen to my problems today’

‘Take care see you next time and good luck with it all, I think you will make a difference!’

‘Thank you again so much for the conversation on Wednesday, It was really good to have an outlet to share my concerns as up until this point these had been things I was holding in for a long time. Having a confidential space to discuss really helped – the next day I felt a lot more positive coming into work’

‘And I cannot thank you enough for your support.’

‘Just wanted to say a huge thank you for last week, your support was so empowering and just saying things out loud really helped me. ‘

‘ I just wanted to thank you again for solving this issue for me. You have lifted a great weight from my shoulders.’

‘I would like to say from the bottom of my heart, thank you for your help and support. ‘

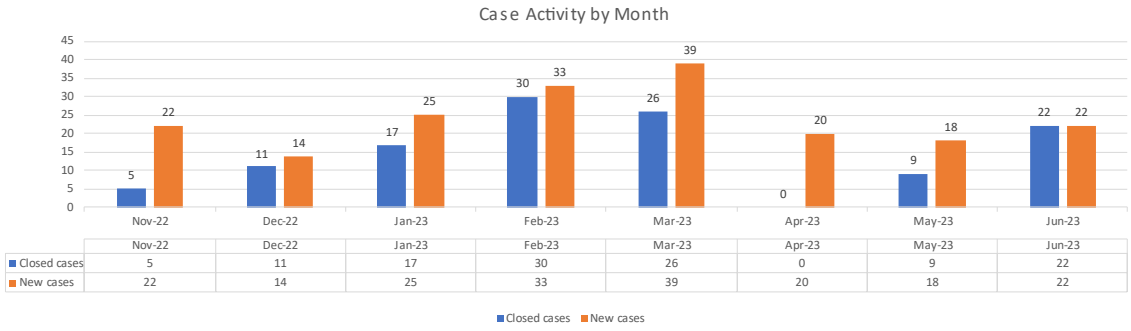
‘Many thanks for taking your time to listen to myself and raise our staffing concerns. ‘

‘After being in contact with you I have since spoken with my manager again who has put me forward for my nursing. Thank you for your help’

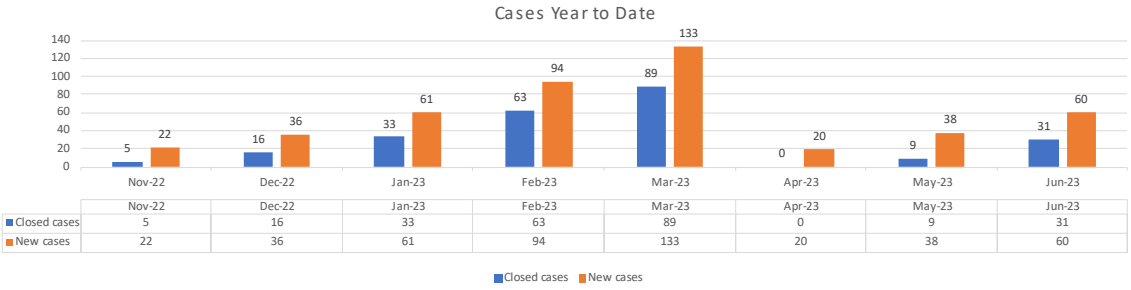
‘The team have a further years funding with a view for development and sustaining within that year – I have no doubt this is due to your escalation of the matter!’

Appendices

Appendix 1 - Cases Activity Nov 22 – Jun 23



	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Closed cases	5	11	17	30	26	0	9	22
New cases	22	14	25	33	39	20	18	22



	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Closed cases	5	16	33	63	89	0	9	31
New cases	22	36	61	94	133	20	38	60

Grant Thornton

Norfolk and Suffolk Foundation Trust's mortality recording and reporting

26 May 2023

Grant Thornton

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26/05/2023

Mortality data recording review

We enclose a copy of our report in accordance with your instructions dated 18th October 2022. This document (the **Report**) has been prepared by Grant Thornton UK LLP (**Grant Thornton**) for NHS Norfolk and Waveney Integrated Care Board (ICB), Suffolk and North East Essex Integrated Care Board (ICB) and Norfolk and Suffolk NHS Foundation Trust (the **Addressees**) in connection with a review of mortality data recording at Norfolk and Suffolk NHS Foundation Trust (NSFT) (the **Purpose**).

We stress that the Report is confidential and prepared for the Addressee and the organisations named in the agreement only. We agree that an Addressee may disclose our Report to its professional advisers in relation to the Purpose, or as required by law or regulation, the rules or order of a stock exchange, court or supervisory, regulatory, governmental or judicial authority without our prior written consent but in each case strictly on the basis that prior to disclosure you inform such parties that (i) disclosure by them is not permitted without our prior written consent, and (ii) to the fullest extent permitted by law we accept no responsibility or liability to them or to any person other than the Addressee.

The Report should not be used, reproduced or circulated for any other purpose, in whole or in part, without our prior written consent, such consent will only be given after full consideration of the circumstances at the time. These requirements do not apply to any information, which is, or becomes, publicly available or is shown to have been made so available (otherwise than through a breach of a confidentiality obligation).

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Addressee for our work, our Report and other communications, or for any opinions we have formed. We do not accept any responsibility for any loss or damages arising out of the use of the Report by the Addressee(s) for any purpose other than in relation to the Purpose.

The data used in the provision of our services to you and incorporated into the Report has been provided by third parties. We will not verify the accuracy or completeness of any such data. There may therefore be errors in such data which could impact on the content of the Report. No warranty or representation as to the accuracy or completeness of any such data or of the content of the Report relating to such data is given nor can any responsibility be accepted for any loss arising therefrom.

Grant Thornton

Period of our fieldwork

Our work was performed in the period between October 2022 and January 2023. This work reviewed mortality data recording and reporting between April 2019 and October 2022. We have not performed any fieldwork since January 2023 and, our Report may not take into account matters that have arisen since then. If you have any concerns in this regard, please do not hesitate to let us know.

Scope of work and limitations

Our work focused on the areas set out in our engagement letter, signed 12th October 2022.

Interviews were held with key staff using Microsoft Teams or other video conferencing applications. Analysis was completed using the data provided by the Trust.

The scope of our work has been limited both in terms of the areas of the business and operations which we have assessed and the extent to which we have assessed them. There may be matters, other than those noted in the Report, which might be relevant in the context of the Purpose and which a wider scope assessment might uncover.

General

The Report is issued on the understanding that the management of Norfolk and Suffolk NHS Foundation Trust have drawn our attention to all matters, financial or otherwise, of which they are aware which may have an impact on our Report up to the date of signature of this Report. Events and circumstances occurring after the date of our Report will, in due course, render our Report out of date and, accordingly, we will not accept a duty of care nor assume a responsibility for decisions and actions which are based upon such an out of date Report. Additionally, we have no responsibility to update this Report for events and circumstances occurring after this date.

Notwithstanding the scope of this engagement, responsibility for management decisions will remain solely with the directors of the Trust and not Grant Thornton. The directors should perform a credible review of the recommendations and options in order to determine which to implement following our advice.

Yours Sincerely,

Grant Thornton UK LLP

Grant Thornton UK LLP

Contents

Executive summary (1 of 4)

Introduction

Norfolk and Suffolk NHS Foundation Trust (NSFT) is a mental health trust in the East of England which provides care to a population of around 1.6 million. The Trust provide mental health and learning disability care for people through inpatient, community and primary care settings.

Grant Thornton has been commissioned by Norfolk and Waveney and Suffolk and North East Essex Integrated Care Boards to review the collection, processing and reporting of data related to patient deaths at Norfolk and Suffolk NHS Foundation Trust.

To do this we:

- Reviewed local guidelines, policy documentation and corporate documentation
- Interviewed key staff members involved with producing and reviewing mortality data
- Analysed anonymised patient level data from clinical and incident reporting systems
- Reviewed internal and external mortality reporting and dashboards.

We have not audited individual records to test their accuracy, nor does this report give any view on the levels of mortality or the circumstances of patients' deaths. We have reviewed mortality reporting at the Trust; we did not review the process for serious incident reporting. Our findings are based solely on the information made available to us during the review. between November 2022 and January 2023.

The Trust has been working with NHS England since September 2022 to improve its processes, particularly in relation to mortality. Changes at the organisation made after January will not be captured within our findings. The recommendations from this report will support these improvements by providing focus and clarity on issues impacting on data recording and reporting.

It should be noted that quality and consistency of mental health data is a recognised national challenge. In addition, national guidelines over mortality reporting for mental health trusts are not as clear and defined as those in place for acute trusts, giving scope for variation in their implementation across different trusts. This lack of detailed national guidance limits the opportunity for mortality data comparisons and provides a challenge for the Trust in applying a nationally consistent process.

Overview

Based on the information made available to us we are unable to provide assurance over the mortality data reported at the Trust. Our findings are outlined below and are described in more detail over the next pages of the executive summary.

The Trust's intended methodology for reporting is in line with the expectations of national guidance, where it exists, and the processes in place at peer organisations. However, the Trust's implementation of this methodology requires further work to improve the reliability and usefulness of the information produced.

The Trust's mortality data management process is unclear and uses multiple systems to record and produce the data. These systems are a mix of applications, with some manual processes used to categorise and transform the data. There is no overarching documentation of the process followed and we saw no clear audit trail of the data as it moved through this process.

The reporting of mortality data to both internal and external audiences is inconsistent – this includes changes in reporting methodology and the way data is presented, and errors in two reports in the way information is interpreted and described were identified during the review.

In particular, the process of categorising and grouping expected and unexpected deaths and the decision making involved was unclear and inconsistent during our review, and the data on cause of death is not available for many community deaths. This is a key part of mortality reporting and the information produced forms part of the corporate board reporting.

These issues have led to questions of clarity within public facing documents, and reduced clinical relevance within the mortality information reported. This results in a lack of confidence of external stakeholders – including regulators and the public – in the data, and in the Trust's understanding of it.

The Trust is often reliant on other NHS providers for cause of death information for community patients and more needs to be done to provide access to this information. In resolving these issues the Trust will need to take responsibility for the actions they are able to complete, and to be clear on the requirements of partner organisations to what additional information they need and which organisation holds it. The Trust will need to be supported by the ICB and the other healthcare organisations within the health system to make this information available.

Executive summary (2 of 4)

The governance structures in place at the Trust are in line with national requirements, but operational understanding of this governance was unclear. More needs to be done to establish end-to-end oversight of the mortality data production and reporting process for all mortality, and to assure the board that mortality data reported is accurate.

Based on the evidence seen as part of our review more work is also required to support services to use the data available in order to ensure it is accurate and to understand key messages. Our experience demonstrates that data that is regularly used is data that improves.

The Trust has strong governance in its approach to deaths resulting from patient safety incidents – on site incidents are followed up by the team, as well as suicides where the coroner has notified the Trust. The Trust needs to bring the same rigour to improve the processes around the reporting of all mortality, and the understanding of all deaths for patients on their caseload. The need for further understanding of all mortality was highlighted as an issue by NHS England at the Trust's quality and safety committee.

Reporting

Within the corporate reporting documentation, board reports and annual Learning from Deaths reports, mortality data is presented inconsistently, and the methodology adopted has gone through multiple changes. This creates challenges to understand performance and fully interrogate the data presented. The lack of consistency within external documents has raised concerns about the accuracy of the data within them.

The Trust does not adopt a consistent reporting standard and has frequently changed both the methodology and presentation of mortality data in its board reports. Over eight consecutive board reports, information and the method of presentation changed six times, including how activity was broken down, how graphs were labelled, and the types of charts used. Within the board report graphs there were missing data points for some months. In others reports, a change in methodology was adopted, without being fully explained and without comparative analysis between the two methodologies being made available. This has led to confusion in both the classification of mortality between expected and unexpected deaths and the numbers of deaths which form part of Trust's mortality statistics. Although the methodology changes were appropriate, inadequate descriptions and an absence of the impact upon historic mortality data can cause confusion.

As a result, when tracking through the chronology of corporate reporting from report to report the mortality numbers lack consistency without adequate explanation of the change in methodology and no comparative information used to show how the new approach corresponds to the previous one. Additionally, in two board reports the numbers of expected and unexpected deaths were incorrectly transposed.

The presentation of the Trust's internal mortality dashboard does not always align with its public board reporting. The numbers attributed to expected and unexpected deaths have differed between reports and the dashboard. Also the volumes attributed to individual groupings of the cause of death do not always align to the dashboard. The dashboard is available on the Trust intranet and has some basic analysis such as team level information and small charts showing timeline of causes of death.

Whilst the dashboard includes basic demographic information this is not presented alongside causes of death, but at an expected or unexpected level. During the review we saw no evidence of detailed analysis of mortality information aligned to population health, understanding health inequalities, or learning from mortality aligned to deprivation or particular patient groups. This level of analysis is crucial for internal and external scrutiny and to enable services to identify opportunities to improve care.

Data processes

The Trust uses a number of systems for the mortality recording process. The Trust's electronic patient record (EPR), Lorenzo, and the incident management system, Datix, are the principal clinical systems used, supplemented by IAPTUS and SystmOne, which support two individual services. Although the bulk of mortality data management and reporting is conducted within core clinical systems such as Datix and Lorenzo, this is supplemented with the manual use of excel, which lacks the same information governance and audit standards of the clinical systems and the use of this should be minimised to mitigate any potential risks to the Trust. The mortality dashboard used for internal reporting uses these systems as its data feed. Although there are pockets of documented processes, there is no comprehensive documentation that covers the process in its entirety.

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Executive summary (3 of 4)

There are multiple methods of identifying a deceased patient within the Trust. Many are inconsistently implemented and lack definitive documentation. From the data analysed by Grant Thornton, 24% of mortality was notified and recorded directly by Trust staff across its inpatient and community teams. The remaining 76% was identified through the electronic process of reconciling patient data against the national NHS Spine, which is undertaken monthly. Other similar organisations perform this check on a more frequent basis. Historically, incorrect assumptions have been made locally that staff accessing a deceased patient's record will have completed the relevant mortality documentation required on the Trust's incident reporting system, Datix. The significance of this monthly time delay and assumptions around accessing patient records will potentially result in data reported by the Trust not being timely or accurate.

The Trust's process for determining the categorisation of death as expected or unexpected, which is a key aspect of mortality reporting and is defined below, is not clear or auditable. Where the death certificate was available, it was used to inform appropriate grouping of cause of deaths which appears on the dashboard, with different staff members assuming this was done in different ways; there was no clinical input or oversight of this step. The reliance on individual interpretation, without support, risks inaccuracies and inconsistencies in the data reported.

Definitions of expected and unexpected deaths

Expected Death: Caused by a pre-existing life-limiting condition or if the person's age and frailty made death from a natural cause a reasonable expectation at the time of their death

Unexpected death: The death of a service user who has NOT been identified as critically ill or death is NOT expected by the clinical team. If there is no known diagnosis of terminal illness or physical health complication meaning that the service user is deemed as approaching end of life or receiving palliative care. Where data or cause of death is unavailable this is defined as unexpected

Source: NSFT Mortality and Learning from Deaths Report, Jan 2022

The generic category of *'Natural cause – specific not available'* is used where no cause of death information is available to the Trust, and accounts for 77% of all recorded mortality activity. Based on the Trust's definitions these deaths are categorised as unexpected.

More should be done to understand the causes of death and contributing factors for these patients. However, the Trust faces challenges in accessing this level of information for all deaths to be included within the Trust's mortality reporting, as it is often reliant on other NHS providers for cause of death information. The Trust is also reliant on partners to provide information on community patients where the coroner has not been involved in the patient death. Improving this position will involve system-wide collaboration. This lack of information is compounded by the number of incomplete fields (null values) that are present within the reported data.

The Trust is planning to implement the Better Tomorrow dashboard, however, it should be noted that the introduction of this will not address issues with the mortality data and reporting outlined in this report, as it focuses on the review aspect of the mortality pathway.

Governance and clinical engagement

The governance structures in place at the Trust are in line with national requirements, but operational understanding of this governance was unclear. The approach to reviewing and learning from deaths was clearly understood; however, there was a confused picture around senior ownership of overall mortality data reporting. This reflects the Trust's focus on serious incident reporting instead of all mortality reporting.

As a result, there are inadequate controls over the end-to-end process of mortality reporting. We saw no evidence of checks on inputs or outputs, limited and out-of-date documentation and insufficient evidence of information governance controls over all systems used within the mortality recording process. More needs to be done to provide assurance to senior staff and the board on the accuracy of underlying data.

The Trust has a good understanding of individual patients, but more work is required to support services to use this data to understand areas of interest that could support or inform potential improvements. During the review two senior clinical leaders stated that members of the Trust's clinical staff have limited faith in their data and do not use or analyse it in a structured manner.

In the patients included in the Trust's mortality reporting our analysis noted 164 patients who were not seen for over 2 years, up to a maximum of 9 years, prior to discharge. This highlights potential issues around caseload management and data management of the discharge process that may be impacting upon the Trust's mortality data.

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Executive summary (4 of 4)

We also saw no evidence of regular clinical validation of the data used to underpin mortality reporting or feedback loop in place between clinical and information teams on mortality reporting. Our work across the NHS has shown that when data gets used its quality improves, meaning it more accurately reflects the patients treated.

A better understanding of mortality reporting will improve the opportunities for learning across the Norfolk and Suffolk health system, and improve the benefit from collaborating with primary care networks and GPs to better understand the cause of death of patients on the Trust's caseload, and with all partners in the system will help to understand the links between physical health and mental health needs.

Recommendations

Based on the findings of the review we have made 16 recommendations across four key themes. These are described on the following page and include:

- Improve the mortality data pathway to automate and digitise the production of mortality reporting
- Agree a standardised reporting structure for internal and external reporting, and provide the tools to interrogate the data
- Improve the controls over mortality reporting and ensure clinical oversight, validation and use of the information reported
- Establish a clear improvement plan to address the issues identified in this report.

These recommendations were created with visibility of the Better Tomorrow quality improvement plan and are designed to supplement the ongoing improvement at the Trust. Our recommendations are focused on the recording and reporting of mortality, and not the process of reviewing deaths which was covered as part of the Better Tomorrow plan.

The Trust is part of a wider health system alongside other providers, and some of the recommendations relate to accessing data held by other providers. For these recommendations the Trust should provide leadership to understanding their requirements in this area, but will require support from the ICBs and other partner organisations to complete the actions.

As part of this review the Trust has completed an action plan which is included on the pages following the recommendations.

Recommendations

The recommendations are structured to focus on different operational groups and their roles within the data pathway. As part of this review the Trust has completed an action plan which is included on the following pages.

Data - focuses on the technical data management to be completed by business intelligence and related teams.

1. Improve the mortality data pathway to automate and digitise the production of mortality reporting, removing manual processes for transferring and transforming the data, and introducing an audit trail where user interaction is required. The data pathway covers: data entry by clinical and service staff, clinical system configuration for capturing and codifying data, export process from clinical systems, data management within data warehouse (or through manual intervention), rules and categorisations applied to support reporting, the presentation of reporting outputs, and the process for validating these outputs.
2. Develop standard operating procedures (SOPs) for each stage of the data recording process, and ensure these are kept up to date.
3. Develop reporting tools or method of measuring incomplete data fields to feed back into the organisation, and support training.
4. Use the Spine as the definitive reference source of identifying deaths, and update this information on a weekly basis.

Reporting – relates to the process of producing internal and external reports, dashboards, and related documentation.

5. Agree a standardised reporting structure for board reports, to include thematic analysis and consistent presentations of figures, axis and scales. Clearly define the Trust's methodology for mortality recording and reporting within board reports. Any changes should be clearly documented and the impact upon historically reported figures should be described to provide continuity.
6. Align the internal dashboard with external reporting to ensure that volumes on the internal dashboard clearly reconcile to numbers within board reports.
7. Work with public health and, when in post, medical examiner to identify key themes in the data and implement timely targeted interventions.
8. Use clinical input to update the cause of death groupings which are presented as part of the dashboard, and used in board reports, so that it is clear where the Trust is awaiting data (pending), or the Trust feels this data will not be accessible or will remain unknown.

Clinical engagement - the process of engaging with clinical service staff in the use and production of mortality data

9. Establish a process of validation and use of mortality reporting and analysis at service level, aligned to corporate reporting.
10. Review the process of retaining patients on caseloads, and subsequent discharge from caseloads, to ensure it results in consistent data across the services.
11. Create supporting training programme for all staff who input data into systems that have an impact upon mortality data. Ensure that the implications and impacts of incorrect or incomplete data entry are understood by staff.

Partnership working - whilst we are recommending that the Trust takes the lead in partnership working outlined in the two recommendations below, the Trust will need support from the ICB and its partner organisations to facilitate this joint working and knowledge sharing.

12. Establish links with primary care networks to explore opportunities to improve the completeness of the Trust's mortality data (including cause of death), supported and enabled by the ICB.
13. Explore opportunities for formal data sharing agreements between the Trust and primary and secondary care in the region.

Governance - the oversight and controls over mortality data production and reporting

14. Update the Trust's Learning from Deaths policy to ensure the Trust's governance addresses the issues in this report and explicitly references community deaths. Ensure the governance in relation to all mortality is clearly understood by clinical and corporate staff involved in the production and reporting of mortality information.
15. Establish a clear improvement plan to address the issues identified in this report, and report progress to a board committee.
16. Introduce a process of assurance over mortality reporting:
    - Introduce a clear audit trail and series of checks to ensure adherence with SOPs, and report outcomes to executive leads on a regular basis
    - Introduce or commission patient level data reviews to provide assurance over the accuracy of data recording.
    - Link to the clinical validation process established under recommendation 9

NSFT action plan (1 of 7)

As part of this review the Trust has completed an action plan describing how it is going to address the recommendations. This has been included on the following pages.

	Recommendation	Priority	Management responsibility	Proposed actions	Timeframe
			Data		
1	Improve the mortality data pathway to automate and digitise the production of mortality reporting, removing manual processes for transferring and transforming the data, and introducing an audit trail where user interaction is required. The data pathway covers: data entry by clinical and service staff, clinical system configuration for capturing and codifying data, export process from clinical systems, data management within data warehouse (or through manual intervention), rules and categorisations applied to support reporting, the presentation of reporting outputs, and the process for validating these outputs.	High	**Executive Lead** Chief Finance Officer (SIRO) **Lead for Delivery** Chief Digital Officer	1.Seagry consultancy and NSFT to review the technology, solutions and processes used to capture, collate and report mortality data. Interoperability, system upgrade requirement as and when required should be included as part of this review. 2. Seagry Consultancy will produce a list of actions with assigned owners to support improvement, processes and tools to assist NSFT in mortality reporting. 3. A single overarching Standard Operating Procedure (SOP) will be implemented following this work. This will include the formal change management process required when reporting requirements change. The SOP will include inputting of data, extracting of data, validating of data and reporting of data within a given timeframe. 4. An audit trail will be incorporated into the process as described in action 1.	3 months – August 2023
2	Develop standard operating procedures (SOPs) for each stage of the data recording process, and ensure these are kept up to date.	Medium	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding and Medical Director for Quality	1. An overarching SOP will be developed which will detail each stage of the mortality data pathway. 2. The SOP will include roles and responsibilities within the process. 3. The SOP will describe the formal change management process when mortality reporting requirements change. 4. The Learning from Deaths policy will incorporate the requirements of the SOPs.	6 months – November 2023

NSFT action plan (2 of 7)

Recommendation		Priority	Management responsibility	Proposed actions	Timeframe
3	Develop reporting tools or method of measuring incomplete data fields to feed back into the organisation, and support training.	Medium	**Executive Lead** Chief Finance Officer (SIRO) **Lead for Delivery** Chief Digital Officer	1. Reporting tool to be developed to measure the data fields missing on clinical record system, such as demographics. All Data fields must be made as mandatory as much as technically possible to eliminate missing data and avoid human errors. 2. To be reported and included in the Care Group Quality and Performance metrics and scrutinised in the Trust's Quality and Performance meeting.	6 months – November 2023
4	Use the Spine as the definitive reference source of identifying deaths, and update this information on a weekly basis.	High	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Chief Digital Officer and Director of Nursing, Patient Safety and Safeguarding	1. Develop a system that utilises NHS Spine's automatic update to Lorenzo to reduce the need for manual downloads. 2. This action is included as part of recommendation 1. 3. A weekly report will be generated to validate any reporting of Death to Trust against the Spine. This assurance check will be included as part of SOP.	3 months – August 2023
			Reporting		
5	Agree a standardised reporting structure for board reports, to include thematic analysis and consistent presentations of figures, axis and scales. Clearly define the Trust's methodology for mortality recording and reporting within board reports. Any changes should be clearly documented and the impact upon historically reported figures should be described to provide continuity.	High	**Executive Lead** Chief Nursing Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding and Medical Director for Quality	1. The proposed standardised reporting structure for mortality will be presented through the Committee structure and agreed by the Board. 2. The Learning from Deaths quarterly Board report will include thematic analysis of key metrics such as age, diagnosis, cause of death and deprivation indices.	3 months – August 2023

NSFT action plan (3 of 7)

Recommendation		Priority	Management responsibility	Proposed actions	Timeframe
6	Align the internal dashboard with external reporting to ensure that volumes on the internal dashboard clearly reconcile to numbers within board reports.	High	**Executive Lead** Chief Finance Officer (SIRO) **Leads for Delivery** Chief Digital Officer, Director of Nursing, Patient Safety and Safeguarding and Medical Director for Quality	1. The Trust are working with Seagry Consultancy to agree the Mortality data pathway. Part of this work will include further development of Mortality Dashboard. 2. This will be underpinned by the work completed as part of recommendations 1 and 5. 3. The ability for Care Groups to drill down within the dashboard will be enhanced so they are able to interrogate their and other Care Groups data. 4. The improved dashboard will be supported by the Patient Safety Team and Mortality Team attending Care Group Governance meetings. 5. The newly developed dashboard will be available on the Trust's intranet.	3 months – August 2023
7	Work with public health and, when in post, medical examiner to identify key themes in the data and implement timely targeted interventions.	Medium	**Executive Lead** Chief Medical Officer **Lead for Delivery** Director of Operations (Medical Directorate) and Medical Director of Quality	1.The Norfolk and Waveney ICB have implemented a bi-monthly Learning from Deaths forum. This includes Public Health and Medical Examiners. NSFT are a member of this forum with data shared as part of this meeting. 2. Learning and themes from NSFT Mortality reviews will be shared with the ICB so wider system learning can be considered. 3. Development of Care Group reports and attendance of Mortality Team and Patient Safety Team to local governance meetings to share learning and implement targeted interventions. 4. Within the Learning from Deaths committee, the Mortality team will share local, regional and national data and learning to guide where improvements need to focus. 4. Ensure that NSFT are part of the membership of the Learning from Deaths forum in Suffolk and North East Essex (SNEE) ICB when commenced. 5. NSFT will continue to attend regional and national forums. 6. NSFT to be members of the Norfolk and Waveney ICB LeDeR forum.	6 months – November 2023

NSFT action plan (4 of 7)

Recommendation		Priority	Management responsibility	Proposed actions	Timeframe
8	Use clinical input to update the cause of death groupings which are presented as part of the dashboard, and used in board reports, so that it is clear where the Trust is awaiting data (pending), or the Trust feels this data will not be accessible or will remain unknown.	High	**Executive Lead** Chief Finance Officer (SIRO) and Chief Medical Officer **Leads for Delivery** Chief Digital Officer Director of Nursing, Patient Safety and Safeguarding	1. Review the data collected in the Trust Mortality dashboard to include all patient demographics, cause of death, diagnosis, medication etc.. to enable the drilling down both locally and strategically of key metrics. This will include 2 'unknown' cause of death categorisations 'awaiting cause of death' and cause of death not available'. 2. The Mortality process, criteria and screening will describe this requirement as part of the overarching SOP (Recommendation 2).	3 months – August 2023
Clinical engagement					
9	Establish a process of validation and use of mortality reporting and analysis at service level, aligned to corporate reporting.	High	**Executive Lead** Chief Finance Officer (SIRO) **Leads for Delivery** Chief Digital Officer and Director of Nursing, Patient Safety and Safeguarding and Medical Director of Quality	1. New Mortality Data Pathway as outlined in Recommendations 1, 3, 5 and 6 will detail the process for capturing, collating, validating and reporting mortality data. 2. Care Groups and Trust committees will be able to utilise the revised Mortality dashboard to drill down into individual Care Groups as well as maintain oversight from a Trust perspective. 3. The mortality data will be centrally produced, therefore the data will be consistent from 'Ward to Board'. 4. The dashboard will be available without patient details on the Trust intranet for all staff to review.	3 months – August 2023
10	Review the process of retaining patients on caseloads, and subsequent discharge from caseloads, to ensure it results in consistent data across the services.	Low	**Executive Lead** Chief Operating Officer and Chief Finance Officer (SIRO) **Lead for Delivery** Chief Digital Officer and Deputy Chief Operating Officer	1. The guidance which details the process for administration staff to follow describing the steps to be taken when discharging a patient from the service will be shared with all Business Managers to action. 2. Further guidance will be developed for administration staff as to the process to follow when a person on the team's caseload is found to be deceased. 3. Caseload Reviews should be carried at a minimum 6 monthly with the involvement of Medical, Nursing, Therapies and Local Manager input and should be embedded in local teams' standard practice	9 months – February 2024

NSFT action plan (5 of 7)

Recommendation		Priority	Trust management responsibility	Proposed actions	Timeframe
11	Create supporting training programme for all staff who input data into systems that have an impact upon mortality data. Ensure that the implications and impacts of incorrect or incomplete data entry are understood by staff.	Medium	**Executive Lead** Chief Finance Officer (SIRO) **Leads for Delivery** Chief Digital Officer, Deputy Chief Operating Officer, Medical Director of Quality	1. Implement training programmes focusing on the importance of mortality reporting dependent on the role the member of staff fulfils. 2. To be supported by learning bulletins which highlight the importance of accurate mortality data reporting and how this can assist in improving clinical care.	6 months – November 2023
Partnership working					
12	Establish links with primary care networks to explore opportunities to improve the completeness of the Trust's mortality data (including cause of death), supported and enabled by the ICB.	Medium	**Executive Lead** Director of Strategy and Partnerships **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Medical Director of Quality and Director of Operations- (Medical Directorate)	1. In order to inform the ICB where their assistance can be best be focused, the Trust will complete an audit of the available cause of death data. 2. NSFT will develop a standardised process led by the Mortality Team for contacting GPs, Coroners, Medical Examiners and clinical data systems to obtain the cause of death wherever possible. 3. This recommendation will be shared with the ICBs through the dissemination of this report and to be added as an agenda item on ICB Learning from Deaths Forums where/when in place.	6 months – November 2023
13	Explore opportunities for formal data sharing agreements between the Trust and primary and secondary care in the region.	Medium	**Executive Lead** Chief Finance Officer (SIRO) Chief Nursing Officer **Lead for Delivery** Chief Digital Officer	1. Establish formal data sharing agreements between the Trust, Primary and Secondary care within the region based on agreed parameters and guidance from clinical Leads.	6 months – November 2023

NSFT action plan (6 of 7)

Recommendation		Priority	Management responsibility	Proposed actions	Timeframe
Governance					
14	Update the Trust's Learning from Deaths policy to ensure the Trust's governance addresses the issues in this report and explicitly references community deaths. Ensure the governance in relation to all mortality is clearly understood by clinical and corporate staff involved in the production and reporting of mortality information.	High	**Executive Lead** Chief Nursing Officer and Chief Medical Officer **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Medical Director for Quality and Director of Operations – (Medical Directorate).	1. Following confirmation of the revised mortality data pathway, the Learning from Deaths policy will be reviewed and updated to include the SOP referenced in Recommendation 2. This will include the nationally defined focus of mortality being both community and inpatient deaths. 2. The Learning from Deaths policy will be supported by a 'policy on a page' which will be available to all staff. 3. The circulation of information and learning bulletins 'Learning from Deaths Matters' will be published and disseminated throughout the Trust. 4. This will be supported by learning events.	3 months – August 2023
15	Establish a clear improvement plan to address the issues identified in this report, and report progress to a board committee.	High	**Executive Lead** Chief Nursing Officer and Chief Medical Officer. **Lead for Delivery** Director of Nursing, Patient Safety and Safeguarding, Director of Operations- (Medical Directorate) and Medical Director of Quality	1. The improvement plan will be monitored through the Learning from Deaths and Incidents committee and reported quarterly to the Quality Committee.	3 months – August 2023

NSFT action plan (7 of 7)

Recommendation		Priority	Management responsibility	Proposed actions	Timeframe
16	Introduce a process of assurance over mortality reporting: • Introduce a clear audit trail and series of checks to ensure adherence with SOPs, and report outcomes to executive leads on a regular basis • Introduce or commission patient level data reviews to provide assurance over the accuracy of data recording. • Link to the clinical validation process established under recommendation 9	High	**Executive Lead** Chief Finance Officer (SIRO), Chief Nursing Officer. **Lead for Delivery** Chief Digital Officer, Medical Director for Quality	1. Mortality Data Pathway: an audit process will be developed and implemented every 6 months. The audit will test the comprehensiveness of the mortality data pathway. This will be supported by the weekly Spine data verification as referenced in recommendation 4. 2. External verification will be sought by an external consultancy team who are experienced in data within the NHS. 3. Newly formed mortality team will provide data for board information via the developed clinical review pathway for deaths reported via the Spine as per recommendation 9.	3 months – August 2023

Introduction and approach

Introduction and approach (1 of 3)

Background

Grant Thornton has reviewed the collection, processing and reporting of mortality data at Norfolk and Suffolk NHS Foundation Trust (NSFT) at the request of the Trust, NHS Norfolk and Waveney Integrated Care Board (ICB) and Suffolk and North East Essex ICB.

The Trust requested independent assurance over its mortality recording and reporting following public and regulatory concern over the reliability and accuracy of reported data. There is concern locally around the clarity of mortality data and the ability to monitor reporting and recording.

Structure of the report

In this section of the report we outline the methodology and approach followed by Grant Thornton along with the stated aims for this piece of work.

The main report that follows this introduction is listed and outlined below. Apart from the background and approach all sections culminate with clear recommendations for improvement, which link back to those presented in the executive summary.

1. Mortality reporting methodology: Summary of the current national mortality guidance, the methodology chosen by the Trust to record and report its mortality data and the comparison of this to other mental health trusts.
2. Processes: The detail of how the Trust enacts its methodology into a process and the challenges this presents them with. Data provided by the Trust has been analysed by Grant Thornton to provide evidence for the impact of the process challenges.
3. Clinical engagement: summary of the evidence provided by the Trust to Grant Thornton of clinical involvement in data interrogation and the evidence of data informing clinical practice in the Trust.
4. Governance: overview of the current and expected governance arrangements to provide guidance and clarity to the current mortality reporting and recording process.

National context

Nationally collected data shows the importance of understanding mortality within mental health. Public Health England's report[1] noted:

- It was estimated that for people with severe mental illness, 2 in 3 deaths were due to physical illness such as cardiovascular disease (CVD)
- Premature mortality is higher for people with severe mental illness (SMI)

Across the country there is geographical variation in mental health mortality. The NHS's mental health taskforce recommended more work to ensure the physical health needs of those living with severe mental illness were met [2].

National guidelines over mortality reporting for mental health trusts are not as clear and prescriptive as those in place for acute trusts, and we know from our work with other mental health trusts and national organisations that there are issues with the depth, consistency and relevance of clinical data. Improving the quality of mental health data was noted in the Mental Health Long Term Plan[3], highlighting a gap between physical and mental health data.

Aims and objectives of the review

The aim of the project was to provide the Trust and the ICBs with a view on the accuracy and effectiveness of processes related to the collection, processing and reporting of mortality data at NSFT. To do this, the following objectives were agreed jointly by the Trust and ICB:

- Establish the methodology for mortality data collection, processing and reporting at the Trust, including which patients are deemed to be under the Trust's care
- Understand whether the data reported accurately reflects the expected methodology
- Compare the established methodology with national guidance and practice at other organisations to understand whether the Trust is reporting in line with national expectations
- Benchmark the Trust's reported data against data from other organisations
- Provide clear expectations for the reported mortality position and make recommendations for improvement.

1. Public Health England: Health matters: reducing health inequalities in mental illness
2. The Five Year Forward View for Mental Health (england.nhs.uk)
3. NHS Mental Health Implementation Plan 2019/20-2023-24 (longtermplan.nhs.uk)
4. Office for Health Improvement and Disparities. Premature mortality in adults with severe mental illness (SMI) published 7 April 2022

Definitions [4]: *Premature mortality rate in adults with SMI* – the number of people with SMI who die under the age of 75 per 100,000 calculated for a three year period. *Excess under 75 mortality rate in adults with SMI* – the difference in premature mortality rate between people with SMI and those without SMI, calculated for a 3 year period.

Introduction and approach (2 of 3)

Our approach

We used an established method for reviewing data processes and controls. We undertook the following activities to develop a clear understanding of the processes related to mortality data production, management and reporting at the Trust.

1. Benchmarking and document review
   a) Review of national guidance
   b) Review of peer guidance / publicly available policies around mortality reporting
   c) Review of NSFT policies and guidelines associated with the mortality recording process
2. Stakeholder interviews (a full list is in the appendix of this document)
   a) Discussing processes managed
   b) Issues / blockers to completing tasks
   c) Identify further supporting documentation associated with these tasks (including training)
   d) Validation or audit processes in place
3. Data analysis
   a) Compare data to Trust's methodology and see if this was followed
   b) Compare analysed data to Trust reported data; understand any variance
   c) Explore themes within the data which may help the Trust to improve reporting and learning going forwards

In following this approach we reviewed the Trust's processes across the mortality data pathway, from data entry to reporting outputs. The steps of the data pathway we reviewed are outlined below:

Step in data pathway	Areas reviewed
Input	• Documentation and Standard Operating Procedures (SOPs) • Training and support • Data entry by clinical and service staff
Systems	• Clinical systems and connectivity • Information captured outside of clinical systems • Documentation of processes and business rules • Links and integration with national systems
Data management	• System output definitions • Database definition and management
Reporting	• Rules applied to reporting outputs • Consistency of local and national reporting • Availability of reporting to service staff • Access to and relevance of benchmarking
Service engagement	• Clinical ownership of data • Use of information and reports by services • Process for data quality improvement
Governance	• Internal and external assurance over clinical data entry • Senior oversight of national submissions • Board reporting on clinical data quality • Effective change control and accountability for data quality

Following this approach allowed us to establish the Trust's current position and compare this to national guidance. Where areas of variance between Trust methodology and data exist we have worked to understand these and have collated this information to form an agreed set of recommendations for improvement.

Introduction and approach (3 of 3)

Glossary of terms

Term	Definition
Care Review Tool	A tool developed by the Royal College of Psychiatrists based on the structured judgement review tool
Datix	A healthcare incident recording system used by the Trust
Death by natural causes	The term used by a coroner when a death is as the result of the normal progression of natural illness, with or without significant intervention. This is not a separate category reported on by the Trust in its dashboard (‘*natural cause – specific non available’* is used and includes unknown information) but natural cause is referred to in Trust bord reports.
Death certificate (also known as medical certificate of cause of death)	An official document, signed by a doctor, which records when and where a patient died and the cause of death. This contains two parts for the cause of death. Part 1 lists diseases or conditions leading directly to death, or the other conditions mentioned in part 1. Part 2 lists other conditions which contributed to death but not related to the disease of condition causing it.
Expected death	As defined by the Trust, a death caused by a pre-existing life-limiting condition or if the person’s age and frailty made death from a natural cause a reasonable expectation at the time of their death
Integrated care board	A statutory NHS organisation responsible for developing a plan for meeting the health needs of the local population and managing the NHS budget and services of an area.
Lorenzo	An electronic patient record system used by the Trust
Mortality	The term mortality is used in medicine as a term for death rate, or the number of deaths in a certain group in a certain period of time.
NHS Spine	The NHS Spine allows information to be shared securely through national services
Patient safety incident	Term used by NHS England to describe unintended or unexpected incidents which could, or did, lead to harm for patient(s) receiving healthcare.
Serious incident	Defined in broad terms by NHS England as an event in health care where the potential for learning is so great, or the consequences so significant, that they warrant using additional resources to mount a comprehensive response. Their occurrence demonstrates weaknesses in a system or process which need to be addresses to prevent future harm.
Statistical process control (SPC)	An analytical technique which plots data over time, helping to understand variation and guide appropriate action
Structured Judgement Review	A methodology developed by the Royal College of Physicians for reviewing mortality which is used in the NHS.
Unexpected death	As defined by the Trust, the death of a service user who has NOT been identified as critically ill or death is NOT expected by the clinical team. If there is no known diagnosis of terminal illness or physical health complication meaning that the service user is deemed as approaching end of life or receiving palliative care. Where data or cause of death is unavailable this is defined as unexpected

Main Report

Mortality recording methodology (1 of 4)

Introduction and summary

This section will focus on the national and Trust defined methodology for mortality reporting. The Trust's methodology is then benchmarked against that of other mental health organisations and the impact of regularly changing the methodology discussed.

The Trust's current mortality recording methodology aligns to the nationally expected methodology. Nationally there is a lack of end-to-end guidance on mortality reporting. There are varied definitions for key metrics nationally making comparisons and benchmarking between trusts challenging. The Trust's currently used methodology is in-keeping with other mental health trusts, with both being derived from similar national sources.

In the two years before the COVID-19 pandemic an average of 49 people per month died within six months of contact with NSFT's services. During the COVID-19 pandemic this rose to 70 but by summer 2021 this had returned to 44 [1]. In January 2022 it was reported that on average one person per month died whilst under the care of the Trust's inpatient services [2].

Defining mortality reporting

Mortality recording and reporting encompasses

(a) the definitions which, when applied, impact the number of deaths to be included within the Trust's mortality reporting
(b) the process by which the Trust gathers and processes mortality information and
(c) how this is then fed back into the organisation for interrogation, understanding and learning.

Mortality recording and reporting is distinct from serious incident or patient safety incident reporting, although there may be overlaps where a single case is reported in more than one place. A death which is the result of a serious incident or patient safety incident should be recorded in that data collection and within the Trust's mortality data. Not all deaths are patient safety incidents and not all patient safety incidents are deaths. Unexpected deaths may not reach the criteria for serious incident review. This distinction is important to understand what this report has examined, and what it has not examined. This report is focused only on mortality recording and reporting and not incident recording and reporting.

Available national guidance and analysis

In the absence of complete and detailed national guidance trusts use a combination of the available guidance, supplemented by statements made in national reports, to establish their methodology for mortality reporting. Within their mortality guidance most trusts reference National Quality Board (NQB) guidance along with the 2015 Mazars report commissioned by NHS England[3]. The latter is not national guidance but a nationally commissioned report, the recommendations of which have been adopted variably by mental health trusts.

The NQB published guidance on Learning from Deaths in 2017. NQB guidance outlines that all Trusts should have a policy on how they respond to, and learn from deaths of patients. There are nationally defined processes in place for the reporting and learning from deaths. Information should be collected and published quarterly on deaths under a Trust's care, reviews, investigations and resulting quality improvement. The NQB report was written a number of years ago and has not been replaced by more recent guidance. In the intervening period to now there remains no one single national document which offers a clear framework and supporting terminology for trusts to apply when designing and implementing their mortality recording methodology and processes.

The 2016 CQC Learning, Candour and Accountability national report, which followed the Mazars report, highlighted issues around mortality identification, reporting and reviews across acute, community and mental health providers [4]. These are summarised below:

- Variation in the way organisations become aware of deaths of people in their care.
- Many patients die having received care from multiple providers. There are no clear lines of responsibility for the provider who identifies a death to inform other providers.
- No consistent process or method for NHS trusts to record when recent patients die after they have been discharged from the service.
- Electronic systems do not support the sharing of information between NHS trusts.
- Trust boards receive limited information about deaths of people using their services other than those that have been reported at serious incidents.
- When boards receive information about deaths, board members often do not interrogate or challenge the data effectively.

1. NSFT Board of Directors public session 23rd September 2021
2. NSFT Board of Directors public session 27th January 2022
3. National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundations for identifying, reporting, investigating and Learning from Deaths in Care
4. Care Quality Commission. Learning, candour and accountability. A review of the way NHS trusts review and investigate the deaths of patients in England

Mortality recording methodology (2 of 4)

National mortality terminology guidance

There is no clear single definition of either an expected or unexpected death in national guidance. Some organisations use the Mazars framework (Appendix A) with others wording their own definitions[1]. There is limited guidance, for Mental Health providers, concerning the time period from discharge for which a patient is considered “under a trust’s care”.

The lack of national guidance means key terminologies are defined locally. The exact wording can impact the number of deaths which a trust reports within its mortality statistics. A detailed comparison of locally used terminology is included the appendix. There is variation around the definition of time frames for the deaths included as part of a trust’s mortality reporting.

The Trust’s current mortality recording methodology

The Trust’s methodology for capturing deaths to be included within the Trust’s mortality reporting incorporates the steps outlined below, which are compared to national practice on slide 20:

- Defining the time period of deaths to be included within the Trust’s mortality reporting
- Monthly Spine tracing
- Categorising expected and unexpected mortality.

National Spine tracing

Accessed through clinical systems or via a designated portal the NHS Digital national Spine allows information to be shared securely between health organisations. This includes summary clinical information alongside basic demographics including birth and death notifications to support identifying patients and matching them to their health record.

When a death is notified by a health professional within their local clinical system or via the secure portal, the death notification message is generated by the Spine and then reflected in the Personal Demographics Service (PDS).

If a patient clinical record is held by multiple providers, then the notification will be acknowledged by those providers by either directly accessing the record of that patient or interrogating the Spine using a standard report called a Spine trace query. This report would notify an organisation of all the patients recorded within their clinical system that had a change in their PDS status including a date of death.

Methodology changes

Methodology changes can be positive and sometimes needed. If changes in methodology occur without explanation, rationale or context they can cause confusion for those trying to understand the data within a report. It also hampers the ability to track through reports and historical data over time. This challenge was reflected in the feedback from some stakeholder meetings. When changes are made the new methodology and the expected impact on mortality data should be explained to an appropriate level of detail within publicly facing documents to support those reading the data.

There is no formal documentation regarding the process for changing or amending the methodology of the mortality recording process. The Trust has changed is methodology on several occasions which impacts on the ability to track and compare deaths over time.

- Between October and December 2019 NSFT changed its approach to reporting of the total number of people known to its services who died. Prior to this period, data had only included people whose death was identified by reporting on the internal incident reporting system, Datix[2].
- January 2022 board reports noted that that the Trust had broadened its definition of those who have died to include people whose deaths were not notified to NSFT at the time of their death[3].
- In January 2023 the Trust changed its dashboard recording, from previously comparing unexpected and expected deaths to now using the terms ‘natural’ and ‘unnatural’. It is important that terminology used is consistent with accepted national practice (e.g. expected and unexpected).

As part of this process the Trust has noted rules which have historically been applied to data which they will change going forward. Rules were applied where deceased patients would not appear on the reporting query when a patient record had been accessed by a member of staff post date of death. It was incorrectly presumed that the individual who had accessed the record would be creating the relevant Datix entry and applying the deceased status to the record.

1. National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundations for identifying, reporting, investigating and Learning from Deaths in Care
2. NSFT Paper I, Mortality Report BoD September 2020
3. NSFT Paper G, Mortality and Learning from Deaths. BoD 27th January 2022

Mortality recording methodology (3 of 4)

* The Trust's methodology is defined with the context of national guidance. In some areas the lack of specific national guidance means NSFT use a different definition to other mental health trusts. The potential issues highlighted here are discussed later in the report.

Area	Nationally accepted practice	NSFT practice	Potential issues encountered by the Trust as a result of the Trust's methodology *
NHS Spine trace (Informing source)	No clear national guidance. Most mental health trusts perform Spine traces (as detailed in the previous slide) on a weekly or daily basis.	Monthly trace from the Spine, along with deaths communicated by inpatient and community teams directly to the Trust.	The time lag between time of death and the time that the Trust learns of it will impact on the relevance reports. Data will appear to change between reports because of the time it takes the Trust to learn of a death.
Time period for deaths to be included within the Trust's mortality reporting	Trusts are required to collect and publish on a quarterly basis, at a minimum, total number of inpatient deaths and those that the Trust has subjected to case record review. Acute trusts were advised to include cases of people who died within 30 days of leaving hospital; mental health trusts were advised to consider which categories of patients were within scope for reviews[1]. Most Trusts use patients who died within six months of discharge from caseload in line with the Royal College of Psychiatrists 'Guidance for reviewers'.[4]	All inpatient and community deaths, including those within six months of discharge from the Trust. The Trust have informed Grant Thornton that their Learning from Deaths 2023 policy describes the case record review selection process in line with NQB Learning from Deaths guidance.	The Trust's approach is in line with national practice, however the details of the definition chosen impacts the number of deaths considered to be part of an organisation's mortality statistics. Changing supporting processes or not keeping accurate caseloads also impacts reported numbers.
Expected and unexpected deaths	Guidance from NQB uses the terms expected and unexpected to outline deaths which should be subject to a case review. All trusts reviewed in our benchmarking exercise split their mortality reporting between expected and unexpected[1], although some broke this down further to use the terminology natural and unnatural. The NHSE Better Tomorrow team reported they would recommend expected and unexpected to be used.	*Expected* - if it was caused by a pre-existing life-limiting condition or if the person's age and frailty made death from a natural cause a reasonable expectation at the time of their death [2]. *Unexpected* - 'The death of a service user who has not been identified as critically ill or death is not expected by the clinical team. If there is no known diagnosis of terminal illness or physical health complication meaning that the service user is deemed as approaching end of life or receiving palliative care. Where data or cause of death is unavailable this is defined as unexpected [3].	Whilst the Trust's approach is broadly in line with national practice there are issues with the process of identifying expected and unexpected deaths which are detailed later in this report. There is a risk of inconsistent implementation without clear decision-making supporting documentation and clinical input.

1. National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundations for identifying, reporting, investigating and Learning from Deaths in Care
2. NSFT Mortality and Learning from Deaths Report, Jan 2022
3. NSFT Unexpected and Sudden Deaths (in-patient areas only' policy, ref no. Q11a, version 06.1
4. Royal College of Psychiatrists: Using the Care Review Tool for mortality reviews in Mental Health Trusts

Mortality recording methodology (4 of 4)

Methodology benchmarking

To benchmark how the Trust has interpreted the available national methodology, we have reviewed the NSFT approach against other mental health trusts. To achieve this, Grant Thornton reviewed the comparator trusts publicly available mortality policies. It has not reviewed their deployment or the adherence to them.

Other mental health trusts follow a similar methodology to that employed by NSFT, with trusts accessing data from within their organisation, the Spine and collating this on an incident management system. The exact processes which underpin this overarching methodology differ between organisations.

Trusts vary as to how frequently they access the NHS Spine with most employing a daily or weekly trace. Some comparator trusts are more advanced than NSFT at linking GP and public health information into their mortality methodology.

The majority of mental health trusts including NSFT count deaths within their organisation mortality data if they are an active patient or occur within six months of discharge. In some cases this is broken into more detail and is reflected in full in the Appendix. Whilst some other organisations have further stratified their reporting rules based on cause of death, six months is the common standard. Due to issues outlined later in this report relating to understanding cause of death for community patients, the Trust would potentially be unable to implement a more sophisticated attribution method using the data available.

Mental health trusts have different wording for what is an expected or unexpected death. Of the trusts' methodologies reviewed most broke down deaths into expected and unexpected, although some chose to break these categories down further. Our experience is that Better Tomorrow recommend the terms 'expected' and 'unexpected' to be referenced in board and external facing reports. This varied wording means trusts do not have comparable categories so benchmarking expected to unexpected deaths nationally is a challenge.

Some trusts choose to break down expected and unexpected deaths into further categories in accordance with the Mazars framework, detailed in Appendix A. This includes subcategories referring to natural and unnatural below the umbrella expected and unexpected terms. A comparison between the Trust's mortality terminology and that of other mental health organisations is included in the appendix of this report. There was no evidence of a Trust using just natural and unnatural as definitions.

Conclusion and areas for improvement

The mortality recording methodology used by the Trust adheres to the principles set out in the available national documentation and follows a similar interpretation to other mental health trusts. Nationally there are mortality data challenges, so the Trust does not have the ability to solve all of the current issues alone.

Monthly Spine tracing results in a lack of contemporaneous information and in this area the Trust is different to other organisations who do this more frequently.

Some parts of the Trust's methodology are prone to individual interpretation. Implementing a continuing training programme for relevant staff to ensure the recording process is consistent and efficient would reduce the risk of variation due to individual interpretation and support staff making decisions on reportable data points.

Recommendations (mapped in detail in Action Plan at the start of this report)

	Recommendation	Priority
4	Use the Spine as the definitive reference source of identifying deaths and update this information on a weekly basis.*	High
5	Agree a standardised reporting structure for board reports, to include thematic analysis and consistent presentations of figures, axis and scales. Clearly define the Trust's methodology for mortality recording and reporting within board reports. Changes should be clearly documented and the impact upon historically reported figures should be described to provide continuity.	High
11	Create supporting training programme for all staff who input data into systems that have an impact upon mortality data. Ensure that the implications and impacts of incorrect or incomplete data entry are understood by staff.	Medium

* The Spine should not be the only source of mortality information but should be the definitive reference source and be accessed in a timely manner.

Processes (1 of 6)

Introduction and summary

This section comments on how the Trust puts into action its methodology. It reviews the documentation, processes and categorisation which make up the mortality recording and reporting pathway.

The Trust currently applies its mortality methodology through processes which involve multiple steps supported by different teams or identified individuals. Some of these individual steps have well-documented procedures, but the end-to-end mortality recording process has no overarching supporting documentation.

There are a number of systems involved in the overall recording process. This should be clearly documented and undertaken in a structured and controlled manner. Where possible this should also be automated and the reliance on individual manual inputs should be removed or mitigated as this can corrupt the final output of the Trust's mortality reporting and provide incorrect data.

Multiple systems are used for the recording of deaths at the Trust, with an individual Excel sheet used between clinical systems. The end-to-end process of mortality recording is undocumented with a lack of clear rules underpinning the recording pathway. This creates points of risk with limited assurance over the whole pathway.

The Trust uses Lorenzo as its main clinical system, but SystmOne and IAPTUS are used by certain services within the organisation. Patients who have records on these systems may also have a Lorenzo record, this is dependent upon which other services they may be registered to within the Trust. Grant Thornton have not seen clear documentation of the process for death notifications in these systems and how it links to the Trust mortality reporting. The exception to this is that we have sighted an SOP for recording a death of a service user within Lorenzo.

The recording process culminates in information stored in the NSFT Mortality dashboard, which informs internal and board reports. This dashboard contains basis demographic information, although this is not aligned to the cause of death.

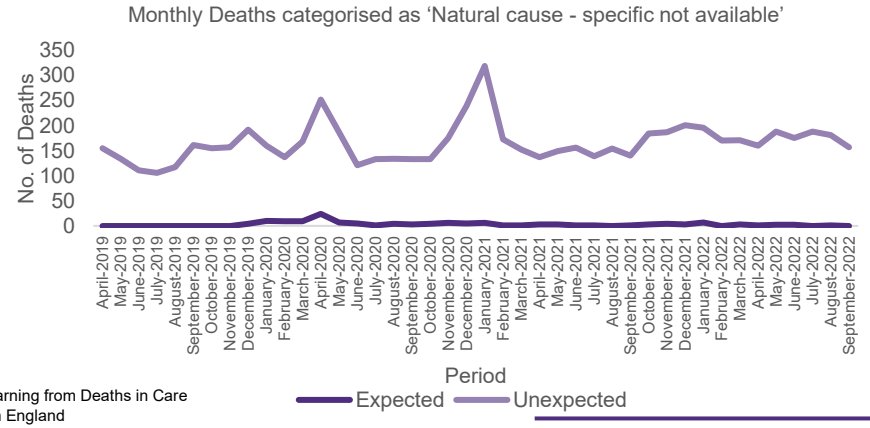
The various processes and the challenges these present are summarised on the next page.

Mortality recording documentation

Similarly to the lack of national documentation the Trust lacks documentation of the end-to end process of mortality recording. A lack of standard operating procedure covering the entire process of mortality recording results in inconsistency of data capture and input into clinical systems. Areas where detailed documentation is absent, but expected, are listed below:

- Grouping of cause of death, which appears on the Trust dashboard
- Categorisation of expected and unexpected deaths and the role undertaken by the patient safety team when reviewing Datix entries
- End-to-end mortality recording pathway
- Process for methodology changes and amendments
- No mortality specific guidance for staff completing Datix forms having been informed of a death
- No clear guidance for review decisions made by patient safety team following Datix review.

Figure 1 showing monthly unexpected and expected 'Natural cause specific non available' death totals from Datix, Lorenzo and the NSFT Dashboard from April 2019 to September 2022



1. National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundations for identifying, reporting, investigating and Learning from Deaths in Care
2. Care Quality Commission. Learning, candour and accountability. A review of the way NHS trusts review and investigate the deaths of patients in England

Processes (2 of 6)

Mortality recording process step	Associated challenges and risks
Death is reported from inpatient unit, community team or monthly patient master index tracing against Spine. Deaths notified by inpatient or community team are recorded to the main Trust electronic patient record (EPR), Lorenzo.	• Monthly tracing limits simultaneous mortality data availability within the Trust resulting in reported data changing over time as the Trust becomes informed of a death. • Grant Thornton saw no evidence of a mandated timescale for recording of deaths within the Trust. The Trust have informed Grant Thornton that this is included as part of the Leaning from Deaths 2023 policy. • Multiple data sources (including Lorenzo, Iaptus, SystmOne and Datix) risk inconsistencies and potential to cause differentials as the process undertaken may vary depending on how the Trust is informed of a death. • Access rights to record deaths on Lorenzo are limited to system administrator, meaning individuals within teams cannot change the death status. There has been misunderstanding within the Trust historically that the death status had been changed within Lorenzo when users accessed a record post date of death, when it had not actually been done.
Information from Lorenzo extracted for review in a spreadsheet	• The use of excel to store and process sensitive information is minimised with audit and security policies appropriately applied where this is necessary. • Extracting data from the clinical system loses audit trail and case/effect within that system.
For notified deaths an entry should be made into Datix (Trust risk management system) by the member of staff receiving the notification of death.	• Reliance on a variety of members of staff to be aware of the need to perform this task and do so in a timely manner. • Potential for individual interpretation when completing Datix without clear mortality specific supporting guidance within the Trust. The Trust could further work on supporting staff completing Datix forms to ensure only relevant information is collected and avoiding duplication with information already within Trust clinical systems.
Datix reviewed by patient safety team to determine next steps regarding reviews and investigation.	• Isolated input in pathway. Lack of involvement at other steps adds to the limited oversight of the pathway and is an example of siloed steps in the overall pathway.
Deaths categorised into unexpected or expected. Categorised based on cause of death and basic age information held within a locally stored excel workbook.	• Patient details held outside of core Trust clinical systems require suitable audit and security policies to be applied.
Death certificate information used to group deaths into cause of death seen on dashboard.	• Process reliant on individuals meaning it is susceptible to inconsistency and it is unclear how continuity remains when key individuals are away. • Bulk of deaths informed via the NHS Spine, where cause of death information is not always available. There is a reliance on individuals to chase the detail associated with these deaths, such as the cause of death, from other parts of the healthcare system, including GPs. This is a nationally recognised challenge for mental health trusts and improvement in the Trust's data for community deaths will require partnership working.
Excel workbook informs Trust's mortality dashboard, from where corporate reports are generated.	• The use of excel outside of core clinical systems is minimised with audit and security policies appropriately applied • Across the whole pathway responsibility is dispersed across a number of staff groups/individuals for the various processes • The final dashboard appears to under-report deaths when compared to Lorenzo and Datix figures (detailed on page 26).

Processes (3 of 6)

Data categorisation

Within the current recording processes there are steps which require categorisation, or grouping, of data. These key decisions are needed in order to inform the final dashboard and reportable figures. This adds value in supporting the Trust to review areas of potential focus. There is no documentation associated with this process which thus relies on individuals to make reliable and replicable judgments. At points this categorisation is done by an individual with no clinical oversight for input or support.

One of the key points of categorisation is expected and unexpected deaths; this delineation is reported regularly in board reports and published externally. Accurately and reliably sorting deaths into these two categories is key, which currently relies on an undocumented judgement processes.

Causes of death, measured per month, make up the main rows of the expected and unexpected screens of the Trust's mortality dashboard. This information is taken from a patient's death certificate and then categorised into the groups displayed on the mortality dashboard. Where available this is taken from the part 1c of the death certificate, followed by 1b with 1a used if neither 1b or 1c are completed. The process of using death certificate information to inform decision making around the groupings which appear on the dashboard is not supported with clinical input or SOPs. There is inconsistent understanding across the organisation as to how cause of death information is grouped.

The Trust's mortality dashboard uses a number of catch all terms which are not defined within its reporting. These terms, described below, lack clarity for those not closely associated with the recording process.

- *Natural cause - specific not available* – Records where a death certificate is not available.
- *Specific not available* – A legacy term which should not be on the dashboard as a separate item and has been replaced by '*natural cause – specific not available*'.
- *Unascertained* – A term only used by the Trust when this has been a coroner's verdict.
- *Unspecified effects of external causes* – This has been used in the past to cover a 1a cause of death of multiple fatal injuries after jumping from a height.

The term '*Natural cause - specific non available*' accounts for 77% of the total deaths analysed in the given period. Figure 1 on slide 22 shows the deaths categorised as '*natural cause specific - non available'* in the expected and unexpected groups over the months from April 2019.

The large proportion of deaths categorised as '*Natural causes – specific non available'* poses a challenge for the Trust in understanding the deaths to be included within the Trust's mortality reporting, and then using this information to implement meaningful learning. Where the Trust has done what it can to access a cause of death, but this information is not available, it may be clearer to use terminology such as 'unknown to the Trust'.

Pending cause of death

Pending cause of death was recorded 315 times across the time period examined by Grant Thornton, 44 of these are in cases of expected deaths and 271 in cases of unexpected deaths.

The majority of these pending cause deaths are in 2022, when 189 are recorded. This reflects the Trust's reported methodology that this term is used when a death is being further investigated, for example by the coroner, and once the cause of death is confirmed this should be updated on Trust records. However, there are still five records which remain under this category from 2019 and a further 12 in 2020.

As the numbers within this category are highest in recent years, this suggests updates are happening when information is passed on to the Trust. The ongoing attribution of some deaths as far back as 2019 to 'pending cause of death' may represent several factors:

- Trust may not be updating all records when causes of death are given. This could be because of difficulties in finding out this information or because the Trust is not checking back on cases it should be updating.
- Mortality investigations, like those through coroners' court, can take a long time, so information may not be available for months or even years after a death.

Processes (4 of 6)

There are challenges in accessing information on cause of death, especially if the death was reported via the NHS Spine. Ascertaining information on cause of death in these situations involves contacting the GP practice: sometimes information is unavailable and on other occasions there are barriers to sharing the information. Grant Thornton's experience is that the medical examiner role, recommended by the NHS England's Better Tomorrow team as part of good practice, should help the Trust to create links into GPs and other organisations to improve access to more information on the cause of death. Improving the quantity of data collected for cause of death will rely not just on the Trust but partnership working across providers in the system.

The lack of this information also demonstrates the need for the Trust to collaborate with other primary and secondary care organisations in the region to ensure that the whole system is learning and improving together and not in silo. Doing this effectively may mean rethinking and improving current pathways and processes.

NULL data fields

Missing data fields, or 'NULL' fields were prevalent across the data. The number of null fields in the data set for each year is shown in the graph on the right. Whilst the 2022 total is only 11,733, compared to 15,316 in 2021, the data for 2022 only covers nine months of the year.

Analysis performed across the 'NULL' fields showed these are particularly prevalent across certain categories including 'Local Specialty' and 'site' fields. There was also a large number of NULL field entries for ward names. For many patients, who were not inpatients at the time of their death, they will not have had an inpatient ward, but in leaving fields blank the data lacks reliability when analysed as a set. Using 'n/a' when a field is not applicable to the patient in question would help distinguish a non-applicable field from a missing data.

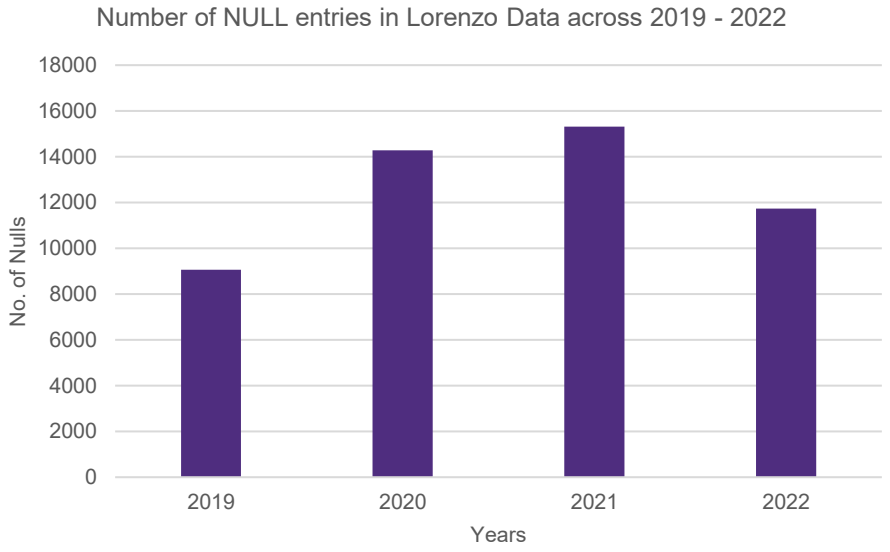
Some data fields were consistently well filled in over time. These include:

- Date of last seen appointment
- Team name
- Registered GP practice.

Lacking a fully comprehensive view of the data limits what Grant Thornton can conclude from the information provided. For the Trust, who use this same data to draw their own conclusions on mortality, the gaps in inputs significantly limit the trustworthy conclusions which can be made. Incomplete and missing fields in data limit the identification of outliers and the opportunity to target tailored interventions in the right areas.

Work to improve this may involve educating staff on what should be input into each field and enhancing staff understanding on why this information is so important. For other areas the Trust may need to consider which fields are necessary, both 'site' and 'local specialty' have two entries within Lorenzo which could cause confusion to individuals completing forms.

Figure 2 showing the total number of NULL entries in Lorenzo between 2019-2022



Processes (5 of 6)

Data gaps between systems

Grant Thornton reviewed data from DATIX, Lorenzo and the Trust's mortality dashboard covering April 2019 to October 2022. The three sources did not all cover the totality of this time period.

The data received was quality checked before analysis commenced, and it was found that the pseudonymised patient IDs were missing from both sets. IDs were mapped against both data sets to illustrate which patients were recorded on both systems and highlight the missing patients across the data. There were found to be 65 missing IDs in Datix, only three of these are attributable to the extra month of data received for Datix data. There were 324 missing IDs in Lorenzo (noting that one ID in Datix was 'Unknown' and 122 were missing/blank IDs). The disparity in data reflects the inconsistencies in recording and this difference in numbers could be deaths from other discrete peripheral clinical systems (IAPTUS, SystmOne) or deaths that occurred where incorrect reporting rules had been applied to exclude patients whose records had been accessed post death notification date.

Datix data had 259 records more than that of Lorenzo. Clinical systems other than Lorenzo are used for certain patient cohorts. These patients would have a Datix raised on death but may never have had an entry on the Lorenzo system. Without examining the other clinical systems (SystmOne and IAPTUS) we cannot be certain whether this is explains the discrepancy regarding the Datix records which do not have a corresponding Lorenzo record.

A significant number of NULL entry data fields were noted throughout the data from both systems and this is discussed later in this report. The initial quality check on the data also noted that local specialty fields in Lorenzo were included twice.

Table 1 showing Lorenzo and Datix pseudonymised ID records received by Grant Thornton from the Trust covering April 2019 to October 2022

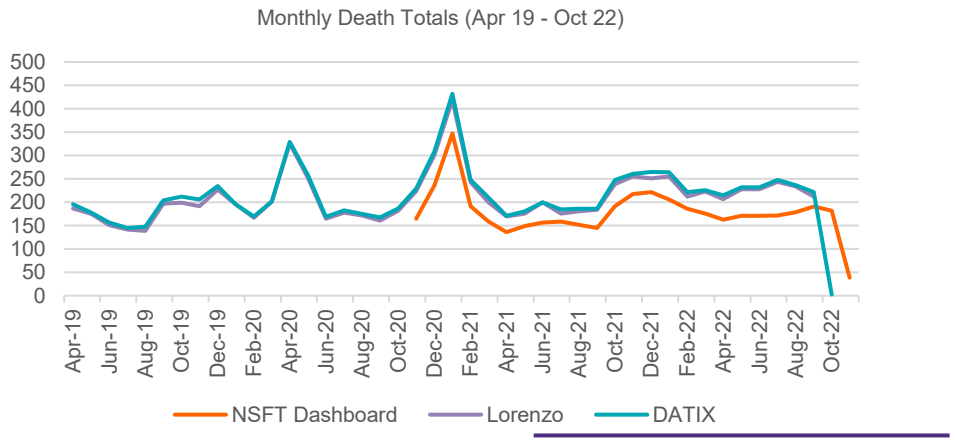
	Lorenzo	Datix
Number of Patient ID records received	8871	9130
Number of records also present in comparator source (Lorenzo for Datix and Datix for Lorenzo)	8806	8806
Number of records not represented in comparator source	65	324

Comparison of sources

The methodology and implementation of current mortality recording processes result in a discrepancy between deaths recorded on Lorenzo and Datix and those which appear in the Trust's mortality dashboard, as shown in figure 3. Following the review, the Trust described a process of validation. Included in that process were additional steps to clarify the six-month standard and a further review of those activities recorded as appointments that were indirect or non face-to-face administrative activities. At the point of review, the process around these validation steps was not available so we have been unable to provide assurance over this. The data field used for the analysis below was 'Date of last seen appointment' and within the data one patient had a discharge date that was beyond the six-month time period.

Grant Thornton has only seen a visual of the dashboard so we have been unable to explore the reasons behind the differential here nor identify which patients are not being represented within the dashboard. The Trust informed Grant Thornton that their informatics team found extra information as part of this review process, this is not included in the graph below and we are unable to quantify the gap between the NSFT dashboard and Datix/Lorenzo that this information may represent.

Figure 3 comparing monthly death totals from Datix, Lorenzo and the NSFT Dashboard from April 2019 to October 2022



Processes (6 of 6)

Conclusion and areas for improvement

In implementing its mortality recording methodology the Trust uses multiple systems that have the potential to result in differences between sources of data. Within its mortality pathway processes, the Trust exhibits deficiencies which limit the potential to provide assurance over the pathway, and thus the accuracy and integrity of the mortality data reported from it. The current process is subject to human error and individual interpretation, with the lack of documentation around these failing to give the process clarity.

For the data recording process, the reliability and trust in the data reported by the Trust, would be improved by reducing the number of manual interventions of recording and reporting, thereby minimising the risk associated with the use of multiple systems and by improving the quality of data outputs and increasing audit capabilities.

Developing documented processes including SOPs for all areas of mortality data captured across clinical systems would help to ensure reliability in key areas of the mortality recording process.

The multiple issues identified with the Trust's processes have resulted in the inconsistency in data reported from different sources. These need to be addressed to ensure there is consistency and clarity in the numbers reported internally and externally.

Incomplete or missing data fields can pose accuracy and reliability issues within the data presented by the Trust. Further clinical engagement is needed to help improve the quality of data inputted into clinical systems and reduce the number of incomplete or missing fields. Increased engagement with other healthcare providers in the area would help to minimise the gaps around cause of death information which limit the conclusions which can be reached from the current data set, especially with regard to community data. The Trust will need support from the ICB in achieving this. Documented processes with clinical support are needed to ensure categorisation and grouping is replicable and aligns to clinical interpretation.

Recommendations (mapped in detail in Action Plan at the start of this report)

	Recommendation	Priority
1	Improve the mortality data pathway to automate and digitise the production of mortality reporting, removing manual processes for transferring and transforming the data, and introducing an audit trail where user interaction is required. The data pathway covers: data entry by clinical and service staff, clinical system configuration for capturing and codifying data, export process from clinical systems, data management within data warehouse (or through manual intervention), rules and categorisations applied to support reporting, the presentation of reporting outputs, and the process for validating these outputs.	High
2	Develop standard operating procedures (SOPs) for each stage of the data recording process, and ensure these are kept up to date.	Medium
3	Develop reporting tools or method of measuring incomplete data fields to feed back into the organisation, and support training.	Medium
4	Use the Spine as the definitive reference source of identifying deaths and update this information on a weekly basis.*	High

* The Spine should not be the only source of mortality information but should be the definitive source and be accessed on a timely manner.

Reporting (1 of 5)

Introduction and summary

This section contains discussion on the Trust's national data submissions, how it presents and evidences interrogation of mortality data within its reports, and analysis of figures presented in board reports compared to data received by Grant Thornton.

The Trust reports mortality data through board, annual and internal committee reports as well as using their data as part of national submissions. Reports vary in both graphical presentation of data and the actual data included over time. This makes it hard to track information and trends over time. Frequent presentation and methodology changes also limited the assurance which can be given over the accuracy of reporting.

Board reports reviewed as part of this report contain minimal evidence of interrogation of data to investigate peaks in mortality or understand areas of interest in the wider data. Board papers make broad, generalised statements to explain peaks in data, but these are not supported within those board papers by analysis of the Trust's data. The Trust does not consistently present the information referred to in its Learning from Deaths guidance. Reports contain more detailed discussions of inpatient deaths and patient safety incidents with limited evidence of community mortality being explored using the data, or the wider learning which may come from these being explored.

Internally, whilst there is a documented line for reporting through sub-committees into the board, members of staff interviewed by Grant Thornton reflected that they felt processes were not clear. Members of staff involved in the mortality reporting process described challenges around the mortality process feeling disjointed with feedback that clinicians could readily access the information they desired to support them. Mortality information is discussed or presented within a number of different forums across the Trust including, but not limited to:

- Trust board
- PSI annual report
- Safety and Mortality Committee (Patient Safety Review Group was renamed the Safety and Mortality Committee in September 2022)
- Quality Committee
- Audit and Risk Committee.

Board reports data presentation and evidence of interrogation

Mortality reporting is presented inconsistently between reports with no clear explanations behind the rationale of changes, or their anticipated impact. There is a lack of detail and thematic analysis within reports which fails to show a level of mortality data interrogation needed to learn wider lessons, especially in regard to community deaths included within the Trust's mortality reporting.

Over the last two years mortality is discussed every four months at board level, with papers included in the supporting papers on most of these occasions. In the Appendix of this document is a series of graphs taken from Trust board papers over time exhibiting the changing presentation style and the subsequent challenge to track through board reports. The inconsistency between these is summarised in the table on the next page, but includes changes in axis, data points and the way the graphs are drawn using different styles and colours. The time periods discussed in board reports varies. In some cases, reports discuss total figures over the past 2 years and in others they refer to monthly averages.

Reporting (2 of 5)

Throughout 2021 data is reported as 'all cause mortality', but in January 2022 the data is split into inpatient and community deaths. The numbers of deaths in the subsequent community graph is higher than the previously presented 'all cause mortality graphs'. At this time, the Trust broadened their definition of those who have died to include people whose deaths were not notified to NSFT at the time of their death. The precise impact of this change is unclear. The graphs presented in January 2022 also contain gaps on the graph, which board papers comment are due to the methodology change, these gaps are not present in earlier or subsequent graphs.

The Trust takes its guidance for what to include in board reports from the NQB Learning from Deaths framework, this is included in the Trust's Learning from Deaths policy[7]. Both documents focus on the collection and reporting of inpatient deaths and deaths subject to a review. Consequently, the Trust does not have guidance in its internal Learning from Deaths policy on the level of detail which should be presented to the board for the reporting of community mortality. On a wider note, regarding data in board reports, in line with NHS Digital best practice recommendations, the Trust has moved to using SPC charts in its Integrated Quality and Performance Reports. SPC is included in serious incident graphs, but not in reporting of all mortality.

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Board report	Coverage	Data presented within graphs in board report	Presentation
January 2021 [1]	Monthly mortality 2018-2020	All cause mortality	SPC RAG colouring of upper and lower limits No data point markers or clear link to time on x axis
May 2021 [2]	April 2018 – February 2021	All cause mortality	SPC Colour of confidence interval and average lines changed Data points clearly link to months on x axis
September 2021 [3]	December 2019 – July 2021	All cause mortality	SPC Similar to that presented in May 2021
January 2022 [4]	December 2019 – October 2021	Split into inpatient and community reporting. No all cause presentation. Missing data in graph	SPC for community; Run chart for inpatient Data points marked but not clearly linked to corresponding months
May 2022 [5]	April 2020 – November 2021	Expected or physical cause mortality and unexpected or patient safety incident mortality	SPC Data points marked but not clearly linked to corresponding months
September 2022 [6]	Brief discussion of mortality in Quality, Patient Safety and Mortality Report within the Quality Assurance Committee report	No graphs presented	No graphs presented

1. NSFT Board of directors public meeting papers 28th January 2021
2. NSFT Board of directors public meeting papers 27th May 2021
3. NSFT Board of directors public meeting papers 23rd September 2021
4. NSFT Board of directors public meeting papers 27th January 2022
5. NSFT Board of directors public meeting papers 26th May 2022
6. NSFT Board of directors public meeting papers 27th January 2022
7. NSFT Q01 Learning from Deaths Version 04 Final Update Sept 22

Reporting (3 of 5)

Board report data accuracy

Below is a comparison of statements taken from NSFT board reports which is compared against the data sample that Grant Thornton received for the Lorenzo and Datix systems. The aim of this exercise was to understand the consistency of board report data against Lorenzo and Datix.

Within the January 2022 board papers data is presented split into inpatient and community groups [1]. From the data sample provided it is not clear how these groupings have been decided upon. For the purposes of this comparison, Grant Thornton have assumed that a death notified via the inpatient team is an inpatient death, and a death notified via the community team or via NHS Spine is a community death. We have not included the small number of deaths that were notified via Legal Services. To aid clarity within its reporting processes the Trust should clearly set out the definitions which it uses in mortality data reporting, and the sources of information which inform these.

From this comparison the following conclusions can be drawn:

- The expected and unexpected death numbers are flipped between the data sample and the board reports
- Board reports change between reporting total or community and inpatient figures. The granularity of splitting out inpatient and community deaths is useful. Switching between the two is challenging for readers to relate numbers to those previously reported.
- Board reports change between using total numbers or average numbers over a 2-year period.

Table 2 comparing unexpected and expected deaths as presented in the board reports of January and May 2022 to the data sample provided. [1, 2] Areas shaded in grey represented no data available (n/a) for that field in the board paper in question.

	Jan 20 - Dec 21 (Community)		Jan 20 - Dec 21 (Inpatients)		May 20 – April 22	
	Unexpected	Expected	Unexpected	Expected	Unexpected	Expected
Board Report (total)	320	2910	**n/a**	**n/a**	**n/a**	**n/a**
Board Report (monthly average)	**n/a**	**n/a**	**n/a**	**n/a**	16	153
Data sample provided (total)	3835	383	16	30	3934	345
Data sample provided (monthly average)	160	16	0.67	1.25	164	14

Reporting (4 of 5)

Evidence of data interrogation

Whilst data is presented in board reports there is limited evidence of interrogation into the data on either a routine or areas of concern basis. Where this analysis does occur, it remains high level and lacks a detailed investigation of the data.

There were efforts during the COVID-19 pandemic to evaluate the impact of the pandemic on the Trust's mortality figures [1, 2]. In this period the Trust benchmarked its expected and actual mortality against that of the region. They reached the conclusion that 'people who were in contact with NSFT's services were disproportionately affected, compared to the whole population of Norfolk and Suffolk'. The Trust explains some of the increased impact by reference to the age of the population in the Trust's area, although there is no statistical analysis of the two. Whilst this compares data in a notably challenging period for healthcare services, there is no clear evidence as to whether the peaks in data being discussed are directly attributable to deaths from COVID-19, factors associated with the pandemic or other factors not revealed due to lack of investigation of the data.

Internal reports present data differently to board reports and whilst they contain more detailed discussion this is focused on inpatient deaths and patient safety incidents. There is limited evidence of community death themes or learning beyond the expected and unexpected death categorisation stage.

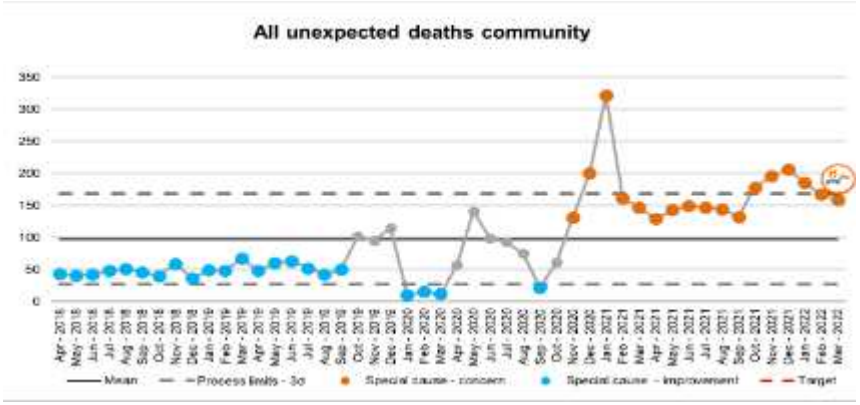
The Patient Safety Incident (PSI) annual report also contains mortality data and reporting which is again presented differently to board reports [3]. In the most recent report unexpected community deaths are pulled out as a separate graph. This graph is another example of data being presented differently across reports and the challenge to follow data through the organisation. Whilst the PSI annual report does attempt to explain the rise in special cause variation within unexpected community deaths, the factors which were identified as contributary are wide ranging and lack specificity.

'The number of unexpected deaths during this period was impacted by Covid-19 and the virus variants, there is also seasonal variation numbers being higher during the winter period. Equally the impact on physical health due to lockdown restrictions (exercise, lifestyle habits and obesity) and restricted access to physical health care is a likely factor in this increase.'

The quote is taken from the PSI annual report. Whilst the comments made may have some general and national applicability, they do not all appear to have direct relevance to the data being presented. Previous winters had seen small rises in mortality, nothing on the level of that seen in 2021. The Trust does not present any supporting evidence for their statement that the impact of lockdown restrictions on exercise, lifestyle and obesity has directly influenced their mortality data.

The Trust should be clearly evidencing, where relevant, the impact of national and local healthcare challenges on the data being presented to ensure that beyond obvious factors, such as COVID-19, it is not missing factors impacting its mortality.

Figure 4 showing all unexpected community deaths as presented in the Trust PSI annual report March 2021.[3]



1. NSFT Board of directors public meeting papers 27th January 2022
2. NSFT Board of directors public meeting papers 26th May 2022
3. NSFT Patient safety incident annual report 1st March 2021 to 30th April 2022

Reporting (5 of 5)

Conclusion and areas for improvement

Reporting between internal and external documents is inconsistent and lacks an explanation for the repeated changes, or the impact that methodological changes, have had on the figures presented. These change makes comparing the data presented over time challenging and increases concern over the reliability of the information reported.

The information contained within board reports does not consistently align to that which is recommended within NQB guidance or Trust guidance. Reports lack evidence of interrogation of the mortality data to identify the themes within the data, which could then be used for improvements and learning.

To improve this position a standardised mortality reporting structure and presentation should be developed and adopted across the Trust. This should include trend analysis to help understand variation and drive the need for timely and accurate data.

A documented change control process should be developed to approve any changes to mortality reporting methodologies. Secondly, when this happens, comparatives should be presented to ensure reporting is consistent, can be monitored and historically tracked.

Mortality data should be clear to enable internal clinical and external public confidence in reporting. Mortality data needs to have a clear, supervised, pathway through the Trust with agreed formats of presentation.

Recommendations (mapped in detail in Action Plan at the start of this report)

	Recommendation	Priority
5	Agree a standardised reporting structure for board reports, to include thematic analysis and consistent presentations of figures, axis and scales. Clearly define the Trust's methodology for mortality recording and reporting within board reports. Any changes should be clearly documented and the impact upon historically reported figures should be described to provide continuity.	High
6	Align the internal dashboard with external reporting to ensure that volumes on the internal dashboard clearly reconcile to numbers within board reports.	High
7	Work with public health and, when in post, medical examiner to identify key themes in the data and implement timely targeted interventions.	Medium
8	Use clinical input to update the cause of death groupings which are presented as part of the dashboard, and used in board reports, so that it is clear where the Trust is awaiting data (pending), or the Trust feels this data will not be accessible or will remain unknown.	High
14	Update the Trust's Learning from Death policy to ensure the Trust's governance addresses the issues in this report and explicitly references community deaths. Ensure the governance in relation to all mortality is clearly understood by clinical and corporate staff involved in the production and reporting of mortality information.	High

Clinical engagement (1 of 5)

Introduction and summary

This section focuses on the Trust's approach to clinical engagement on mortality reporting, including the approach to clinical validation and use of mortality data within the Trust. It also explores partnership working.

Within the data mortality reporting pathway there was a lack of evidence of how the collected mortality data is fed back to and used by service teams. The Trust has a good understanding of individual patients and clinical management of incidents, but more work is required to support services to maximise the use of mortality data to understand areas of interest that could support or inform how services could improve.

During the review two senior clinical leaders stated that members of the Trust's clinical staff have limited faith in their data and do not use or analyse it in a structured manner. This was reflected by other staff members we spoke with during the review who suggested a disconnect between the data production and reporting process, and its use in supporting clinical services. Moreover, there is limited evidence of the use of public health or health inequalities information to inform or supplement this data.

Clinical engagement forms part of data quality with the accuracy of information input to systems forming part of the data which is analysed in the mortality recording pathway. When clinical engagement with data is achieved this helps to improve both the quality of the data, which improves when the data is used, and subsequent improvements in patient care.

The Trust has highlighted engagement with primary care colleagues as limiting its access to death certificates which would better inform the cause of death element of the mortality pathway. The Trust attends public health and inequalities forums and undertakes work in specific areas such as suicide. To build on this, the Trust could further its engagement with public health or inequalities specialists to undertake mortality data analysis to support wider population health management. Doing so would benefit the Trust to help understand geography aligned to health inequality and allow targeted interventions.

Validation and use of data

Mortality data analysis needs to be clinically led to best understand the impact the Trust has on care provision and ensure any learning is fed back into the organisation. This needs to happen both at an organisation wide level and at a service level.

By empowering those who input data into the recording systems to use the data in practice, this will help to improve the quality of the data which is input. The Trust will need to work with services and individuals at the organisation who currently express concern about the purpose of data collection.

As well as having an organisational mortality data lead each service should have an identified lead for the mortality recording and reporting process in that area. Responsible individuals should be involved from the data entry point, working to focus on accurate, timely data entry to reporting and outcome discussion. Their knowledge of their services can help understand and inform service level data in formal outputs. These individuals should take part in the validation of mortality information and ensure feedback-loops back into services are working by tracking and reporting changes and improvement.

The need for clinical input into mortality data is shown by examination of the peak in January 2021. The most common cause of death here was '*Natural cause – specific not available'* (355), followed by 'COVID-19' (50), with the most common age profile being 65 and older (415 of 481 deaths). Examining the January 2021 raw data 'COVID-19' categorised deaths alone do not explain the spike in deaths. Table 3 below shows the number of deaths in the months pre and post January 2021. Depending on the source of death information, deaths in January 2021 increase between 111 and 203 per month from December 2020, far more than the 50 reported in January 2021. Given that the '*natural cause – specific non available*' category is used when the Trust is unable to access the death certificate there may have been deaths from COVID-19 within that category which are not reflected in the Trust's analysis.

The Trust is reliant on other providers for the cause of death in some situations and will need support from partners in helping to get a more holistic view of the causes of death of patients who are part of its mortality data.

Table 3 comparing monthly death totals from Datix, Lorenzo and the NSFT Dashboard from November 2020 to March 2021

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
NSFT dashboard	165	236	347	192	159
Lorenzo	224	301	419	243	200
DATIX	229	229	432	248	210

Clinical engagement (2 of 5)

As discussed earlier, board reports show limited evidence of analysis into the reasons behind this spike. Within the PSI annual report there is a brief discussion exploring the possible cause for the increased number of unexpected deaths in the community. The various explanations proposed include the impact of COVID-19, seasonal variation, the impact of physical health due to lockdown restrictions and restricted access to physical health care. There does not seem to be any analysis specific to the Trust underpinning these propositions, limiting the ease of attributing these factors to the data presented.

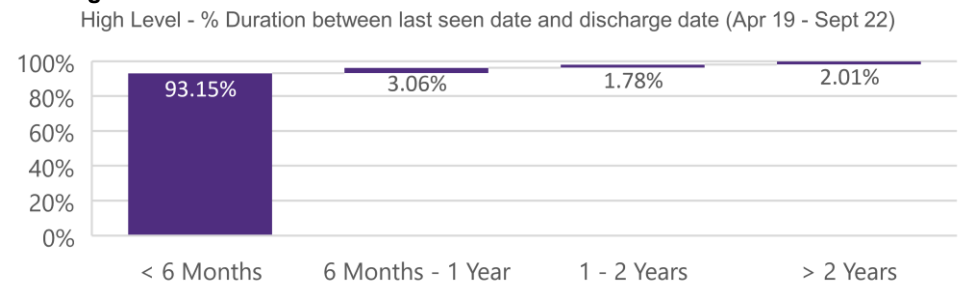
The Trust should look to provide statistical and data analytical support for the narrative suggestions within their reporting, to ensure they make evidence-based conclusions in their corporate reporting. Clinical input into this will help to interrogate the data and may help to combat the concern as to how data is used by involving the clinical community. These processes will need to be documented and clear to avoid causing more concern.

Caseload management

According to its own definitions NSFT should only include, within its mortality statistics, deaths of patients currently under the Trust's care (inpatient or community) or within six months of discharge.

As part of this review the Trust noted an element of its case management where records of patients who had not been seen for a number of years were still being included in Trust mortality data. The figure below shows a number of patients forming part of the Trust's mortality statistics where the patient had not been seen for over a year, and some who had not been seen for over 2 years.

Figure 5 showing the time lag between date of last seen appointment and the date of discharge



The Trust should review this cohort of patients to understand why these patients were retained on caseload, whether they required further clinical input prior to their discharge and whether there is learning that can be obtained to inform future care delivery.

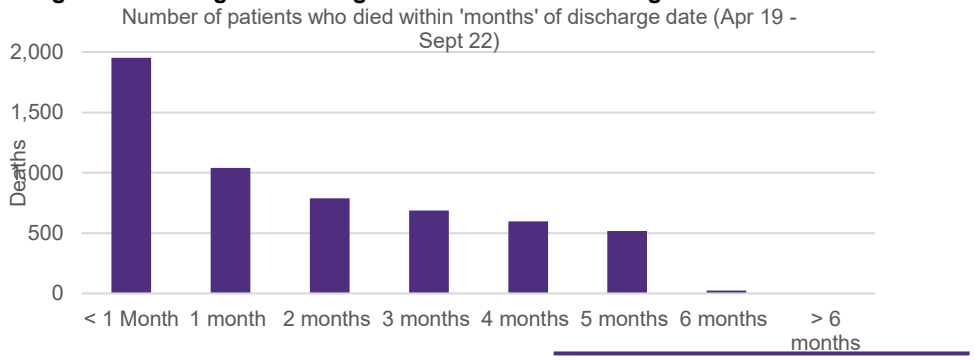
If these patients have been discharged but this status not updated they will have been unnecessarily included in the Trust's mortality figures. As part of rectifying this specific issue the Trust has informed Grant Thornton it plans to undertake the required data cleansing and provide further training to team administrators regarding appropriately closing referrals and discharging patients in a timely fashion, following the completion of their clinical care. This will help ensure that the number of deaths included within the Trust's mortality reporting accurately represent the Trust's activity.

Discharges within one month

For 1,953 patients whose death is considered part of the Trust's mortality reporting, the date of death is within one month of discharge. This includes 278 patients whose date of discharge is the same day as the day they died. Of these 158 were informed via NHS Spine, 112 via community teams, and 6 through inpatients teams.

Given the number of patients who die within a month of discharge, more work is needed to understand this cohort, ensure this data is accurate and act on any learning. The Trust is currently working with GPs through Primary Care Networks to try to improve the capture of cause of death to inform this insight.

Figure 6 showing the time lag between date of discharge and date of death



Clinical engagement (3 of 5)

A further 3261 patients, 37% of the total, had a discharge date recorded after the date of death. The majority of these were in the old age psychiatry or adult mental illness specialities, and 2699 of them were aged over 65.

There is a process question needed to ascertain why some patients are discharged on the day of death and why other records remain open for a number of days or weeks after death until they are discharged. The Trust needs to align its policy in this area and ensure staff understand and undertake their responsibilities around mortality reporting so that the data that is analysed tells the most accurate story.

Benefits of analysing by trend

Analysis of trends helps the Trust to both better understand the mortality attributed to it and, where necessary, undertake learning or changed practice. Trend analysis could be used to better inform individual services and help them to become more involved in the mortality recording process. For example, trend analysis on causes of death could help identify specific physical health causes of death, and where these are outside that expected of the local population. The Trust could use this information to target specific areas of the physical health agenda. Trend analysis will also identify variation and enable the Trust to see a deteriorating or improving pattern early, and intervene in good time if required.

Trend analysis can also be examined with regard to the accuracy and completeness of data, with the Trust being able to ascertain if there are particular services or teams that need more support to engage in the data process. The NSFT Mortality dashboard is available on the Trust intranet where it can be filtered to team level across care groups. Two senior clinical leaders suggested this information was not being accessed or used regularly by clinical staff.

Data is recorded for the registered GP practice and address of each patient. Extrapolating this information can give the broad geographical areas patients lived in. Understanding where a patient lived is important for informing detail around community deaths considered part of the Trust's mortality reporting. Geographical analysis may also help to understand areas where patients have certain physical or mental health challenges which could be targeted on a specific intervention basis.

The Trust has a Quality Improvement Plan which focuses on physical health care and includes interventions such as a smoke free programme.

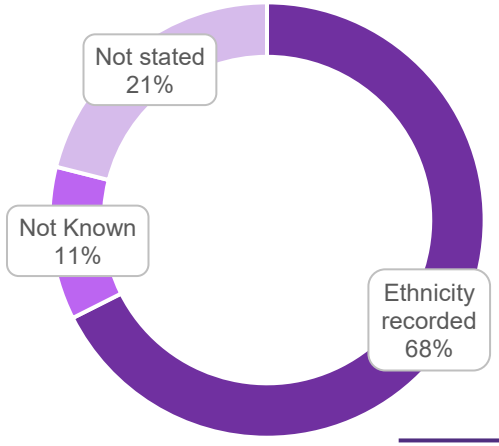
Ethnicity

In January 2022 the board requested more information within its reports to ensure there was no disproportionate impact on protected characteristics. More information was requested in future reports on what was being done on the back of this information. In order to explore this properly the Trust will need to know the ethnic representations in the community it serves in order to understand any disproportionate impact.

Between April 2019 and September 2022 1868 deaths had an ethnicity recorded as 'not stated' and 1009 as 'not known', shown in detail in the appendix. Figure 7 below shows the number of patients that had an ethnicity recorded within the data provided to Grant Thornton. Without knowing ethnicities represented within the 'not stated' and 'not known' categories, the Trust will struggle to accurately understand whether or not there is a disproportionate mortality impact on certain protected characteristics.

The Trust have informed Grant Thornton that work is ongoing to improve this recording, which is being led by the Equality, Diversity and Inclusion (EDI) practitioner and ICT.

Figure 7 showing the recording of ethnicity for mortality reporting between April 2019 and September 2022



Clinical engagement (4 of 5)

Partnership working

Understanding and learning from mortality is not only the responsibility of metal health trusts, but also primary, acute and community providers involved in a patient's care. Given the well documented challenges mental health patients can have accessing physical health care, there may be system wide learning from which the Trust and its patients could benefit.

The Trust has noted the challenges it currently has in accessing information for some patients when liaising with other providers. If providers across the system can come together the benefits extend beyond learning opportunities listed below.

Learning opportunities associated with information sharing

- Death certificate sharing to better inform causes of death
- Care learning for mortality cases where care is split between providers
- Better understanding of patient journey between services
- Better understanding of provision of care between services.

The Trust attends ICB forums on Learning from Deaths and Addressing Inequalities of Health. This provides the opportunity to facilitate better joint working, sharing data and realising the potential benefits of these forums. By working together providers in the system have the opportunity to widen their understanding of the challenges patients can face, these are outlined in the table on the right.

The Trust is also part of public health suicide prevention workstreams, where they report that their data aligns, and undertake smoking cessation work alongside Public Health England (PHE).

Area	Opportunity
Physical health	• Better understand the challenges faced by mental health patients • Work together to improve physical health care access for mental health patients
Public health and inequalities	• Better understand the correlations between social inequality and health outcomes in the system • Map publicly available public health data on to geographical areas served by the Trust • Opportunity for the ICBs to enable public health experts to work across the system and providers
Service access and availability	• Align service provision to the areas it is most needed to help address inequality • Opportunity for jointly commissioned services aligned to combat the physical health challenge faced by mental health patients

Some comparator trusts undertake more work with partner organisations to link GP and public health information into their mortality methodology. These are highlighted in the box below.

Mental Health organisation best practice

- Linking into public health data and work with public health consultants to triangulate key messages
- Central team makes decision on expected/unexpected deaths
- Work with hospital library services to research and pull information to link into mortality data
- Work with organisations in the community to proactively help mental health patients access physical health care. For example, working with local GPs on mortality of patients with Serious Mental Illness (SMI).

Clinical engagement (5 of 5)

Mortality reviews

Whilst the Trust produces an annual report of Patient Safety Incidents (PSIs), more needs to be done to undertake routine structured analysis that triangulates mortality data with mortality reviews and safety incidents. The Trust's PSI guidance states that incidents which must be reviewed include 'Acts and/or omissions occurring as part of NHS funded healthcare (including in the community) that result in unexpected or avoidable death'. [1]

The Trust has outlined set criteria to determine whether a death is subject to a Structured Judgement Review (SJR).[2] This criteria includes 'all unexpected inpatient deaths attributed to natural cause and/or end of life care. A selection of community deaths where physical co-morbidity is a cause for concern'.

The Trust also considers analysis of deaths in line with the Patient Safety Incident Response Framework (PSIIF) 2022 where: bereaved families and carers, or staff, have raised a significant concern about the quality-of-care provision; particular diagnosis or treatment groups where a 'red flag' has been raised or; deaths where learning will inform the provider's existing or planned improvement work

Data from Datix was analysed to explore the number of SJRs performed over recent years. This is shown in Appendix G. Records in Datix where a review was undertaken were collated and grouped according to the type of review. In 2021, according to Datix, there were three inpatient unexpected deaths, two of these are recorded on Datix as having had an SJR. Of the 11 SJRs recorded for the same year five were for unexpected deaths and six for expected deaths. Seven SJRs were performed for inpatients, three for those informed via the community team and one informed via the NHS Spine.

Conclusion and areas for improvement

Internal and external clinical engagement is key to understanding, interrogating and using the Trust's mortality data and this is missing across the pathway as a whole.

It is only with clinical input and engagement with mortality data, and the process of its recording, that quality of data and the themes arising from it can be identified. Our analysis shows a lack of detailed investigation of peaks in mortality data. There is a lack of proactive caseload management which impacts on the number of deaths part of the Trust's mortality reporting.

Missing field completion in the data around protected characteristics and poor caseload management further limit the accuracy of conclusions which can be drawn from the available data. The Trust needs to solidify its processes around clinical engagement to move towards a more complete set of data.

Establishing closer links with partner organisations may help to improve the completeness of mortality data and help access those partners' expertise to better inform mortality. Clinical oversight and support should be provided for data captured within the reporting process. There is particular need for support around categorisation. Finally, staff should be educated around the use of mortality data. Knowledge of how data is used will help clinical engagement with the recording process.

Recommendations (mapped in detail in Action Plan at the start of this report)

	Recommendation	Priority
9	Establish a process of validation and use of mortality reporting and analysis at service level, aligned to corporate reporting.	High
10	Review the process of retaining patients on caseloads, and subsequent discharge from caseloads, to ensure it results in consistent data across the services.	Low
11	Create supporting training programme for all staff who input data into systems that have an impact upon mortality data. Ensure that the implications and impacts of incorrect or incomplete data entry are understood by staff.	Medium
12	Establish links with primary care networks to explore opportunities to improve the completeness of the Trust's mortality data (including cause of death), supported and enabled by the ICB.	Medium
13	Explore opportunities for formal data sharing agreements between the Trust and primary and secondary care in the region.	Medium

1. NSFT Q11 Patient Incident and Patient Safety Incident Investigation (PSII)
2. NSFT Q01 Learning from Deaths Version 04 Final Update September 2022

Governance (1 of 4)

Introduction and summary

This section explores the current governance arrangements and controls over mortality data and presents the governance standard which national documentation suggests should exist.

Governance systems need to identify areas of risk and poor practice to enable timely intervention and improvement. Mortality governance should be transparent to enable assurance in the recording and reporting process. NQB guidance is clear that mortality governance processes should consider mortality rates and the results of case record reviews and investigations as part of a single governance framework.[1]

Whilst overall mortality performance is reported to the board and supporting committees there is limited scrutiny on community deaths and the underlying data. The Trust's governance over mortality focuses on serious incidents. The Trust's oversight over the end-to-end process of mortality reporting requires improvement and there are inadequate controls to ensure the data reported accurately reflects the service's understanding of their patients.

Learning from deaths guidance

The NQB Learning from Deaths guidance sets out the responsibilities expected from the board and non-executive directors, which those at the Trust will need to demonstrate [2]. These include:

- Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care
- Ensuring processes are robust and can withstand external scrutiny by providing challenge and support
- Being curious about the accuracy of data and understanding how it is generated, who is generating it and how they are doing this including whether the approach is consistent across the Trust, and being undertaken by sufficiently trained staff
- Ensure timely reviews/investigations.

From the Trust's current documentation it is not clear how these responsibilities are being consistently met.

Governance over mortality reporting at NSFT

The governance over mortality reporting at the Trust is complicated and straddles a number of corporate functions, in line with national requirements. The Trust's Learning from Deaths guidance lists responsibilities for different roles and teams within the organisation. These responsibilities are summarised in the table below [3] and the Trust's organisational governance diagram is included in the appendices of this document.

Role	Responsibility (from Trust's Learning from Death guidance)
Trust board	Ensuring robust systems to recognise, report and review deaths along with systems for learning from outcomes of reviews.
Non-Executive Directors	Testing the level of assurance that the Trust provides of safe and effective systems, Providing challenge when needed.
Chief executive	Holds overall responsibility for policy implementation.
Chief Medical Officer	Responsible for application of learning from deaths systems and assuring review outcomes with measurable actions.
Chief Nurse	Executive responsibility for the application of patient safety incident review system and patient safety incident framework and ensuring learning outcomes of reviews with measurable actions.
Medical Examiner (when appointed)	Seek assurance around the cause of death, the need for coroner notification and whether care before death was appropriate
Learning from Deaths Lead	Responsible for implementing the Learning from Deaths policy and ensure opportunities for learn from deaths
Safety and Mortality Committee	Assurance and understanding of mortality data; identifying trends and themes.
Patient Safety Team	Administration of the systems for Learning from Deaths and patient safety incidents.

1. NHS Improvement. Implementing the Learning from deaths framework: Key requirements for trusts boards July 2017
2. National Quality Board; National Guidance on Learning from Deaths 1st Edition March 2017
3. NSFT Q01 Learning from Deaths version 04 Final update September 2022

Governance (2 of 4)

The complexity of responsibility across the mortality recording, reporting and reviewing is demonstrated in this table. Some of the individuals spoken to as part of this process reflected challenges which suggested the documented process is not the experience on the ground, and there was a confused picture around senior ownership for overall mortality data reporting.

Based on the above table the board has responsibility for ensuring the processes for reporting are robust, and the responsibility for assurance and understanding of mortality data sits with the Safety and Mortality Committee. Mortality is also an agenda item within the Quality Committee, which is attended quarterly by ICBs quality leads.

The Trust has strong governance in its approach to inpatients – on site incidents are followed up by the team, as well as suicides where the coroner has notified the Trust. The Trust needs to bring the same rigour to improve the processes around the reporting of all mortality, and the understanding of wider community deaths for patients on their caseload.

This issue was highlighted by an external review by NHSE around Patient Safety Incidents. It was subsequently noted within the Trust that sight of mortality had been lost in the Patient Safety Review Group. This has since been renamed, in September 2022, the Safety and Mortality Committee, with an aim to split its focus between, on the one hand, patient safety incidents and, on the other hand, the impact that the Trust's care and treatment has on deaths in the community and inpatient populations. Grant Thornton has not seen minutes of subsequent meetings to measure progress against this aim[1] but understand that this group now meets with new Terms of Reference and workplans.

The consistency and completeness of mortality reporting to the board needs to be improved, alongside the quality and depth of analysis and narrative provided for community deaths. The board needs to ensure the data presented for monitoring is accurate, and that the analysis provided by the Trust gives them the tools to discharge their responsibilities in scrutiny and assurance over all mortality reporting, including community deaths. This is especially important given the seriousness of the subject matter and the level of scrutiny the Trust is under locally on this issue.

We have also highlighted the lack of evidence of structured clinical engagement with the data, and the lack of clinical ownership of the information reported. Governance processes at the Trust should ensure that information reported externally and nationally is a full and accurate reflection of the services' understanding of their patients.

To address this the Trust should update the Trust's Learning from Death policy to ensure the Trust's governance addresses the issues in this report and explicitly reference community deaths and the production of mortality data and reporting. It should also ensure the governance in relation to all mortality reporting and community mortality reporting is clearly understood by operational staff

Alongside this the Trust should introduce processes that cover gaining assurance over data processing, as well as ensuring data is validated with clinical staff. The mortality reported internally and externally should be subject to a clear process of senior-sign off.

It is recognised that national guidelines over mortality reporting for mental health trusts are not as clear and prescriptive as those in place for acute trusts, and that there are challenges for mental health trusts in producing consistent and accurate data. More robust controls and checks on the data will help to mitigate these issues and ensure there is clarity around the information reported by the Trust.

The table on the next page sets out how governance for the mortality reporting and recording pathway should be updated to address the issues outlined in this report. This brings together NQB guidance, learning from our experience of reviewing data quality across the NHS, and the issues identified during this review process.

1. NSFT Safety and Mortality Committee September 2022, approved notes

Governance (3 of 4)

Area	Expectation
Senior oversight	• Clear board level oversight and responsibility linked to relevant subcommittee that includes a clear focus on community deaths • Single executive level oversight of end-to-end mortality reporting processes and outputs, including sign-off of submissions and reports • Clear responsibilities for senior clinical scrutiny of community deaths • Mortality lead with end-to-end mortality data process understanding to help ensure a joined-up process
Data quality and monitoring	• Established process for service level validation of data, and provision of tools to enable analysis and interrogation of data by clinical staff • Clear feedback loops for data quality issues to be identified and addressed • Quality check of inputs and outputs against source data • Full use of internal and external audit to establish the reliability of processes and the underlying patient level data to ensure data is reported accurately
Documentation	• Clear methodology made available publicly • Documentation of pathway including named responsible individuals • Audit trail for decision making steps (e.g. categorisation of expected and unexpected)
Information security	• Use of secure systems to hold and report patient identifiable information • Clearly documented information security protocols, and regular review of access • Regular information security training for all staff across the organisation

Partnership working

The Trust faces challenges with accessing data which is primarily held within primary care and other health organisations in the area. By facilitating the sharing of key mortality data the ICBs can play a role in increasing the quality of the mortality data reported by the Trust.

Work is also required to facilitate a greater degree of cross-sector analysis of mortality data. Working with public health professionals offers the opportunity to identify areas where inequalities may be playing into the mortality picture.

The Trust is part of the East of England mortality group and should look to work with organisations in this group to learn more about how mortality data is recorded at organisations with more established pathways. The ICBs can support the Trust by sharing best practice for mortality recording and data handling across the system, and where appropriate direct the Trust to engage with experts working in the system.

Alongside this, the Trust mortality leads attend the National Mortality Leads Improvement Group led by Better Tomorrow NHSE and the mortality team attend safety committees at other trusts to learn examples of best practice.

The ICB should also support the Trust to ensure appropriate plans and resources are in place within the Trust to address the improvements required in the Trust's processes, and to hold the Trust to account for the plans it sets.

Governance (4 of 4)

Conclusion and areas for improvement

The controls over mortality reporting at the Trust require improvement, and the governance and accountability needs to be clarified and reinforced. The Trust focuses its policies and scrutiny on serious incidents and inpatient mortality, and the overall governance over mortality is complex, resulting in a lack of ownership of the end-to-end reporting process.

The board needs to ensure the data presented for monitoring is accurate, and that the analysis provided by the Trust gives them the tools to discharge their responsibilities in scrutiny and assurance over all mortality reporting, including community deaths. A lack of evidence of structured clinical engagement with the data, and the lack of clinical ownership of the information reported, will also impact on the accuracy of the data recorded.

The findings of this review suggest that there is a need for assurance across patient level data. This could be done internally but an external review is suggested in order to provide independent assurance.

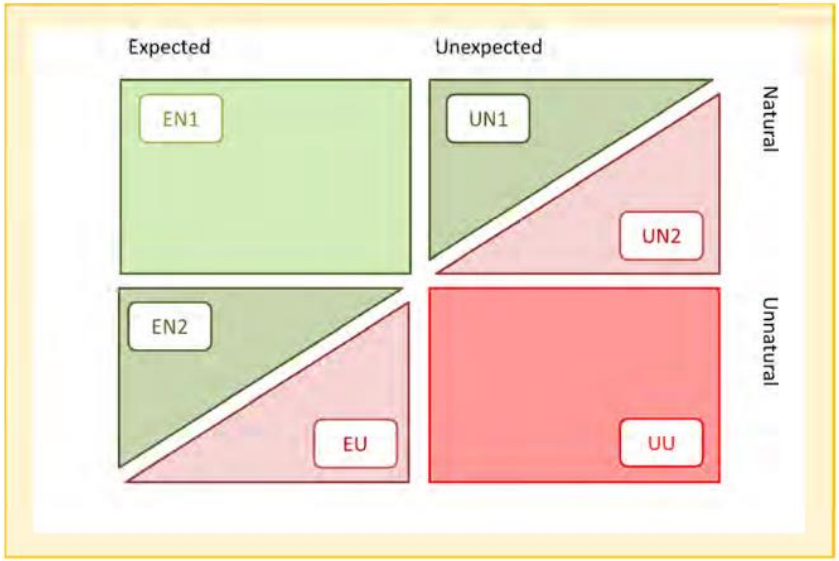
Recommendations (mapped in detail in Action Plan at the start of this report)

	Recommendation	Priority
14	Update the Trust's Learning from Deaths policy to ensure the Trust's governance addresses the issues in this report and explicitly references community deaths. Ensure the governance in relation to all mortality is clearly understood by clinical and corporate staff involved in the production and reporting of mortality information.	High
15	Establish a clear improvement plan to address the issues identified in this report, and report progress to a board committee.	High
16	Introduce a process of assurance over mortality reporting: • Introduce a clear audit trail and series of checks to ensure adherence with SOPs, and report outcomes to executive leads on a regular basis • Introduce or commission patient level data reviews to provide assurance over the accuracy of data recording • Link to the clinical validation processes established under recommendation 9	High

Appendix

Appendix A: Mazars framework [1]

Below is a framework suggested by the Mazars report for classifying deaths. The aim of the suggested framework was to ensure deaths were considered for review with a degree of consistency. The table on the right is also taken from the Mazars report and is their broad descriptions of the suggested categories. The suggestion within their report was that a similar framework should be developed for each group of service users.



Type	Description
Expected Natural (EN1)	A group of deaths that were expected to occur in an expected time frame. E.g. people with terminal illness or in palliative care services. These deaths would not be investigated but could be included in a mortality review of early deaths amongst service users.
Expected Natural (EN2)	A group of deaths that were expected but were not expected to happen in that timeframe. E.g. someone with cancer but who dies much earlier than anticipated These deaths should be reviewed and in some cases would benefit from further investigation
Expected Unnatural (EU)	A group of deaths that are expected but not from the cause expected or timescale E.g. some people on drugs or dependent on alcohol or with an eating disorder These deaths should be investigated.
Unexpected Natural (UN1	Unexpected deaths which are from a natural cause e.g. a sudden cardiac condition or stroke These deaths should be reviewed and some may need an investigation.
Unexpected Natural (UN2)	Unexpected deaths which are from a natural cause but which didn't need to be e.g. some alcohol dependency and where there may have been care concerns These deaths should all be reviewed and a proportion will need to be investigated
Unexpected Unnatural (UU)	Unexpected deaths which are from unnatural causes e.g. suicide, homicide, abuse or neglect These deaths are likely to need investigating

1. National Guidance on Learning from Deaths; A Framework for NHS Trusts and NHS Foundations for identifying, reporting, investigating and Learning from Deaths in Care

Appendix B: Local definitions of expected and unexpected deaths

The table below outlines the different approaches between NSFT and peer organisations around classifying expected and unexpected death in reporting.

Organisation	Expected death definition	Unexpected death definition
NSFT	'if it was caused by a pre-existing life-limiting condition or if the person's age and frailty made death from a natural cause a reasonable expectation at the time of their death'. [1]	'The death of a service user who has NOT been identified as critically ill or death is NOT expected by the clinical team. If there is no known diagnosis of terminal illness or physical health complication meaning that the service user is deemed as approaching end of life or receiving palliative care. Where data or cause of death is unavailable this is defined as unexpected'. [2]
Mental Health Trust in the East of England	The following subcategories are used for expected death: • Expected unnatural death – (EU) Expected but not from the cause Expected or timescale. e.g. some people who misuse drugs, are dependant on alcohol or with An existing disorder. • Expected natural death – (EN1) Expected to occur in An Expected time frame e.g. people with terminal illness or within palliative care services. • Expected natural death – (EN2) –was not Expected to happen in the timeframe. e.g. someone with cancer or liver cirrhosis who dies earlier than anticipated.	The following subcategories are used for unexpected death: • Unexpected unnatural death (UU) An Unexpected death from unnatural causes e.g. suicide, homicide, abuse, neglect. • Unexpected natural death (UN1) from a natural cause e.g. a sudden cardiac condition or stroke. • Unexpected natural death – (UN2) from a natural cause but didn't need to be e.g. alcohol dependence and where there were may have been care concerns.
Mental Health Trust in the South of England	Where a patient's demise is anticipated in the near future and his/her Doctor (GP or consultant) has seen the patient within the last 14 days before the death (for the condition that they died from). Further break down their deaths into the expected subcategories EN1, EN2 and EU	All other deaths that do not fit the criteria for expected Further break down their deaths into the unexpected subcategories UN1, UN2 and UU
Mental Health Trust in the North of England	Any death occurring at a stage in the patients' disease pathway at which death is inevitable and no active intervention to prolong life is planned or on-going.	Any death which has not been expected.

1. NSFT Mortality and Learning from Deaths Report, Jan 2022
2. NSFT Unexpected and Sudden Deaths (in-patient areas only' policy, ref no. Q11a, version 06.1

Appendix C: Local definitions of deaths to be included within mortality reporting

The table below outlines the different approaches between NSFT and peer organisations around deaths to be included within a Trust's mortality reporting which will be included in mortality reporting figures and may be subject to other mortality processes for example, structured judgement review (SJR).

Organisation	Attributable time
NSFT	Deaths within six months of the last contact with NSFT
Mental Health Trust in the East of England	Within their learning policy the Trust list out a number of categories which are listed below. • All child and infant deaths • All deaths of patient with an open/active referral • All deaths from suicide where the patient was discharged within the preceding 12 months • Deaths resulting from suspected self-harm or suicide post assessment by RAID Teams within the preceding 6 months (unless the patient had been referred into another Trust service, then use 12 months post discharge from the referred team • All inpatient deaths • Deaths of inpatients discharged in the preceding 30 days • Patients who die following transfer to an acute/general hospital • All learning disability deaths within 12 months of last contact including palliative care patients
Mental Health Trust in the North of England	Deaths up to six months after discharge
Mental Health Trust in the South of England	All deaths of people under the care of the Trust or discharged within the preceding 6 months
Mental Health Trust in the South of England	Within their learning policy the Trust list out a number of categories which are listed below. • Majority of unexpected deaths of service users/patients currently under the care of Oxford Health NHSFT or who have received a clinical interaction within the last six months. This should include unexpected unnatural and unexpected natural (UN2) • Those services which provide a 'single contact' such as street triage services/GP OOH will only need to enter such deaths if the care provided was the last care prior to death or if concerns were identified in the initial screening • All learning disability deaths • All inpatient mental health deaths • Expected deaths where any care concerns or areas for learning were identified by the clinical team • All patient who are detained
Mental Health Trust in the South of England	Deaths of patients up to six months post discharge are reportable (with the exception of those with Learning Disability, which is 12 months)
Mental Health Trust in the Midlands	All deaths of service users expected and unexpected who currently receive care from BSMHFT services including HMP Birmingham, are to be reported. Additionally deaths of patients up to six months post discharge are also reportable

Appendix D: Stakeholder engagement list

Individuals with the following roles from the Trust and external organisations were met with on at least one occasion as part of this review. Alongside this Grant Thornton also observed a session between the ICB and a local patient representative group in order to understand the wider public concerns around mortality reporting at the Trust.

Position
CCIO NSFT
Medical director for quality NSFT
Consultant Forensic Psychiatrist/Caldicott Guardian NSFT
Director for nursing for CFYP and NSFT patient safety specialist NSFT
Patient Safety Officer (Mortality) NSFT
Mortality DATIX processor NSFT
DATIX Data Manager NSFT
Chief Digital Officer NSFT
Information Governance Officer NSFT

Position
Information assurance manager NSFT
Information rights manager NSFT
BI manager NSFT
Data Protection Officer NSFT
Director of performance, transformation and strategy Norfolk and Waveney Integrated Care Board
Medical Director Suffolk and North East Essex Integrated care Board

Appendix E: Document review list

Document name
NSFT Quality Account 2020-2021
NSFT Quality Account 2021-2022
Discharge from Trust Services
NSFT 72 Hour Follow Up Standard Guideline
QO1 Learning From Deaths Version 4 FINAL update Sept 2022
ACCESS standard operating procedure
NRLS Organised data workbook period April 20 to March 21
Patient Safety Incidents and Patient Safety Incident Investigation (PSII) (Q11)
PSI annual report 21 22 v3
Unexpected and Sudden Deaths (Q11a)
Board Assurance Framework September 2022
Guidance to Governance Reporting and Accountability Framework December 2021 v5
NSFT Governance Architecture October 2021
NSFT Risk Management Framework v2.2 Nov 2021
Risk Management Strategy on a Page June 202
Risk policy v5.5 Dec 2021
East and west Suffolk QPM Report October 2022
GYAQ QPM Report October 2022
N&W CFYP Core QPPM Report October 2022
NN&N QPM Report October 2022

Document name
Minutes QAC 16th August 2022 - unconfirmed
Minutes QAC 20th July - unconfirmed
Confirmed Audit Risk Committee minutes 17th May 2022
Audit Risk Committee minutes 8th July 2022 unconfirmed
Mortality and learning from deaths BoD 23rd September 2021 Final
Mortality and learning from deaths – BoD 27th January 2022 Final
Mortality and learning from deaths report – BoD 27th May 2021
Mortality Report – BoD 28th January 2021
Mortality Report BoD 21st May 2020
Mortality Review and Learning from Deaths Reports BoD 23rd January 202
Mortality Report BoD September 2020
Norfolk and Suffolk scope document Nov 2022 v1.2
Secure services QPM Report October 2022
Wellbeing QPM report October 2022
WSN QPM report October 2022
Approved July PSRG notes 22
Approved September notes for SM

Appendix F: Board paper comparison graphs

Figure 9 showing Monthly Reported Mortality from 2018-2020 as reported in January 2021 papers. [1]

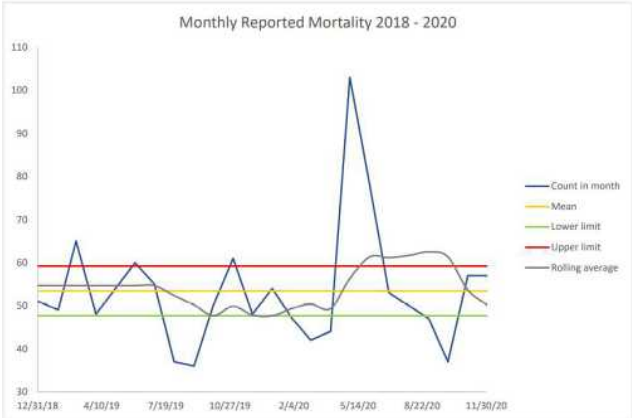


Figure 10 showing all cause mortality over three years of the total number of people who have been in contact with NSFT's services as reported in May 2021 papers. [2]

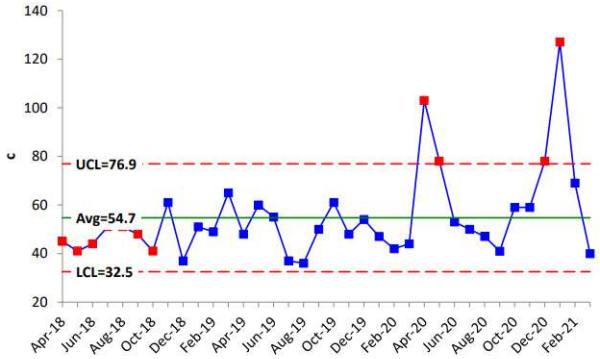


Figure 11 showing all cause mortality from December 2019 to July 2021 as reported in September 2021 papers. [3]

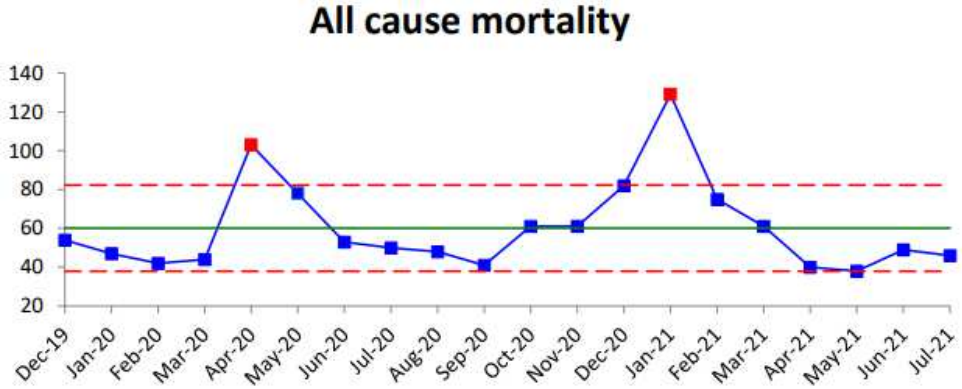
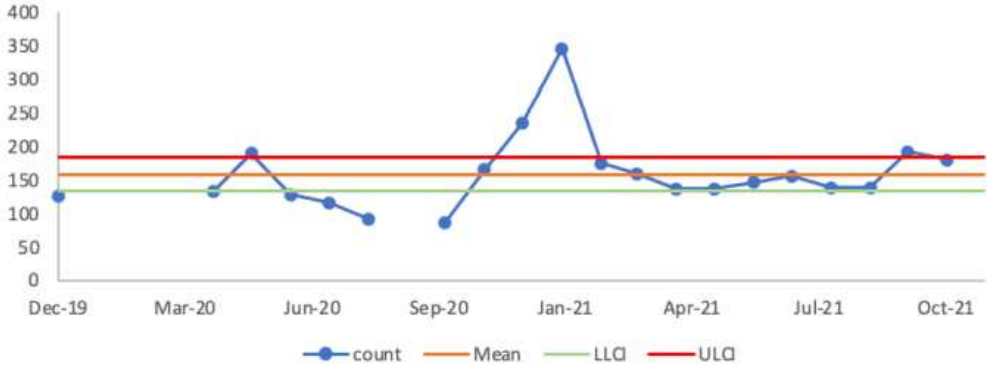


Figure 12 showing an SPC chart of community deaths within six months of contact NSFT from December 2019 as reported in January 2022 papers. [4]

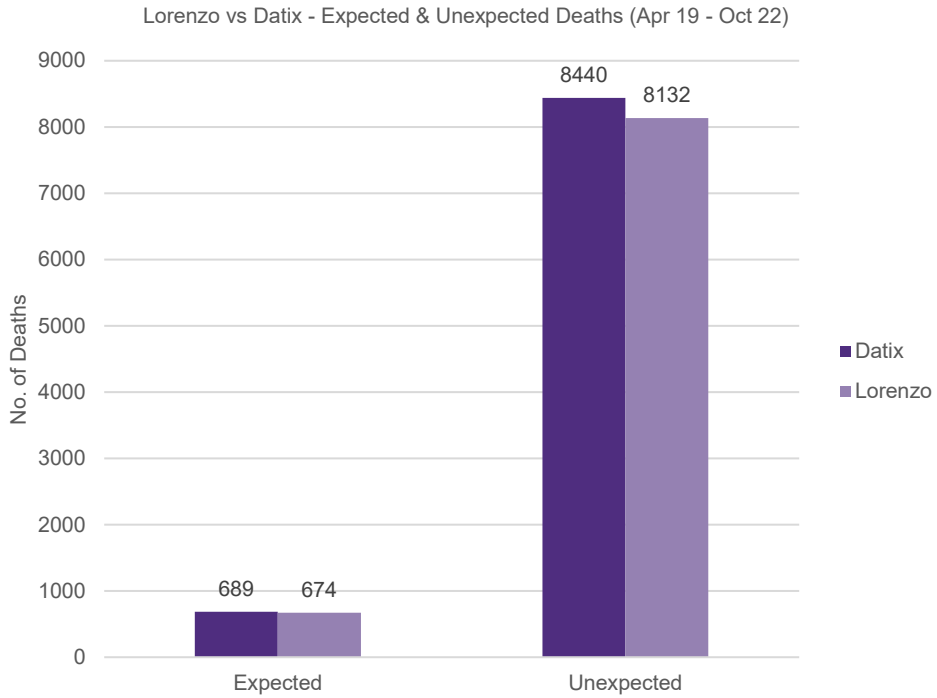


1. NSFT Board of directors public meeting papers 28th January 2021
2. NSFT Board of directors public meeting papers 27th May 2021
3. NSFT Board of directors public meeting papers 23rd September 2021
4. NSFT Board of directors public meeting papers 27th January 2022

Appendix G: Reference graphs (1 of 4)

Unexpected v expected deaths

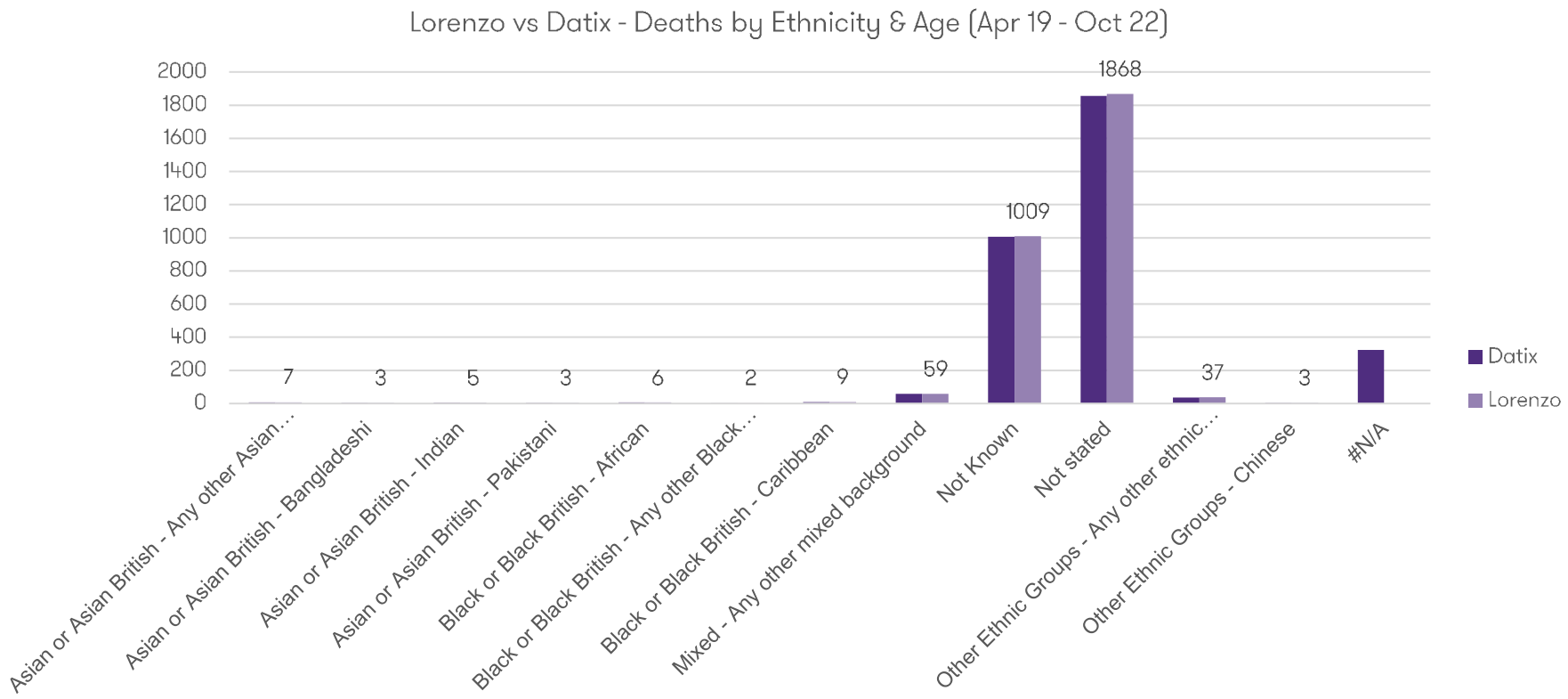
Figure 13 comparing unexpected and expected deaths from April 2019-Oct 2022



Appendix G: Reference graphs (2 of 4)

Ethnicity

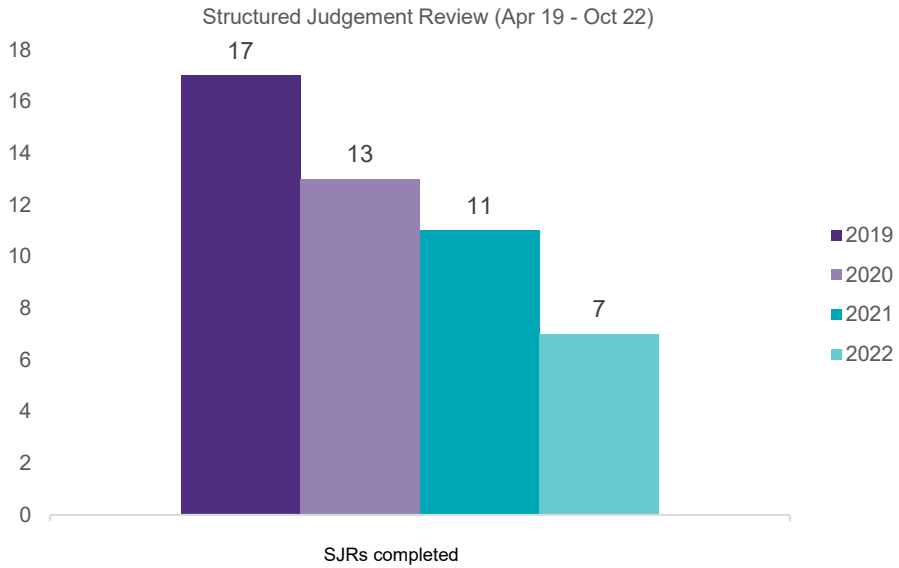
Figure 14 displaying the number of deaths for ethnicity classifications excluding white ethnicity from April 2019-Oct 2022



Appendix G: Reference graphs (3 of 4)

Structured judgement reviews

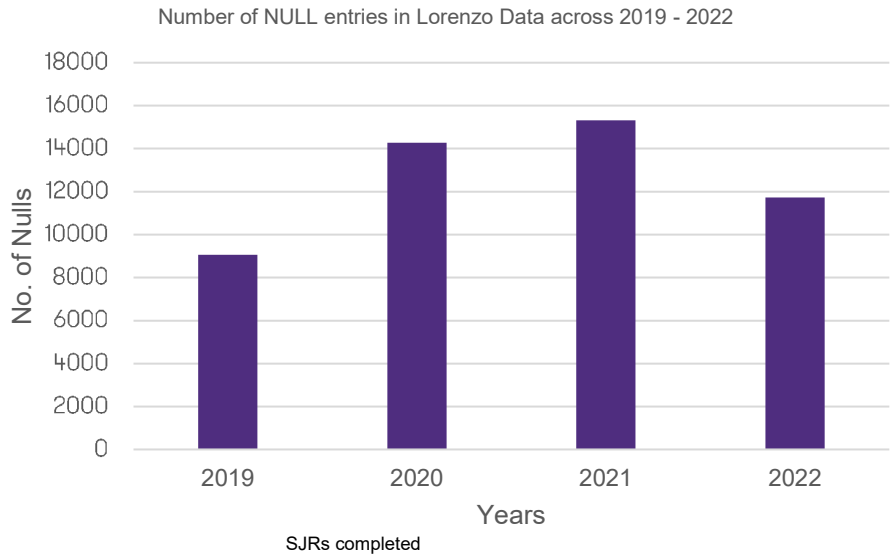
Figure 15 showing the number of structured judgement reviews performed each year from 2019 to 2022.



Appendix G: Reference graphs (4 of 4)

Missing data (Null fields)

Figure 16 showing the number of missing fields in Lorenzo data over the years analysed. Of note, 2022 data was not a complete 12 months. The table on the left shows the fields which were included as part of this analysis.



NULL Data Fields
Inpatient Discharge Date
Local Specialty 1
Local Specialty 2
Site 1
Site 2
Discharge destination
Date of lastseen appointment
Ward name
Team name
Referral closure or rejection reason
Local Authority/ Locality
Registered GP Practice

Appendix H: Data request

The following data was requested from DATIX

•Pseudonymised patient ID

•Age

•Date of death

•How was death identified

•Incident date

•Incident severity

•Unexpected/expected view

•Cause of death

•Discharge date

•DATIX rejection

•Learning disability review

•Under 18 child death review

•Service level investigation

•Serious incident

•Structured judgement review

•Other review

•Local authority/locality

•Registered GP practice

The following data was requested from Lorenzo

•Pseudonymised patient ID

•Age

•Gender (MSHDS)

•Ethnicity (MSHSDS)

•Date of death

•Date of recording of death

•Death cause recorded text

•How death was identifies

•Inpatient discharge date

•Local speciality

•Ward name

•Site

•Discharge destination

•Team name

•Date of last seen appointment

•Date of last DNA appointment

•Discharge date

•Referral closure of rejection reason

•Local authority/locality

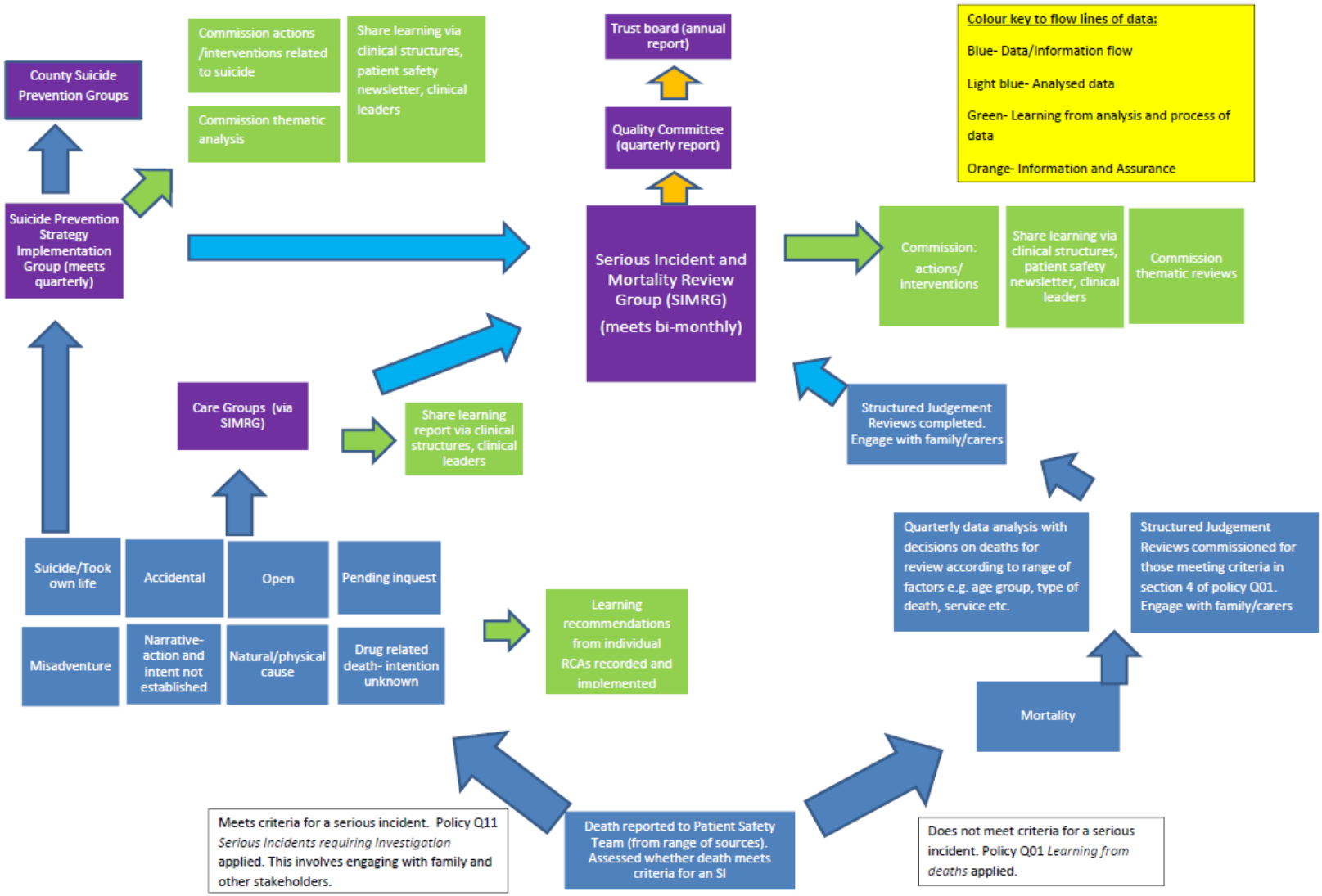
•Registered GP practice

•Dementia flag

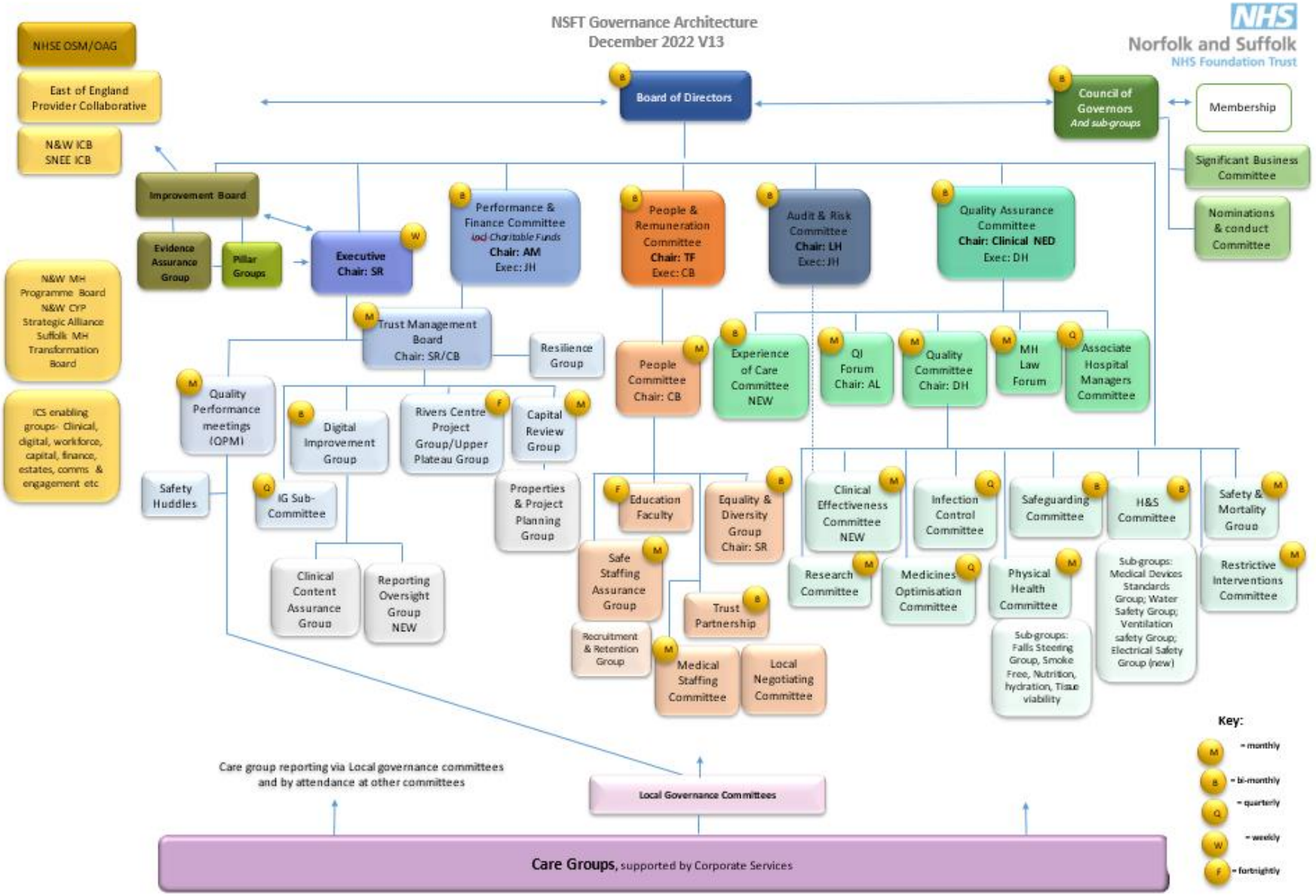
•Long term condition flag

•On end of life/palliative care pathway

Appendix I: Learning from deaths pathway



Appendix J: NSFT governance architecture



Grant Thornton

Forever Gone: Losing Count of Patient Deaths

An independent response to the Norfolk and Suffolk NHS Foundation Trust's mortality recording and reporting review by Grant Thornton (2023)

Dedicated to the people who have lost their lives and those left behind

By Caroline Aldridge, Anne Humphrys and Emma Corlett

7th July 2023

Trigger warning: this report contains distressing content relating to deaths including suicides

A response to the Norfolk and Suffolk NHS Foundation Trust's (NSFT) mortality recording and reporting report by Grant Thornton 2023

Introduction - as an open letter to Rt Hon Stephen Barclay MP (Secretary of State for Health and Social Care) and Rt Hon Maria Caulfield MP (Minister for Mental Health)

Every life lost to due to mental illness (which includes premature deaths from associated physical illnesses) is the loss of a precious life. This has an impact on the health and wellbeing of those left behind. It is vital to learn from deaths and to identify themes or poor practice so that actions can be taken to prevent further deaths. If a Trust cannot even count, let alone identify, who has died and why, they are not in a position to learn and improve. From the bereaved relatives and mental health campaigners' perspectives, the casual and chaotic practice that Grant Thornton reveal in their audit of NSFT is not a surprise. We had been consistently flagging up concerns about inconsistencies and poor quality of the mortality data at NSFT for years. The message conveyed to bereaved families is that their loved ones are of so little value that their deaths are not even worthy of being recorded correctly.

The key findings in Grant Thornton's report are disgraceful. They present evidence of shocking and unacceptable problems with NSFT's recording and reporting of mortality data yet in the report, governance is described as 'strong' or 'requires improvement'. Instead of providing the promised 'single truth' and verification of the mortality data, this report feels to bereaved relatives like corporate 'gaslighting' and a minimisation of deaths which further harms bereaved people.

Concerns about NSFT, including the management of mortality, are longstanding. In 2016, Verita conducted an independent review into the numbers of 'unexpected deaths'. Verita highlighted issues with data management and poor oversight from the Board and made recommendations. It is clear that these have not all been acted on. Thus another 7 years of poor practice, questionable governance, potentially avoidable deaths and grief for families.

In April 2022, NSFT was rated 'inadequate' by the Care Quality Commission (CQC) for a fourth time and campaigners stated that there had been over 1,000 deaths since 2013. NSFT said they 'did not recognise' that figure. Clive Lewis MP raised this in Parliament. We presented our concerns to a group of MPs, including the then Minister Gillian Keegan, in July 2022. We said that NSFT had 'lost count' of deaths because their systems, processes and governance were inadequate, and that reporting of deaths to the board and external bodies showed inconsistencies and gaps in data. Subsequent closer examination of the documents in the public domain suggested that 1,000 was an underestimate, and we identified at least 2,600 deaths. From the data Grant Thornton refer to, it is more likely to be several thousand deaths.

NHS England and their National Quality Board (NQB) have been aware of mortality data problems across NHS Trusts since 2016. The Care Quality Commission (2017 and 2019) committed to addressing these during inspections of trusts. Those responsible for internal and external governance, leadership and monitoring, have allowed the deaths of our loved ones and community to be lost *in plain sight*. Those whose responsibility it is to scrutinise and ensure safe practice seemed to be oblivious and unable, or unwilling, to take action.

A key aim of the review (point 1 of the Statement of Requirements) was to establish how many have died: *"Verification of the number of deaths associated with care or treatment at NSFT per year…".* In their report, Grant Thornton state: *"Based on the information made available to us we are unable to provide assurance over the mortality data reported at the Trust"* (GT report p5). Establishing how many have died under the care of NSFT proved impossible due to the impenetrability and inaccuracy of mortality data. We will simply never know how many precious lives have been lost in Norfolk and Suffolk, or why. This is heart-breaking for families. Since publication of the report the messages from the local system have consistently set a wrong tone and caused offence and further distress to bereaved families.

We have been paying attention and gathering evidence for a decade and we are convinced there have been many avoidable deaths. We respectfully suggest that we hold knowledge and understanding of the context that the system does not. We are not statisticians, neither are we people with expertise in patient safety, NHS systems or, mortality data. If *we* could see the mortality data was skewed and flawed why couldn't the people with responsibility for overseeing data gathering throughout the system? Our motivation in writing this response and in asking for specific actions is to support positive change. In the supporting evidence to this letter, we will explain in layman's terms, what the problems are, why it matters, the questions that still need answering, and what actions are needed to reassure the public that mortality data supports patient safety. We underpin our opinions with evidence. We must not see a repeat of the Verita report, where NSFT committed to acting upon the recommendations but they disappeared into a 'pit of inaction' and change did not happen.

We would prefer to work constructively with everyone. However, what the report reveals about NSFT and the wider system, and their corporate behaviours since publication, has further dented our confidence in their capability and willingness to make the necessary changes. Sir Robert Francis states: *"The experience of many previous inquiries is that, following the initial courtesy of a welcome and an indication that its recommendations will be accepted or viewed favourably, progress in implementation becomes slow or non-existent."*

Grant Thornton's report is one of at least four reviews into deaths at NSFT. None have led to the mortalities being recorded and reported with the diligence and gravitas they deserve. We are determined and persistent and will not be accepting a continuation of the status quo or tolerating any more gaslighting behaviours because too many people are forever gone.

We believe that other trusts' handling of mortality data is similarly flawed and this reflects a whole system failure. Whether by acts of commission or omission, the corruption of data within the NHS is totally unacceptable and it must be exposed and addressed. We believe this justifies a Statutory Independent Public Inquiry. We are also asking our MPs to task the Department of Health and Social Care with providing the guidance and resources to urgently address what are known national problems. These critically important issues are both historical and current, and if no action is taken now, will remain unchallenged into the future. To achieve this, we need the active involvement of government ministers.

Caroline Aldridge
Bereaved mother &
Mental health campaigner

Anne Humphrys
Carer &
Mental Health Advocate

Emma Corlett
Campaigner &
County Councillor

Contents

Glossary

Campaign – Campaign to save mental health services in Norfolk and Suffolk
CEO – Chief Executive Officer
Chair – Chairperson of the board
CoG – Council of Governors
CPA – Care Programme Approach
CQC - Care Quality Commission
CRHT – Crisis Resolution and Home Treatment
EADT – East Anglian Daily Times
EDP -Eastern Daily Press
EqIA – Equality Impact Assessment
FOI – Freedom of Information request under data protection.
Grant Thornton - Auditors who reviewed the data and wrote the report
GT report – Grant Thornton review of mortality at NSFT
HOSC – Health Overview and Scrutiny Committee (NB: there are two covering NSFT – Norfolk HOSC and Suffolk HOSC).
HSIB – Healthcare Safety Investigation Branch
HSSIB - Health Services Safety Investigations Body
ICBs – refers to the Norfolk and Waveney, and the Suffolk and North Essex, Integrated Care Boards
NED – Non-executive director
NHSE – NHS England
NQB - National Quality Board
NRLS – National Reporting and Learning System
NSFT – Norfolk and Suffolk NHS Foundation Trust
PFD – Prevention of Future Deaths report issued by coroners
SoR – Statement of Requirements
SUF – Suffolk User Forum
Verita – independent auditors who investigated

Executive Summary

There is a plethora of evidence within Grant Thornton's report that the systems, processes, governance and culture at NSFT, surrounding mortality data recording and reporting, is extremely poor. This aligns with other evidence we have been tracking over the last decade that shows the trust has lost sight of how many of their patients were dying. For bereaved families, this compounds what is already likely to be complex and traumatic grief. The inadequate mortality data recording and reporting does not provide staff with the information they need to learn and improve. The diluting of Grant Thornton's findings (between the executive summary and body of the report), and deflection from governance to operational staff and system partners, suggests to us a culture that staff would find frightening. This mortality review not only disrespects bereaved families but also the honest, hard-working members of staff who apply due diligence to their roles.

I think there are people inside the Trust that are interested in making changes but they are overruled/ignored by certain individuals on the Executive who are responsible for the systemic and ongoing failure to implement a data driven strategy that keeps patients safe and their families well informed. Those individuals are driven by maintaining an ever-present defensive attitude with the prime intention of protecting their own backs.
(A bereaved mother)

We are stepping into a disaster zone (mental health deaths) whilst those who are employed to protect lives, through the design, commissioning and delivery of services, seem to be stepping away to distance and protect themselves. It is imperative that the whole system from government through to frontline staff involve themselves in owning and addressing the concerns we raise. The publication of Grant Thornton's report and our response means that those who say they are our colleagues or allies will need to make a choice about where they stand. This is a defining moment where people will either do the right thing or reveal themselves as complicit. The actions we have identified need to be implemented swiftly and incisively.

"We need people to challenge so that the deceased matter."
(A bereaved relative)

Key Points

- NSFT have lost count of how many people under their care have died
- There is no consistent end-to-end system to record a coherent data journey from death, through board and beyond

What did Grant Thornton find wrong at NSFT?

- Missing data
- Confusing and missing categorisation of deaths
- Consistent under-reporting of deaths attributable to NSFT
- Frequent changes in methodology
- Internal leadership and governance issues at NSFT
- Unhealthy culture
- Lack of transparency
- The quality of mortality data reflects a systems failure
- Lack of oversight and actions from regulatory and monitoring bodies
- Unsafe practice has been masked
- Inability to compare with other NHS trusts and localities
- Lack of learning from data

What needs to happen?

- A public apology for the distress caused to bereaved families
- Work in collaboration with bereaved families to repair relationships and confidence and support change
- Acknowledging the impossibility of establishing how many have died
- Creation and implementation of a credible, concrete, and co-produced plan
- Review of the 2016 Verita Report
- Answer outstanding questions
- Government intervention
- A Statutory Public Inquiry into mortality at NSFT

In preparing our response we have been limited to evidence available in the public domain. We feel that we have knowledge and experience (including lived experience) that offers analysis of Grant Thornton's report from a different perspective. We do this from a position of wanting bereaved families' concerns to be addressed and with a heart for supporting positive change. We consulted some of the bereaved families we are in touch with for their responses and have included their views. We were mindful of the distress that reading some of the content in the Grant Thornton report will cause those who have lost loved ones, so we limited ourselves to consulting only those we know to be emotionally strong enough.

Between February 2023 (when Grant Thornton submitted their report to NSFT and both ICBs) and 28th June 2023 (when the report was published), campaigners began to suspect that the delays in publication might be due to the report being re-written to present NSFT in a more favourable light.

"Suggests a culture of secrecy and closed doors. It layers pain on top of pain."
(A bereaved aunt)

On 9th May 2023, campaigners wrote to the chairs and CEOs of both ICBs and the chair of NSFT raising their concerns and specifically asking how many versions of the report there were (Appendix 1). The CEO and Chair of Norfolk and Waveney ICB, who led on commissioning the report, replied on behalf of both ICBs on 30th May 2023 (see Appendix 2). They stated:

> *"In terms of the number of drafts of the report, there was an original draft produced that was used to assess for factual accuracy … Once all the factual accuracy matters were agreed, another draft of the report was produced for approval."*

We agree with the ICB chairs and CEOs comment in their letter to campaigners that "*Only by understanding a challenge can it be solved, so it is vital we have a full and clear understanding of the situation."*

We find it hard to articulate the impact the report and the responses by the trust have had had on us personally. We genuinely believed that those individuals in senior positions who commissioned the report were, finally, going to be transparent and identify and rectify poor practice. So, we were saddened and angry to hear that in some briefings it was implied that we might not understand the data and the trust did not know how we had arrived at our concern that a 1000 people had died. To clarify, it was us who told NSFT that they were conflating terms and criteria. We provided them with our working out which was based on the data they had provided.

The impact was perhaps felt hardest by Caroline Aldridge because she is a bereaved parent who has been harmed not just by the loss of her son but by the actions of leaders at NSFT in the aftermath. Caroline details these experiences in *He Died Waiting* (2020). This replication of delay, defend, distract, deny behaviours by individuals across the local system is re-traumatising for all three of us because we have so much direct involvement with bereaved relatives.

The Grant Thornton report examined 2.5 years of mortality data provided by NSFT (between April 2019 and October 2022).

There are some curious inconsistencies between the executive summary and some of the evidence cited within the body of the report, which portrays a starker and more concerning picture. Likewise, the conclusions in the Grant Thornton report somewhat understate the gravity of the issues and their recommendations do not reflect the seriousness of the findings they present.

What is missing from Grant Thornton's report is enough curiosity or analysis of why the inadequacies surrounding mortality data have occurred. Of equal concern to us are some of the other issues Grant Thornton raise which have patient safety and delivery of care implications although it is harder to discern.

> *"These issues have led to questions of clarity within the public facing documents and reduced clinical relevance within the mortality information reported. This* results *in a lack of confidence of external stakeholders - including regulators and the public - in the data, and in the Trust's understanding of it"* (GT report p5).

We would like to see recommendations be translated into robust actions that reflect the severity of the findings. We would like to see granular detail about how inadequacies will be remedied and assurance that there will be actual independent scrutiny. We believe it is time NSFT either provide verifiable mortality data or own the impossibility of this given their mortality data processes and offer a full and unreserved apology. Precious loved ones are forever gone and their families deserve the truth and to know things will change.

"The Trust needs to get rid of those who think meaningless apologies are enough. They need people who are driven by making changes and can be seen to do that."
(A bereaved parent)

NSFT have lost count of how many people under their care have died

Our starting point in analysing Grant Thornton's report is to hold in mind that datafication of people dehumanises them and that we are not counting numbers, but humans who have lost their lives. Counting lost lives is not a neutral act and when mortality data obfuscates humanity and the grief of those left behind, it renders some of those most vulnerable and neglected in life to be invisible in death.

> *"The truest story to be told on these dashboards is a simple fact that someone, somewhere, is forever gone. The most fragile lives are broken, and those most desperately held onto are lost. If we were to approach death counting with the intentionality of individual mourning, how would we react differently and who would finally notice?"* (Raji, 2020).

Nevertheless, we believe that keeping count of deaths is important. It demonstrates that the lives lost matter and that the trust cares about each individual under their care and management.

"The trust should know the exact number and the name of every service user they failed, because the loved ones left behind will never forget"
(A bereaved daughter)

"It matters because it was a person who mattered to us. Losing count suggests our relatives weren't worth NSFT's time."
(A bereaved relative)

When asked how many service-users had died since 2014, NSFT's Deputy CEO referred the Norfolk Health Overview and Scrutiny Committee (NHOSC) on the 8th September 2022, to the commissioning of Grant Thornton's report, saying:

> *"It's not that we don't know [the number of deaths]. It's that there is a difference of opinion so we are taking a different approach and this review will provide a single version of the truth on deaths in our trust"*[1].

If the trust know how many they think have died, why did they consistently refused to answer questions and provide a figure? At the outset it seemed that the primary purpose of Grant Thornton's review was to establish how many have died and the first point in the Statement of Requirements for the Grant Thornton report (SoR) states: *"Verification of the number of deaths associated with care or treatment at NSFT per year…".* We note that the aim to verify the number of deaths in the SoR was missing from the aims and objectives in Grant Thornton's report. It is disappointing that they did not explain why this requirement was not addressed. Presumably their mandate was changed. But the decision-making surrounding that is not transparent.

Nevertheless, it is clear from the report that Grant Thornton would have been unable to establish how many had died, and provide the promised single version of the truth, due to multiple issues that will impact on the reliability and usefulness of the information provided by NSFT.

Given the how unreliable and chaotic Grant Thornton found the data to be, we were surprised NSFT published numbers alongside the publication the report. Until NSFT can come up with verifiable figures, our opinion will continue to be that they do not know or do know but will not reveal them. The evidence presented in the Grant Thornton report suggests that it is the former. The figures NSFT published on 28th June 2023 are based on flawed data and are misleading.

It is vital that NHS trusts have good quality data to draw on:

> "*High quality data is important to the NHS as it can lead to improvements in patient care and patient safety. Quality data plays a role in improving services and decision making, as well as being able to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services*." (NHS England, 2023)

[1] Video of NHOSC meeting 2:02:10

"If the data isn't there or it's kept hidden, whether through ineptitude or deliberately used to hide the facts, it makes challenges very difficult. I suspect both. A bit like having a bow with no arrows."
(A bereaved mother)

There are multiple issues with the mortality data and poor systems and processes at NSFT. That these include basic errors. Some of NSFT's processes rely on manual inputting which can corrupt the final output of the Trust's mortality reporting and provide incorrect data. Of the many data errors described in the report, the loss of some patient IDs (GT report p30) means that any hope of tracking back and verifying the data is lost. This is a basic error. There might be some double counting but equally there might be deaths that were missed. We discuss the discrepancies in death numbers and what this looks like to the public in the body of our report.

NSFT disputed the death figures campaigners cited. We had collated these from NSFT's published documents and spotted discrepancies. We realised that they had lost count because they could not say what the correct number of deaths was. NSFT need to either provide a verifiable figure or admit they do not know. Each life lost is heart-breaking. It is difficult to find words to express what this means to bereaved relatives. It leaves them feeling their loved ones are demeaned to a point where they do not even feature in statistics let alone be seen as people whose lives, and deaths, mattered. Put simply, there are bereaved families who, despite this report, still have no idea whether their loved one has been counted.

"This suggests that patients' lives are not worthy of being counted."
(A bereaved aunt)

"My son's mental health and suicide has impacted hundreds of people, his family, his peers, his friends. The cost is unimaginable. To not count his death. To not understand his death. Why would we not want to learn what can be done better, or understood better to improve other people's chances?"
(A bereaved mother)

There is no consistent end-to-end system to record a coherent data journey from death, through board and beyond

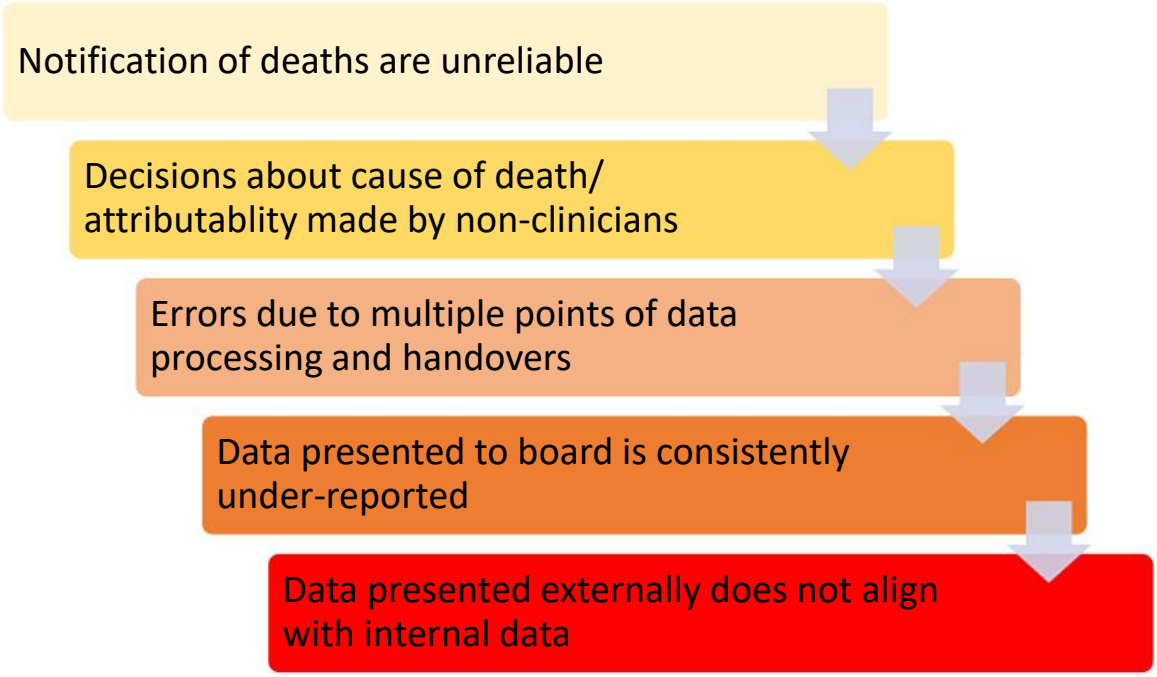
> *"Our Trust monitors and reports on the death of all people who have contact with our services, whether their death was due to natural causes or unexpected, regardless of cause"* (NSFT 2022 Annual Report).
>
> But: *"Although there are pockets of documented processes, there is no comprehensive documentation that covers the process in its entirety"* (GT report p6).

Grant Thornton are clear that there is no end-to-end data journey and they describe NSFT's poor and inadequate mortality data management. For some of our loved ones, the data is flawed, incomplete or skewed, from the day they died. In the following weeks and months, the fragmented and error ridden processes compound the problems because there are multiple points at which the data can be further corrupted.

Somehow, the data that is presented to the board for scrutiny via the dashboard is consistently an under-representation. And, at the points where data leaves NSFT, any hope of the statistics reflecting the true picture is further reduced due to missing data that regulatory bodies do not seem to challenge. This is an exemplar of Reason's Swiss Cheese Theory of error in that every layer of the system has holes that align. These are the gaps that our loved ones have fallen through.

The data journey is complex and there is no end-to-end system but we have attempted to make sense of it, based on the points raised in the Grant Thornton report, in our discussion and analysis.

Figure 1: The journey that mortality data goes on from death through to public scrutiny



Summary of our analysis

It is worth noting here how overwhelmed we were at the sheer number of concerning points Grant Thornton's report raised. This is a dense report and each page flagged up many issues that merited reflection and discussion. We have not followed Grant Thornton's order of points because we wanted our response to provide a coherent narrative. Each of the points below are the things we feel are important in Grant Thornton's report and will be discussed in more detail in the long-read section of our response.

Compounding factors

	Page(s)
Missing data	
There are significant gaps and missing data that limit the trustworthiness of the mortality data.	32-34
Grant Thornton found a list of 'absent but expected' data and documentation.	32
The misuse of 'null' fields skews the data.	33
There are missing patient IDs, which alone is inadequate practice by an NHS trust, and in this case, makes tracking back impossible.	33
Details such as ethnicity and protected characteristics are frequently not captured.	33
Confusing and missing categorisation of deaths	
The categorising of expected and unexpected deaths is complicated by NSFT's processes.	32
The use of natural and unnatural categories instead of expected and unexpected is not used by other NHS trusts.	35
It is not clear how people who die due to their physical health are included/excluded from the statistics if their mental health is a contributing factor.	35-36
The use of 'Natural - non specific cause' for any unknown cause of death means attributable deaths can be missed.	36
Categorisation of death decisions are made by non-clinicians.	36-37
National guidelines do not set down consistent categorisation.	37
Consistent under-reporting of deaths attributable to NSFT	
The data presented on the dashboard is consistently less than mortality data from other NSFT sources.	37
There are discrepancies between deaths reported on different internal systems (e.g. Datix and Lorenzo).	37
The data presented to internal and external audiences does not align.	31
NSFT have changed the way they report on Prevention of Future Death numbers in a way that minimises them.	77-78
Changes in methodology	
"Over eight consecutive board reports, information and the method of presentation changed six times" (GT report p6).	38
The presentation of mortality data in graphs changes and the statistics are not presented accurately and accessibly.	38

There have been changes in inclusion and exclusion criteria which make comparisons impossible.	39
The mortality data in board papers is impenetrable and overshadowed by patient safety data.	39-41, 49-50
It seems NHSE's *Better Tomorrow* have been working with NSFT and have/will (it is unclear which) change the methodology used.	40
Grant Thornton's findings contradict the CQC's 2023 findings about the quality of data presentation.	50
Culture	
Long standing concerns about the culture at NSFT	41-43
Staff have limited faith in the data.	68
Transparency	
The board, external stakeholders, and the public, are not presented with data that is understandable, consistent, and reliable.	43
What is visible is so lacking in credibility that it should have raised alarms across the system long before this report was commissioned.	43
Some important reviews into mortality have not been published.	43-45
NSFT cannot exercise a Duty of Candour, if they do not know which families to exercise this to.	45

Accountability

The quality of mortality data reflects a systems failure	
There are similarities to the Francis Report.	45-46
Internal leadership and governance issues at NSFT	
There is poor governance over the process.	47
There are no clear lines of accountability for mortality data.	50-51
There is a longstanding lack of 'curiosity and challenge' from the Board and Council of Governors.	47-49
The recommendations of the Verita report in 2016 have not all been implemented.	90-91
Lack of oversight and action from regulatory and monitoring bodies	
Integrated Care Boards need to be more involved in requiring NSFT to gather and use mortality data, and hold them to account.	52-53
The Care Quality Commission have not consistently demonstrated oversight of mortality at NSFT across successive inspections.	53-56
National Quality Board have not updated their guidance since 2017 which indicates a lack of national interest.	56
It is unclear what part NHS England have played with regard to mortality data.	56-58
It is unclear what the Better Tomorrow support for NSFT is and whether this is linked, as it should be, to the wider system.	59-60, 93
NSFT do not consistently upload their mortality data to the National Recording and Learning Service and this seems to go unchallenged.	60-61
Concerns about mortality have been raised by independent scrutineers but these have not been taken seriously enough.	61-64

Why the poor mortality data matters

Unsafe practice has been masked	
Bereaved families are distressed and horrified by the findings of the report.	64-65
The issues are serious enough to merit a Healthcare Safety Investigation Branch inspection.	65-66
It would be prudent to ask the Health and Safety Executive to offer a view of whether this merits investigation.	66
Comparison with other NHS trusts and localities	
It is difficult to compare with other NHS trusts and this is a longstanding issue.	67
Identifying excess deaths is difficult due to the poor quality of the mortality data	67-68
Lack of learning from data	
The promises to bereaved families and others about learning lessons have been broken.	68
The quality of the data and the systems used do not support trend analysis to improve the quality of care.	29
The data quality impacts on partnership working with other organisations across the system.	38-39
The data necessary to deliver the best care for community patients waiting for, or under the care of the trust, is impacted.	58
The data gathered during Covid masked deaths and was not investigated.	70
With high numbers of deaths occurring within 1 month of discharge, the issue of unsafe discharges needs urgently investigating.	71-72
No understanding of a cohort of patients who have been open to NSFT but not seen by clinicians in the months or years preceding their death. This raises issues about a lack of follow-up of at-risk patients.	72-73
There needs to be more exploration of the role coroners play in gathering and using mortality data and monitoring trends.	73

The following quotes from Grant Thornton's report, which asserts 'strong governance' over mortality data give an indication of how concerning the issues with NSFT's mortality data are:

"The Trust exhibits deficiencies which limit the potential to provide assurance over the pathway, and thus the accuracy and integrity of the mortality data reported from it" (p31).

"The generic category of 'Natural cause - specific not available' is used where no cause of death information is available, and accounts for 77% of all recorded mortality activity" (p7).

"There were found to be 65 missing IDs in Datix ... [and] 324 missing IDs in Lorenzo" (p30).

"The Trust's process of determining the categorisation of death as expected or unexpected, which is a key aspect of mortality report … is not clear or auditable" (p7)

An evaluation of Covid-19's impact on NSFT's mortality figures: "…reached the conclusion that 'people who were in contact with NSFT's services were disproportionately affected, compared to the whole population [of Norfolk and Suffolk]'" (p36).

"The end-to-end process of mortality recording is undocumented with a lack of clear rules underpinning the mortality pathway. This creates points of risk with limited assurance over the whole pathway" (p26).

Between April 2019 and September 2022: "For 1953 patients whose death is considered part of the Trust's mortality reporting the date of death is within one month of discharge. This includes 278 patients whose date of discharge is the same day as they died" (p38).

"Between April 2019 and September 2022 1868 deaths had an ethnicity recorded as 'not stated' and 1009 as 'not known' …[therefore] the Trust will struggle to accurately understand whether or not there is a disproportionate mortality impact on certain protected characteristics" (p39).

Actions required

Working with bereaved families NB: this might not be possible because NSFT cannot confidently identify who **all** their bereaved families are.	
Unreserved public apology to bereaved families	82-83
Going forward each bereaved family needs to have their loss fully acknowledged, including confidence that their loved one's death is counted and learnt from.	83
Bereaved families need to be involved in the actions, responses and monitoring of the Grant Thornton report.	84
National, ICBs, and trust policies, on working collaboratively and transparently with bereaved families, must move from policy to reality.	84-85
A co-produced and fully resourced reparation plan is urgently needed.	21, 80-81, 83, 87
Establishing how many people have died	
Admission by NSFT that they are unable to provide this information and acknowledgement of the seriousness of this.	86
A credible and transparent plan and resources from the system about how the number of deaths might be identified.	86
A full stop to the continuation of the current poor mortality data so that going forward we can have confidence that all deaths are correctly identified, categorised and reported.	86
Retraction of the data published by NSFT on 28.6.23 because it is at best incomplete and at worst misleading and totally inaccurate.	104-106
Critique of Grant Thornton's action plan	
The recommendations do not reflect the severity of the report findings.	86
The action plan needs reviewing to re-focus oversight and governance away from the finance director to clinical staff (pages 10-16).	87-88
The priority level given to the recommendations has not considered what the priorities would be for bereaved families, service users and carers.	87-88
The action plan has not been co-produced with system partners and key stakeholders, which is a missed opportunity.	89
There are key recommendations missing from the action plan, which can be drawn from the findings of the report.	86-87
Creation of a credible and concrete plan	
A transparent and accountable process that ensures the basics are right and there is an effective end-to-end mortality data journey.	90
A swift and wise response that avoids further drift is needed because there are current risks.	90
Robust external oversight and management of the action plan by local and national bodies.	90
Clarity about how NSFT will work collaboratively with their system partners, from across both counties, to ensure a consistent approach to mortality data.	90
Review the Verita Report	
The Verita Report made a number of recommendations pertaining to unexpected deaths at NSFT. These need to be reviewed to see which remain outstanding or only partially implemented.	90-91

The wider picture

NSFT sits within the wider health and social care system. Grant Thornton touch on some national issues that have contributed to some poor practice regarding mortality at NSFT. The problems here echo those that have been flagged up in other NHS investigations and there seems to us to be a trans-trust endemic problem that has grown over decades. It is ten years since Sir Robert Francis published his report into the Mid-Staffordshire NHS trust. In January 2023 he, and Rachel Power, CEO of the Patients Association, wrote to the Secretary of State expressing concerns and asking for government intervention:

> *"This level of crisis in the NHS is a serious threat to patient safety and it is clear lives are being lost as a result. What we are witnessing across the NHS is the Mid-Staffs scandal playing out on a national level, if not worse".*

In our analysis of, and response to, Grant Thornton's report we are mindful of the responsibility each part of the system has played in inadequacies relating to mortality data. We wonder if the conditions, guidance, and monitoring that has enabled NSFT to get into such a mess is, in part, due to a societal 'shoulder shrug' that views some lives as having less worth than others. It is as if in every sense they do not count. And their deaths are not worth counting. Is this a reflection of 'societal stigma' concerning mental health? Or are concerns such as these about NSFT to be found in NHS Acute Hospital trusts too?

"D was my brother for 49 years. He was a huge part of my life and I adored him. If you cannot even count his death, how can you learn from it?"
(A bereaved sister)

"It feels terrible and it worries me that nothing is changing and many more deaths will follow."
(A bereaved aunt)

Harm upon harm

Since publication of Grant Thornton's report, we have been staggered by NSFT's response to its publication. Rather than reassure, these confirm that NSFT still do not seem to grasp their data is fundamentally flawed and that they continue to manipulate data to try and minimise how many deaths there have been. Their communications messages have been crass, lacked sincerity and/or humility, and further distressed the bereaved relatives we are in touch with.

To coincide with publication there should have been an action plan in place and clear signposting for sources of support for bereaved relatives. We have all had distressed people contacting us via any means they can because there is no mechanism for people to express their concerns and seek clarity or help. This includes members of NSFT's staff who felt unable to work and have been left totally unsupported. They have expressed a general feeling of how can they continue 'working for truth twisters' (this is our polite paraphrasing). Likewise, bereaved people who are involved in working with NSFT to improve things have been left wondering if they are naïve and have been used in tokenistic ways. Did nobody think beyond learning their carefully worded comms lines and consider taking some responsibility for the fallout?

The damage to confidence and trust is huge. Any clumsy attempts to be seen to do the right thing now could be counter-productive and further traumatise people. The ICBs and NSFT need to urgently look at co-producing a reparation plan.

Long read response with supporting evidence

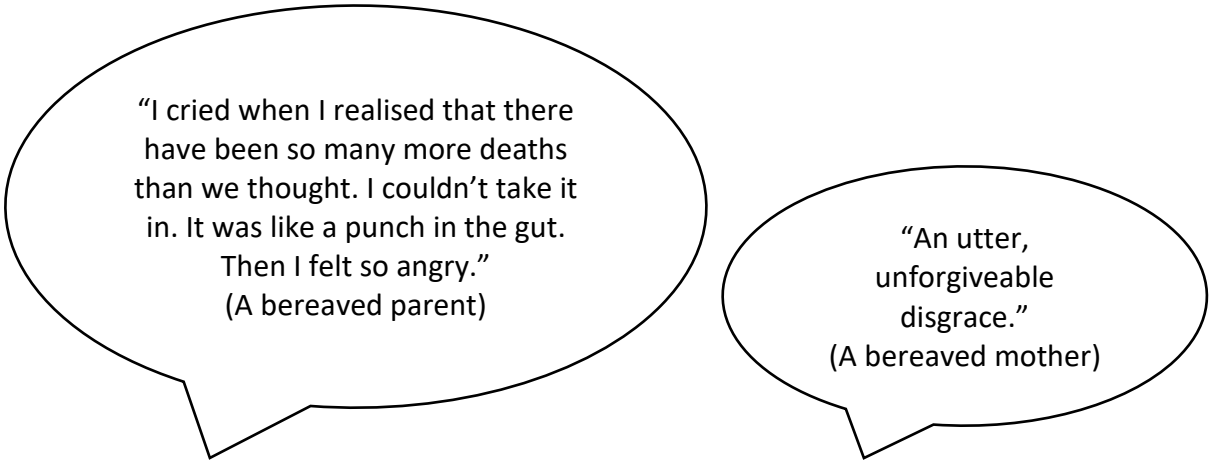
The positives

We would like to acknowledge the positives relating to Grant Thornton's report. Although we note these things we have yet to see evidence of the impact for some of them.

- The reinstatement of board papers to the website, following a request from campaigners, has assisted us in our analysis.
- Some of the recommendations of the 2016 Verita report into 'unexpected deaths' at NSFT have been acted on.
- The quality of serious incident reporting is better.
- NSFT created a suicide prevention strategy.
- There is a governor improvement plan which has a section on holding the non-executive directors to account for the performance of the board.

The scale of deaths is much worse than we knew - we still do not know how many have died

Although the figures are unreliable, it would be fair to conclude from Grant Thornton's findings that there is under rather than over reporting. Several times Grant Thornton cite numbers in thousands when referring to a short timeframe. Each of these exceeds the numbers we found for a nine-year period. It is devastating for bereaved families to read some of the statistics presented in Grant Thornton's report.



The discrepancies between NSFT's different internal data sources should be a red flag. For example:

> *"…depending on the source of death information, deaths in January 2021 increase between 111 and 203 per month from December 2020, far more than the 50 reported in January 2021"* (GT report p37).

We are left questioning - did 50, 111, or 203 people die in January 2021? And let's not forget these are human beings whose lives have been cut short, not numbers.

We believe it is important to try and establish the scale of loss at NSFT. We do not know why Grant Thornton side stepped answering this question. However, we have used the data they cited to create averages and apply these over the 9-year period (that the refuted 1,000 deaths applied to). Depending on which sets of figures shared by Grant Thornton (that they gleaned

from different NSFT data sets) are used, there is huge variation in our extrapolated guesstimates. To be clear our possible totals are guesses not verifiable statistics. Which is not unreasonable because the 'official' data seems to be little more credible than guesses too. From the data NSFT shared on 28.6.23 (11,379 over 5 years) we can see that our figures over 9 years are in the right 'ball park'. What our guesstimates show is how nonsensical the NSFT mortality data is.

Table 1: Possible numbers of deaths from 2013-2022. There are 'guesstimates' created by taking monthly averages from data presented in Grant Thornton's report and applying them over the 9-year period.

On page 37, table 3 shows 1,099 (total across row 1) deaths reported on the dashboard over a 5-month period (a monthly average of 219). If this figure is used to create an average per month and applied over 9 years then there could be as many as **23,738** deaths.
On page 53 the graph comparing unexpected deaths from April 2019 to October 2022 (42 months) is 8440 on Datix and 8132 on Lorenzo. These would be an average of 200 and 193 per month respectively. The total deaths over 9 years would be **21,702** (Datix) and **20,920** (Lorenzo).
If we take the average deaths per month from *only* Datix figures (9130) taken over a 3.5 year period the average is 217 per month (p30). If this was applied over 9 years the number of deaths would be circa **23,477**.
If we take the 1953 deaths attributable to the trust over a 41 month period (p38) then the average per month is 48 and the 9-year total is **5,184**.
On page 39 it states that some 3261 patients represented 37% of a sample of patients in an unspecified time period (presumably only the years Grant Thornton were reviewing). 100% would be **8,813** deaths. Without knowing the timescale we cannot scale this up.
On page 39 it states between April 2019 and September 2022 1868 deaths had an ethnicity recorded as 'not stated' and 1009 as 'not known'. The total is 2877 which averages at 70 per month. Applied over 9 years this is **7,560.** This is only part of a larger data set where ethnicity is known.

This figures NSFT have submitted are:

The total number of deaths NSFT reported to NHS England via their annual accounts is **6,864** However, the second half of 2016/17 and all of 2019/20 are missing from data available to us.
The total number of deaths NSFT reported to NRLS is **267** from March 2014-February 2023. NB: There is some missing data from April - September 2017, April 2019 to January 2022 and 6 months in the last year.

We cannot comprehend the staggeringly high possible numbers of deaths there have been at NSFT. It is too heart-breaking to contemplate the scale of loss. Whichever set of data we choose (other than NRLS which is a small sub-sample), the numbers cited in the report vastly exceed either the disputed 1,000 or the circa 2,600 that campaigners had identified. How these statistics can be reduced to the numbers reported to the board is beyond credible. For example, **just 1 death in 2 months was reported in April 2023's board papers**.

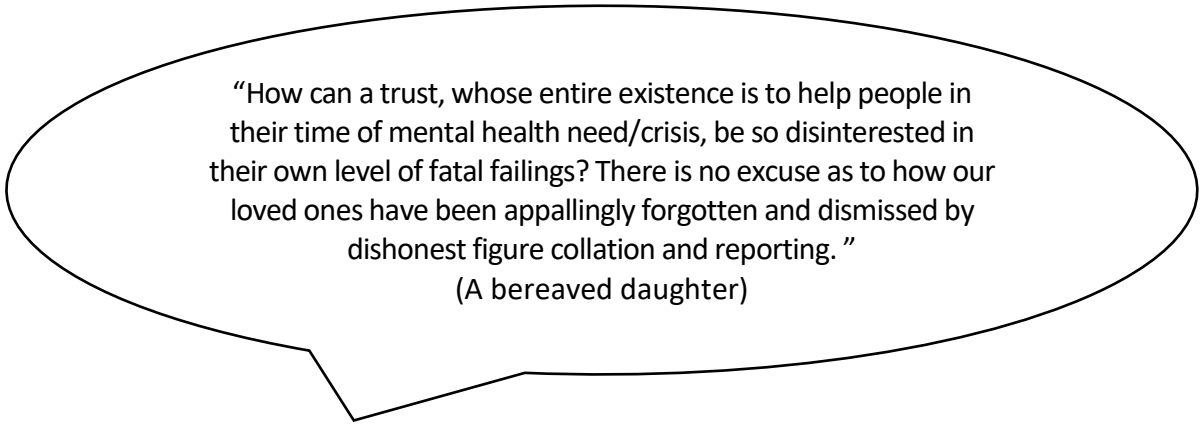
The death statistics submitted to NHSE show a dramatic increase in deaths over the last decade:

Table 2: Deaths reported by NSFT to NHSE in Annual Quality Accounts

NB: It is likely that the methodology changed in 2016

2013-14	32
2014-15	14
2015 – 16	24
2016-17	25 (second half year not submitted)
2017-18	560
2018-19	564
2019-20	Missing- presumably due to Covid-19
2020-21	829
2021-2022	1929
2022-23	2864[2]
Total	**6,841**

Another whole year has passed since campaigners challenged the death statistics. It is now 10 years since the disastrous 'radical redesign' at NSFT which saw death rates start to rise. Another year of deaths. There is an incalculable number of people who will have died this year and should be added onto the above totals.



There is no end-to-end data journey

High quality data is: *"fit for their intended uses in operations, decision making and planning"* (NHS England, 2018). Mortality data begins with death notification and identifying the death of someone under the care and treatment of the trust has occurred. Then the cause of death is established and categorised. This data is used to determine which deaths should be subject to reviews or investigations. Mortality data is presented internally to the board and externally to NRLS and NHS England. For various legitimate reasons these things might not occur sequentially. Grant Thornton found there was no end-to-end data journey. Nevertheless, we shall attempt to follow the data using the information in their report:

[2] NSFT Annual Quality Account 2022-23 pg. 81

Notification of death

> *"Grant Thornton have not seen clear documentation of the process for death notifications in these systems and how this links to the Trust mortality reporting"* (GT report p 27).

Death notifications are recorded on Datix, Lorenzo, IAPTUS, or SystmOne by health professionals and these trigger a death notification message to the NHS spine so providers can access and update their own records (GT report p6). Most trusts check the spine daily but NSFT checks less frequently which "*…results in a lack of contemporaneous information and in this area the Trust is different to other organisations who do this more frequently…"* (p25). NSFT's Learning from Deaths policy says:

> *"There is no mandated timescale for the recording of deaths within the trust, this is overseen by the attending medic, Medical Examiner and/or Coroner. In some instances, the trust receives late notifications of deaths, this is due to the information not being available via the national spine in a timely way, and is currently beyond the control of the trust"* (NSFT, 2023 p7).

We noticed in January 2021's board papers that:

> *"… NSFT has supported Real Time Surveillance (RTS) of suspected suicide in Norfolk and Suffolk. RTS allows timely awareness of where people are thought to have taken their own lives. RTS means that we do not need to wait for coroners' verdicts to spot where there are changes in rates of suspected suicides. RTS includes people who have never been in contact with NSFT's services. The RTS programme in Norfolk is now reporting weekly on numbers of people suspected to have taken their lives in real time. The Real Time Surveillance programme in Suffolk is yet to supply data but this is expected imminently".*

We were somewhat confused by this. We are unsure of whether this was started and stopped, or whether Grant Thornton were provided with this information about a system used by NSFT, because there is no mention of it in their report.

The NHS Digital *Mortality Data Review* (2020) acknowledged that there are national problems with the timeliness of death notifications and not all deaths are reported on the NHS Spine in a timely manner. NSFT check the spine less frequently than comparator trusts. The frequency which NSFT checks the national spine is within their direct control.

In the executive summary, it states that the Trust *"…is often reliant on other NHS providers for cause of death information"* (GT report p5). Surely, this is true of all trusts. *"Some comparator trusts undertake more work with partner organisations to link GP and public health information into their mortality reporting"*. Helpfully, Grant Thornton provide some examples of best practice (p40).

Trust staff identify 24% of deaths and the other 76% are identified via a monthly 'spine trace query' of the electronic database (the NHS spine) (GT report p7). Therefore, there is going to be a time lag for a substantial proportion of the death notification data.

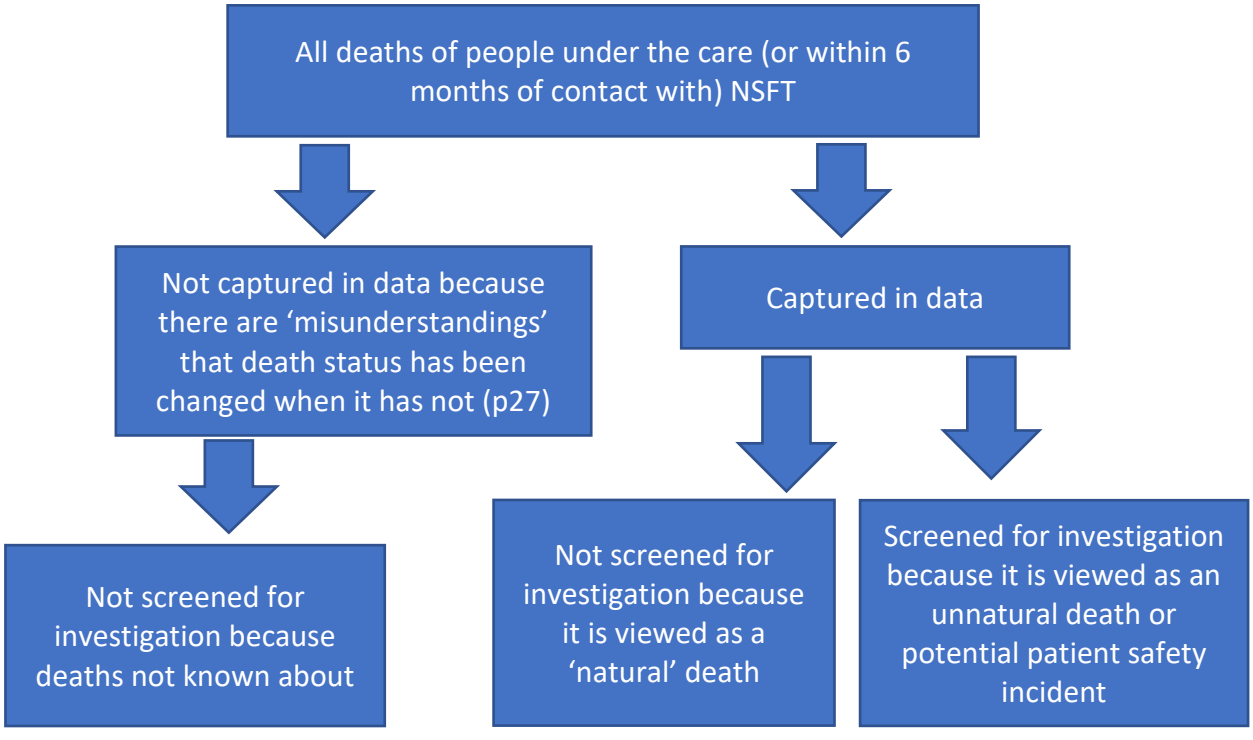
> *"All deaths will be reported on the incident reporting system by the patient safety team, regardless of origin e.g. family member, GP, national spine"* (NSFT's *Learning from Deaths Policy,* 2023 p7).

If a death is notified to NSFT it might in fact *not* be inputted to the various systems. For example, NSFT had applied rules that meant if a staff member had accessed a patient record after their death *"it was incorrectly assumed that the individual who had accessed the record would be creating the relevant Datix entry and applying the deceased status to the record"* (GT report p23). Similarly, there have been misunderstandings *"..that the death status had been changed within Lorenzo when users accessed a record post date of death, when it had not actually been done"* (GT report p27). If, as this report suggests, governance is poor, how can we be assured this will happen, and even if it does, that there will be adequate interrogation of the information?

So, at this very first point in the mortality data journey, verification of death and notifying it on the system, there is confusion and inconsistency. This is doubly alarming given that Verita highlighted similar issues which NSFT told NHOSC and their own Governors they had addressed.

The validity and the integrity of the data is compromised and this begs the questions – How many deaths were not recorded at all? We will never know how many of those unrecorded deaths should have been investigated. How can we share Grant Thornton's confidence that patient safety processes will pick up and investigate all the deaths it should when the first point in the process is so fundamentally flawed? We have illustrated this below. We are convinced that NSFT do not know how many people fit into the different categories:

Figure 2: Flow chart illustrating why not all deaths are screened for investigation NB: This is a logical analysis based on the information presented in the report



In the following weeks and months after a death

Decisions about cause of death and whether attributable to the trust are made. Once NSFT have established a cause of death, they are categorised. Not all errors lead to adverse outcomes and not all adverse outcomes are attributable to failings in care. So, a critical element is for trusts to establish proximity to the service and to the unexpected severe outcome (death). Not all deaths will occur concurrently or in the immediate period after contact with a health service and a care failing might not have a fatal consequence in the following days and months (Kelsey, 2017 p22). Additionally, several agencies might be involved. Therefore, each death should be assessed to establish cause and the likelihood of the death being related to mental illness and/or proximity to services. In addition to establishing a literal 'cause of death' (a citation on a death certificate) it seems important that at this stage the broader question of why someone has died must be considered. For example, a cardiac arrest might be defined as 'natural causes' but if it might be linked to mental illness (medication, lifestyle, high distress levels) then cause might include narrative/contributory elements. It is vital those making these decisions have the right clinical skills and systems in place to support consistency and validity.

In the trust's Patient Safety Incident Response Plan 20-23 it states *"**all** unexpected community deaths will be subject to Mortality Screening (incorporating the RCPsychs guidance tool) and an Early Learning Review (ELR) to ascertain if there are concerns related to care and service/treatment delivery"* (p10). This is part of deciding whether a patient safety incident review is necessary. What is not clear is where in the journey this occurs and who does this screening. Grant Thornton do not mention this in their report.

Grant Thornton's portrayal of the categorisation of deaths could be described as a 'catalogue of errors' which we explore in more depth in the relevant sections of this report. These include: Categorisation of deaths being undertaken by non-clinicians; changes in methodology; changing criteria and definitions; and the use of 'natural non-specified cause of death'. Collectively, these issues mean that attribution of deaths to the trust is at best unreliable, and at worst, a misrepresentation.

Contributory factors of death being incorrect was an issue Verita found in 2016 (page 40). They cited the example of 'heroin overdose' being used on several occasions when the root cause *"derived from care management problems*". This miscategorising absolves the trust from accountability and could be argued to be misrepresentation. From Grant Thornton's report we can make an educated assumption that miscategorisation is an embedded, long-standing problem.

In order to try and understand what should happen when a death occurs, we looked at NHS Digital (2020) information on mortality data. There are clear systems for verification and certification of deaths within health and social care and these were updated and clarified to speed up the flow of data from death to inclusion in ONS statistics (NHS Digital, 2020 pages 5-8).

There is a national issue with recording deaths particularly where there are delays in issuing death certificates and the data within healthcare systems might not be complete because they are "*not an enforced method of reporting deaths*" (NHS Digital, 2020 p3). Nevertheless,

"*an 'informal' death flag*" is usually placed on NHS Digital's Personal Demographics Service (PDS) by any spine-connected institution (NHS Digital, 2020 p3). 14% of deaths are referred to coroners and the majority of these will receive a death certificate within a few days although 0.1% might take longer than a year (NHS Digital, 2020 p6). Trusts generally manage delays in certification by tracking patient deaths where they are waiting for a coroner to rule the cause of death.

At NSFT they use the category 'pending' when waiting for a cause of death to be confirmed. Some of these pending deaths go back as far as 2019.

> The *"Trust may not be updating all records when causes of death are given. This could be because of difficulties in finding out this information or because the Trust are not checking back on cases it should be updating"* (GT report p28).

During the timescale covered by the report cause of death was 'pending' in 315 cases; 44 'expected' deaths and 271 'unexpected deaths' (GT report p28). We have not been able to ascertain from the report what percentage of overall unexpected deaths the 271 'pending cause of death' are. We wonder if anyone is able to provide this with confidence and factual accuracy. The inability of NSFT to 'ID track' individuals adds to this problem.

The death certificate information which is used to group the causes of death on NSFT's dashboard is *"…reliant on individuals meaning it is liable to inconsistency and it is unclear how continuity remains when key individuals are away"* (p27) and this is *"…not supported by clinical input or SOPs"* (GT report p29). Where a cause of death is unknown and/or there is no death certificate, NSFT use the Natural – non specific cause of death' category (GT report p28). In Grant Thornton state:

> *"Where, the Trust has done what it can to access a cause of death, but this information is not available, it may be clearer to use terminology such as 'unknown to the Trust"* (GT report p28).

We agree that clearer terminology is important, however, we think the term 'unknown to the Trust' is ambiguous. We wonder how many deaths waiting for Coroner's conclusions and death certificates an incorrectly recorded as 'natural'.

NSFT's use of 'natural' and 'unnatural' instead of 'expected' and 'unexpected' is not consistent with accepted national practice. In the papers we have looked at the terms unexpected, unanticipated, unascertained, potentially avoidable are used synonymously. There is nothing in NSFT's *Learning from Deaths Policy* that explains the use of 'natural' to categorise deaths with unknown causes (NSFT, 2023). NSFT used to use expected and unexpected but, for reasons that are unclear and have not been explained in their publicly available information, they stopped. From the evidence presented by Grant Thornton it seems NSFT does not have a reliable system for categorising deaths. It is disappointing that the recommendations do not include stopping using natural/unnatural and use definitions and categorisations in line with national guidance where it exists.

There are multiple points of data processing and handovers that are potential for errors. It seems as if the quantity of data handoffs and systems involved in the recording processes

have opportunities for failure and inaccuracy across the data pathway (GT report p22). There is too much reliance on individual manual inputs and the use of Excel spreadsheets which can lead to errors. There is ample evidence within the final report to suggest human error and information governance risks.

At some point before or after a death, patients are discharged from services on NSFT's systems. Between April 2019 and September 2022:

> *"… for 1953 whose death is considered under the management and care of the Trust the date of death is within one month of discharge. This includes 278 patients whose date of discharge is the same day they died"* (GT report p38).

From the graph linked to this point on page 38, it seems that over 5,000 people died within 6 months of discharge in a 42-month period alone. If the figures in the graph are correct, then each week an average of 11 patients who are discharged will die within a month and an average 27 per week within 6 months (GT report p38).

The data presented in Grant Thornton's report can be interpreted in different ways. For example, discussion surrounding date of death and date of discharge (see above) is confusing and open to different interpretations. On balance, we think this is most likely this a reflection of the ambiguous nature of the data provided to Grant Thornton by NSFT.

There are gaps in the data which further distort it. For example, a high percentage of 'null' data and information on protected characteristics.

Grant Thornton highlight numerous examples of changes in methodology in data recording. Regular methodology changes impact on the reliability of data and trend analysis, and limit the ability to track changes over time, which can lead to frustration and mistrust of mortality data.

> *"Methodology changes can be positive and sometimes needed. If changes in methodology occur without explanation, rationale or context they can cause confusion for those trying to understand the data in the report. It also hampers the ability to track through reports and historical data over time"* (GT report p 23).

What we, and others, observe is that the frequent changes in methodology may in some instances be necessary but at NSFT these are so frequent it has become impossible to track and compare mortality data year-on-year. Or sometimes even month-on-month.

Thus, we see how the data has been further distorted and obscured as it winds its way through the system over time. *"Internal and external clinical engagement is key to understanding, interrogating and using the Trust's mortality data and this is missing across the pathway as a whole"* (GT report p41). We are curious about the chains of supervision and accountability that have enabled this muddle to go on for so long.

When the data goes to board

> "*Following the review, the Trust described a process of validation. Included in that process were additional steps to clarify the six-month standard and a further*

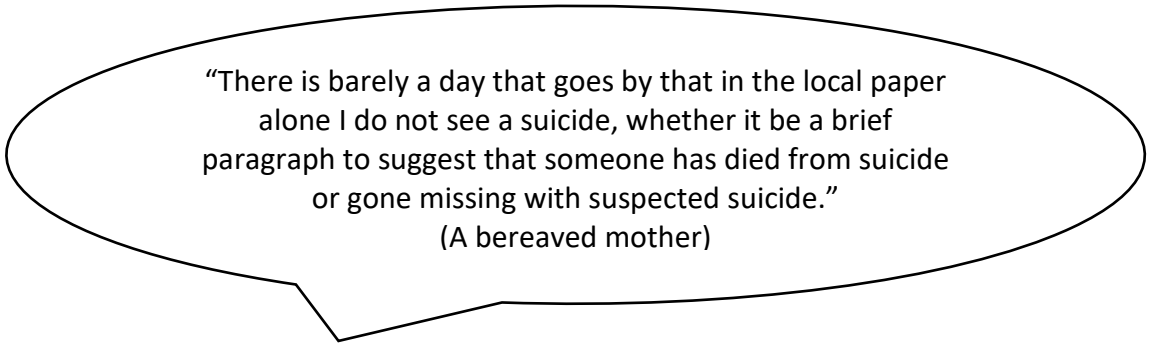
review of these activities recorded as appointments that were indirect or non face-to-face administrative activities" (GT report p30).

We are curious about who makes the decisions about what figures to present to the board and who is overseeing those who generate and collate the data. The conversion into data for the dashboard seems to us, as outsiders, a critical point where deficiencies and inconsistencies within the raw data should be checked for accuracy. However, Grant Thornton refer several times to a lack of checks and auditing of mortality data.

Somehow, rather than picking up omissions and inaccuracies and correcting them, the numbers of deaths are arbitrarily reduced without it being clear why. For example, between January 2020 and December 2021, 3835 were in the data sample provided to Grant Thornton but only 320 were cited in the board report (p34).

There are concerning basic errors such as "…*the expected and unexpected death numbers are flipped between the data sample and board reports"* (p34). Why did no one in the chain of governance notice this?

There is a lack of alignment between patient safety incident and mortality data. Not all patient safety incidents are deaths and not all deaths are patient safety incidents (GT report p22). This confusion and misalignment results in the mortality data almost slipping from sight. The mortality figures in January 2023 and April 2023's board papers, have just 5 deaths recorded within a 4-month period. This is incomprehensible and hard to reconcile with the figures in the Grant Thornton report or with our observations.



NSFT's board usually meets bi-monthly. We have examined every set of papers since 2014. Often the figures presented in the bi-monthly meetings do not correlate with those in the AGM papers and to the Annual Reports lodged with NHS England. Grant Thornton's report does not seem to identify a single place where all data (mortality, patient safety and serious incidents) are brought together and analysed systematically for board and public scrutiny. This is incompatible with the view that there is 'strong governance' (GT report p6). It is also incompatible with NSFT's self-assessment that they were *"on track to be in the top quarter of trusts for quality and safety by 2023"* (NSFT briefing for Norfolk HOSC March 2021). We find the trust's lack of insight into their problems with mortality deeply concerning. Saying something, and even believing it, does not make it true – that is magical thinking.

We agree with Raji (2020) who says that there is a sense that the people believe that numbers are objective and they will protect organisations. She says:

"If I could see faces and names on my dashboards, perhaps it would be harder to ignore the human being hiding and much easier to understand the weight of meaning that this count holds".

Within Grant Thornton's report we see how the numbers are presented in ways that minimise how many have died and obscure the individuals who have lost their lives. Even important details such as their ethnicity or cause of death are not clear.

When the data is reported externally
Grant Thornton describe it is a challenge for them, as auditors, to follow data through the organisation.

"There is no overarching documentation of the process followed and we saw no clear audit trail of the data as it moved through this process" (GT report p5).

Consequently, it is not surprising that data extrapolated for external stakeholders seems at times almost random. We do not say this lightly. From our perspective we never know if we will see single figures through to thousands; any number and type of categorisations; data presented monthly, annually or biannually; or as totals, averages or rolling averages in the statistics available in the public domain. In short, the mortality data presented to the board lacks the validity, integrity and completeness that would be expected from good quality NHS data.

The presentation of the Trust's internal mortality dashboard does not align with its external reporting. We created a table that compared deaths reported to the board with deaths reported to NRLS.

Table 2: Comparison of deaths reported to the board and NRLS

	Deaths reported in board papers	Deaths reported to NRLS
September and October 2022	**1**	**29**
November and December 2022	**4**	**3**
January and February 2023	**1**	**0**
March and April 2023	**0**	**13**

Once again, we have found inexplicable discrepancies in mortality data presented for public scrutiny.

As evidenced above, mortality data goes through a series of reductionist processes without clinical justification. Nationally, these processes have developed because NHS trusts are overwhelmed with deaths that could merit investigation and therefore it has been decided to focus on investigating particular types of death or themes with a view to learning from them. In NSFT's Patient Safety Incident Response Plan (2022-23), the processes NSFT use to select deaths to investigate are detailed. They are in effect using a purposive sampling methodology and (in line with NRLS criteria) only reporting a sample of deaths. What concerns us is the way

this small sample often get presented as *the* mortality rates. Additionally, NSFT are presenting one thing internally and another externally which is very concerning.

We asked bereaved relatives their views on the low figures presented in board papers and externally:

"Fear of bad media attention is driving systemic defensive attitudes which impact negatively on patient safety and inhibit transparency. Currently there is a complete lack of transparency to the point of being actively aggressive in withholding information."
(A bereaved parent)

"Just why? If the numbers mean so little to them, why even bother with a zero or a number 2. Just don't put anything!"
(A bereaved parent)

Compounding factors

In this section, we will draw on some compounding factors identified within Grant Thornton's report. Some refer to poor processes and practice but others to more nebulous concepts such as culture or transparency.

Missing data

There is data missing within NSFT systems. From the action plan and the Trust's responses we can see there are significant gaps. We are puzzled why these are not detailed in the report. Grant Thornton state that data has been provided by third parties and they *"…will not verify the accuracy or completeness of any such data. There may be errors in such data that could impact on the content of the report"* (p2). Within the body of their report they cite specific pieces of missing data. For example, that they only saw a visual representation of the dashboard (GT report p30). It is difficult to extrapolate accurate data from graphics and it was highlighted in the report how poor NSFT graphs are. We are curious about why Grant Thornton did not have access to the data that the dashboard is based on. Without the numerical data to support the dashboard graphic, NSFT were unable to show its 'working out'.

Grant Thornton list the mortality data documentation which is *"absent but expected" (*p26). This includes: categorisation of deaths; categorisation of expected/unexpected deaths; the role of the patient safety team reviewing Datix; end-to-end mortality recording pathway; methodology processes for changes/amendments; guidance for staff completing Datix when informed of a death; and guidance for reviewing decisions once Datix review complete.

"Missing data fields, or 'NULL' fields were prevalent across the data" (GT report p29) and analysis showed this was particularly so for 'local speciality' or 'site' fields and this means analysis will lack reliability (GT report p29). Data on speciality or site is critical for identifying problem areas and addressing any spikes in deaths.

Grant Thornton checked pseudonymised patient IDs before analysing the data. They were unable to verify whether there was any double counting because 324 Datix and 65 Lorenzo records had missing IDs (p30)

"Between April 2019 and September 2022 1868 deaths had an ethnicity recorded as "not stated' and 1009 as 'not known" (GT report p35). In the NSFT Board papers citing the September 2021 'mortality and learning from deaths paper' NSFT's Chief Medical Officer stated that 72% of the 133 people who died within 6 months of contact with NSFT between May and July 2021 had their ethnicity recorded but all of these were identified as White British (p 44/45). Of those 133 people the cause of death was unidentified in 1 in 3 cases and 83% of those with a known cause was due to natural causes (p45).

It was difficult to analyse the statistics regarding ethnicity because what Grant Thornton reports is similar to information in the CQC 2022 report and in 2021 board papers. However, the descriptors are in places the same but the numbers differ, when reporting the same time periods. This left us feeling confused and concerned that cutting and pasting information between reports might be leading to errors.

The omissions in recording of ethnicity is of great concern. This is however an issue that was first identified decades ago. The 2004 Bennett Inquiry Report (into the death of David Rocky Bennett at the Norvic Clinic) found *that "No indication that his racial, social, or cultural needs were adequately attended to"* and they therefore made several recommendations. Recommendation 7 - *"there should be a mandatory requirement to include details of each person's ethnic origin".* At the time, NSFT staff were trained on the importance of recording ethnicity. The Bennett Inquiry Report also emphasised that staff should be culturally competent and for the organisation to be proactive in challenging *"overt and covert racism and institutional racism"* (p 67). In September 2022, board papers reported on NSFT's cultural transformation programme and stated that:

> *"… ongoing and historical issues are contributing to an unhealthy culture in the trust … there are deep pockets of discriminatory and marginalising behaviour widespread across the trust. This includes racism, sexism and homophobia among others"* (p40/41).

That ethnicity is still not even recorded, and when it is everybody is White, indicates that racism is endemic. For two decades, NSFT has been stuck in a revolving programme of eliminating racism that seems to have made no progress at all.

We suggest it would also be prudent for mortality data to be checked for other protected characteristics. There seems to be an urgent need for NSFT and the two ICBs to undertake Equality Impact Assessments (EqIA) to ensure that mortality data is understood and responded to lawfully under the Equality Act 2010, by ensuring that anyone with a protected

characteristic is not being discriminated against. This will of course be a challenge because the data does not capture things like ethnicity well enough.

Grant Thornton presented a graph showing month by month the numbers of deaths from ethnic groups other than white. It shows the percentages of ethnicity recorded (68%), not stated (21%, and not known (11%) (GT report p39). It is clear then that *only* 68% had their ethnicity recorded which is not good enough.

Setting this in context, there are national issues relating to mortality data and ethnicity, with a likelihood of deaths in ethnic minority populations being underestimated - one issue is the way ethnicity is not recorded on death certificates[3]

Reading Grant Thornton's report, we can see there are many important questions that need answering. There is nothing in the action plan that will support NSFT and the ICBs ability to identify trends across different cohorts of patients or across different services. Some examples (this list is not exhaustive) of very basic questions that NSFT and commissioners could not currently answer are:

How many patients under the care of NSFT, waiting for assessment or treatment or within in 6 months of discharge who have died since 2013:

- Are black or from a minority ethnic heritage?
- Have a disability?
- Are looked after or care-experienced?
- Are carers?
- Under 18?
- Are on a waiting list?
- Have a diagnosis of schizophrenia?
- Are over 75?
- Are LGBTQ+
- Are under the care of the crisis team?
- Under the care of each locality?
- Are pregnant or post-partum?

We cannot see how NSFT and commissioners have met their public sector equality duty when they have no way of knowing whether their services are less safe for any patients with a protected characteristic or in a vulnerable cohort.

The Grant Thornton report is as impenetrable, in terms of its use of unclear language and jargon, as NSFT's board papers. Where are the 'easy read' versions? Or translations? Or even copies in large enough print for those who cannot read tiny font? We think an easy read version of Grant Thornton's report is needed but we would not trust NSFT or the ICBs to produce this in a way that accurately reflects the contents.

[3] https://www.nhsrho.org/blog/ethnic-inequalities-in-mortality-rates-and-life-expectancy-in-england-and-wales-why-we-should-treat-experimental-statistics-with-caution/

Confusing and ineffective categorisation of deaths

Fundamental in mortality recording is: establishing how someone receiving services (or within 6 months) from NSFT, has died; determining whether this is an expected death or unexpected death; and whether the death might be attributable to mental illness or their care and treatment; so that NSFT can include or exclude from the deaths in their figures. We are in no doubt from Grant Thornton's report that establishing which deaths NSFT should include in their statistics is a chaotic process. The reasons for this are unclear.

NSFT are deciding whether or not to include deaths without even determining the cause of death and they are conflating 'natural deaths' with deaths where the cause is unknown. Trusts usually use the terms expected and unexpected to categorise the deaths attributable to them, although there is no standardised definition nationally (GT report p23). At some point, and for unclear reasons, NSFT started using the terms natural and unnatural which differs from practice at other trusts: *"There was no evidence of a trust using just natural and unnatural as definitions"* (GT report p25) which makes them an outlier. We believe that this confusion could mask the numbers of deaths attributed to NSFT because the exact wording can impact the number of deaths which a trust reports.

Unpicking physical and mental health related deaths

It is known people with mental illness die earlier than the general population[4]. Often this is due to physical illness associated with mental illness. This might be due to reasons such as lifestyle or poverty but they could be more directly linked to the care and treatment of someone by mental health services. For example, Public Health England suggest that 2 in 3 deaths of people with mental illness were due to conditions such as cardio-vascular disease. People with severe mental illness often have physical co-morbidities which *"increase the risk of premature death"*, however, *"research shows, SMI is rarely recorded as an underlying cause of death …and indeed, is often not recorded on death certificates even as a contributory cause"* (Office for Health Improvement and Disparities, 2023).

Mental health providers should undertake physical health checks, the ICBs are responsible for ensuring primary and secondary care services are performing them[5]. The latest data[6] shows there is a significant amount of work to be done. Our analysis of the Grant Thornton report leads us to question if the high percentage of deaths due to natural causes might, in part, be due to NSFT's practice regarding physical health checks and shared care agreements. This is something we feel the ICB mental health collaboratives should explore.

From the processes described by Grant Thornton, we have no confidence that deaths due to physical causes, where mental illness was a contributing factor, would be included. For example, self-neglect, malnutrition or inability due to mental illness to safely manage medication for physical conditions such as epilepsy or diabetes. This is due to the lack of clinical input at the earliest stages where natural and unnatural deaths are categorised.

[4] https://www.gov.uk/government/publications/premature-mortality-in-adults-with-severe-mental-illness/premature-mortality-in-adults-with-severe-mental-illness-smi

[5] https://www.england.nhs.uk/mental-health/adults/cmhs/

[6] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2023/05/Physical-Health-Checks-SMI-Statistical-Press-Notice-2022-23-Q4.pdf

A clear example of someone with diabetes, who struggled to manage it due to mental illness, is Eliot Harris (a PFD was issued in August 2022). Diagnostic over-shadowing will be difficult to identify and address without accurate data.

'Non-compliance with care processes' and 'poor self-management of conditions' is linked to early death for people with a serious mental illness (Great Yarmouth and Waveney et al CCGs, 2019). There have been Prevention of Future deaths and inquests reported in the media where people with mental illness have died because their physical health needs have not been met.

As previously discussed, NSFT records 'natural cause-specific not available' where a death certificate is not available. How do they know it is natural if they do not know the cause? These self-described 'natural-non-specific deaths' account for 77% of NSFT's total deaths. Grant Thornton say:

> *"The large proportion of deaths categorised as 'natural causes-specific not available' poses a challenge for the Trust in understanding the deaths to be included within the Trust's mortality reporting, and then using this information to implement meaningful learning…"* (GT report p28).

Our data only comes from that in the public domain and we accept that we are having to interpret data that has been diluted to suit different audiences. However, we found an anomaly relating to deaths by natural causes that merits explanation or further investigation. In January 2021 the board papers state: "*56% of those who died in the last 6 months can confidently be said to have died of 'natural causes",* but in Grant Thornton's report it states that between May and July 2021 77% of deaths were due to natural causes (p28). Curiously, in April 2022's annual report to NHSE (April 2021 -March 2022) natural causes had risen to 94% of deaths but the spike in deaths that the trust attributed to Covid was in January 2021. We cannot make sense of a) why there is such a huge jump in the proportion of deaths being 'natural' and b) why no one has noticed or commented on it.

Similarly, there is confusion in NSFT's mortality data about expected deaths and unexpected deaths which Grant Thornton say *"currently relies on undocumented judgement processes"* (p28). They say *"… accurately and reliably sorting deaths into these two categories is key…" (*p28). We agree and want to see evidence that this happens.

Lack of clinical oversight

From the Trust's responses and the report action plan it is clear that clinical categorisations that inform reporting were, and might still be, being made by non-clinical staff. Why is this not in the report? It is not clear from the report which staff undertake categorisation and whose responsibility it is to provide the necessary oversight and supervision. Likewise, it is not clear to what extent senior staff were aware of this practice and their role, if any, in checking for factual accuracy.

In NSFT's recently updated *Learning from Deaths Policy* it does state there is a 'Clinical Decision Panel' but this seems to have a purpose of deciding which deaths should be reviewed (NSFT, 2023 p7). We note that on 18th June 2023 the policy on the public facing NSFT website

is one dated 2017. It is not clear from the GT report whether this panel has a clear view of all deaths.

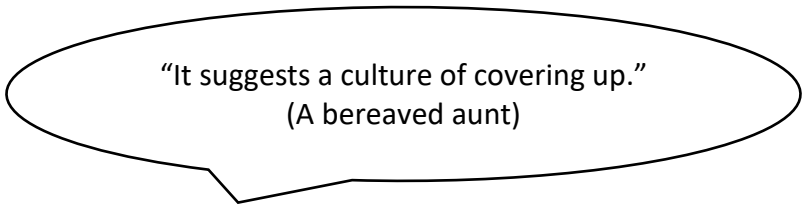
National guidelines are not clear

Within the Grant Thornton report there are several references to the way the terminology and categorisation of deaths is not nationally agreed and open to misinterpretation and that this had been identified by the 2015 Mazar's report. NSFT were fully aware of this difficulty because Verita highlighted it to them (Verita, 2016 p72). This national issue continues which indicates to us a whole system failing. Rather than addressing this issue by adopting clear and consistent terminology, NSFT further compounded it by creating their own categories that no other trust used.

The Verita report noted a *"…lack of national [unexpected deaths] data on which to base analysis"* (p13) thus limiting *"meaningful comparisons between mental health trusts".* They went on to state this was outside NSFT's control but recommended that NSFT inform NHS England (Verita, 2016 p19). If NSFT reported this to NHS England (and they told Norfolk HOSC that they would), then NHS England have not addressed the problem. It remains a live risk. We believe that it should be of interest to the ICBs to find out whether NSFT did report this to NHS England at the time, and if so what actions NHS England took in response.

Consistent under-reporting and minimising of the deaths attributed to NSFT

The mortality dashboard appears to under-report the mortality figures it is concerning that the dashboard does not capture all of the deaths held within the Trust's clinical system. For example, there are discrepancies between the data entered on Datix and Lorenzo and these differ from the data presented to the board (GT report p30). It is implied in the report that the chaotic and inconsistent approach to data management might be the cause of under-reporting. However, we feel exploring why this under-reporting occurs merits further comment and why this has not been picked up and challenged needs further investigation. There is insufficient evidence available to us at this stage to rule out deliberate obfuscation and a minimisation of any harm caused to protect organisations' reputations.



As members of the public we cannot make any sense of the data and we are familiar with such documents. Due to our personal experiences and the high level of contact we have with bereaved relatives, we have become attuned to people who die who might be attributable to NSFT. We often look at the numbers quoted in board papers and on NRLS in disbelief because the numbers do not tally with what we see and hear in our communities. In NSFT's Improvement Programme, under 'What will be different this time?' it states:

> *"Meaningful and valid measures developed with stakeholders, that triangulate reported data with what can be seen and heard. Improving data quality and insight,*

as well as integrated performance oversight a key part of improvement work" (slide 9).

With regards to mortality data there is a very long way to go.

We would like to see the action plan address the many shortcomings highlighted by Grant Thornton co-produced with bereaved relatives. There needs to be independent oversight of the plan by people who have a high level of statistical processes and auditing skills. There also needs to be a willingness to work alongside people who have identified and raised concerns, to ensure what is promised is delivered.

Changes in methodology

On page 23, Grant Thornton detail some of the changes in NSFT's methodology surrounding their criteria for including deaths in their statistics which call into question the overall governance. Were these changes due to chaotic and incompetent processes or a deliberate attempt to obscure or mislead? We do not know.

Over eight consecutive board papers there were six changes in methodology this included *"how activity was broken down, how graphs were labelled, and the types of charts used"* (GT report p6). On page 33 there is a table showing these changes. Appendix F shows examples of the different forms of graphs and criteria used to present mortality data to the board (GT report p52). As an example of discrepancy or difference in the way data is presented we have looked at the data for May 2020. Figure 9 shows c. 105 deaths, Figure 10 shows c. 83, Figure 11 shows c. 78 deaths, and Figure 12 shows c. 140 deaths. These figures appear incompatible with each other and do not tell a coherent or credible story. How can it be that the numbers of deaths in the subsequent community graph is higher than the previously presented 'all cause mortality' graphs? We are left wondering how a conclusion of strong governance can be justified.

We have looked at all board papers for 2023 to date. There have been more changes in methodology since Grant Thornton's audit. Reporting death figures has been dropped and it requires persistence in searching within the papers to find the minimal references to mortality that are there. It has required a lot of time to track deaths at NSFT due to the methodology changes which make it very difficult to compare like-for-like data. It is now nearly impossible for the public to track death rates which does not align with promises of transparency.

We noted in the March 2023 papers *"recalculation of the average and control limits from July 2022 following evidence of reduction over a period of seven months"* which looks like it might be referring to deaths. We have no idea what this means. If it is referring to mortality then it is another methodology change that could further obscure the data.

Concurrent with the publication of Grant Thornton's report, NSFT published an overview of their mortality data (see Appendix 3). We are incredulous that having been heavily criticised by Grant Thornton for frequent changes in methodology, because it obfuscates and confuses, at the first opportunity NSFT published data that included changes in methodology. See section 'Harm upon harm' for more detailed discussion. This leaves with a feeling of despair and concern that NSFT that incapable of change. It is as if those responsible for mortality

recording and reporting cannot understand and retain information that indicates they need to stop certain behaviours.

Inclusion criteria
Over the years. NSFT have made some fundamental changes in their inclusion/exclusion criteria and who they count in their mortality statistics. This *"impacts on the ability to track and compare deaths over time"* (GT report p23). Aside from drug and alcohol related deaths no longer being included because services were outsourced, there are whole groups who have been missing from the data. We have been flagging up that it was impossible to compare like with like deaths for years. It is unclear but from Grant Thornton's report precisely what has been included in NSFT attributable deaths but we picked up the following:

- Between October and December 2019, NSFT changed to reporting the total number of people known to their services who had died, previously the data only included those identified on Datix (GT report p23). The evidence is clear that Datix only accounts for some of the deaths. This means before October 2019 (and possibly after December 2019) a sizeable, but unquantifiable, proportion of deaths that should have been included were not.

- In January 2022, NSFT *"…broadened its definition of those who had died to include people whose deaths were not notified to NSFT at the time of their death"* (GT report p23). We have no information about what this means in terms of inclusion/exclusion criteria or where NSFT found deaths attributable to them that they had not been notified about. Grant Thornton evidenced that NSFT had multiple flaws in the way they identified those who had died and their notification systems were poor. One interpretation could be that before January 2022 NSFT were not gathering data via NHS Spine checks but were reliant solely on deaths they were notified of. Another interpretation could be that NSFT were only including deaths they were notified of within a short timeframe around the time of their death. As the process of death notification is prone to delays this would be equally concerning. Either way, an incalculable number of people under their care and management who died will simply not have been counted.

We have noticed, and been concerned about, the way data has been manipulated and presented for public scrutiny over the last decade. Campaigners have been raising concerns about the way methodology changes apply to mortality reporting for years. Frankly, it is beyond comprehension why these things would not have been challenged by the board.

How mortality data is currently presented to the board
The presentation of data to the board is poor. Even if the data gathered was not flawed, incomplete and skewed because of all the points where errors might be made as outlined in the data journey above, it would fail to be useful for a host of other reasons. The report does not provide evidence to show that NSFT is able to identify deaths across different service lines, care groups or diagnosis. E.g. youth service, eating disorder, learning disability, adult community, older people, dementia etc. This is essential information for thematic analysis, learning and improvement.

"Whilst the dashboard includes basic demographic information this is not presented alongside causes of death but at an unexpected or expected level. During this review we saw no evidence of detailed analysis of mortality information aligned to population health, understanding health inequalities, or learning from mortality aligned to deprivation or particular patient groups" (GT report p6).

"The data is poor. Just like the service."
(A bereaved aunt)

Grant Thornton mention the work being done with NHS England's *Better Tomorrow* team. But this did not correlate to their recommendations. They wrote, NSFT are planning to introduce NHS England's *Better Tomorrow* dashboard. We fail to see how this will address issues with mortality data and reporting outlined in this report. Grant Thornton state that the *Better Tomorrow* quality improvement plan (which focussed on the process of reviewing deaths not recording and reporting of mortality data) would *"supplement the ongoing improvement at the Trust"* (p8). However, there is no mention of the *Better Tomorrow* work in the action plan presented in the final report. Instead we find action points to improve the mortality data pathway being undertaken by the Seagry consultancy (GT report pages 10 and 12). We are confused about who is doing what and concerned that the die is cast for a series of methodology changes without explanation or alignment to NSFT's other data processes.

We are in no doubt from the evidence we have gathered that until NSFT get the basics right, in terms of identifying and correctly categorising the deaths attributable to them, any attempts to improve things down stream will be futile.

We have been tracking and raising issues with nonsensical mortality data in board papers for years. Caroline Aldridge mentioned this in her aforementioned speech to MPs in July 2022 and she provided Grant Thornton with information about the inconsistencies in presentation of mortality data to the board for them to verify themselves.

We looked at the latest board papers to try to understand what this looks like currently. The board has adopted a format which means a lot of information is presented on a single sheet. The mortality data is literally in the small print. It is reported minimally within the patient safety section, hence our argument that the governance of mortality data is linked to patient safety. There are also mentions of mortality in the transforming culture and exit criteria from the Recovery Support Plan sections.

Firstly, the January 2023 board papers -
In the Quality and Safety Executive Summary, no numerical data on deaths was presented in the graphs relating to patient safety incidents. The mortality data was presented in a series of confusing statements as follows:

"The number of confirmed or suspected suicides remains within special cause, now this constitutes an improving shift. Unnatural death incidents reported as patient safety incidents in line with the patient safety incident (PSI) priorities remain in normal or common cause variance … There have been four patient safety incidents reported

as patient safety investigation priorities all were patient deaths; this metric remains in common (normal) cause variation" (p54).

Then, on page 57 it says: "*There have been four patient safety incidents reported in this period, two of which occurred outside of this reporting period. Two of the incidents relate to inpatient deaths…"* and on page 58, *"There was one fixed point ligatures in this period, resulting in the tragic death of a patient".*

We are left wondering how many people had died.

More recently, the April 2023 papers stated there was only 1 mortality (a homicide) within the 2-month reporting period.

This data presentation epitomises the confusing way death numbers are presented within patient safety data. There is a glossary which explains the terms used. However, without numerical anchors, statements such as 'within special cause', 'improving shift' and 'remains in common (normal) variation' are meaningless. Surely, nobody reading these papers can make sense of this bafflegab. We are genuinely puzzled why governors and scrutineers are not noticing or challenging this. Or, how this demonstrates 'strong governance'.

We are equally puzzled by the CQC's view. They wrote: *"Papers for Board meetings and other committees were of a reasonable standard and contained appropriate information"* (CQC inspection report, 2023 p16). The CQC concluded their inspection in November 2022 but Grant Thornton continued to examine data until January 2023. Presumably the CQC and Grant Thornton had sight of the same board papers, therefore it is concerning that their conclusions differ so widely. We wonder if the CQC were made aware of the commissioning of Grant Thornton's report and had the opportunity to cross-reference information. If not, this seems a missed opportunity.

Culture

There is a plethora of evidence that links culture to patient safety and to learning lessons from errors or investigations and inquiries. Goodwin (2019) analysed the cultures at trusts associated with avoidable deaths (including Mid Staffs, Morecombe Bay, Bristol Royal infirmary) and found that each of these trusts had 'problematic cultures' but in different ways. Goodwin asserts that culture is complex and evolving but she did identify similarities. The CQC (2019) *Learning from Deaths* report stresses the impact of culture, *"…there needs to be a culture where staff, patients and leaders all feel able to speak up and work collaboratively to learn"* (p15). The issue of NSFT having an unsafe culture and not being a learning organisation has been raised over and again in reports, staff surveys, board papers, and the media. For example, the CQC full Inspection report (28th April 2022) states:

"Whilst positive changes in leadership and culture had occurred, we found safety of services remained a concern because leaders lacked oversight and did not respond at pace which had led to services such as acute admission services and child and adolescent mental health services not making improvements quickly enough" (p18).

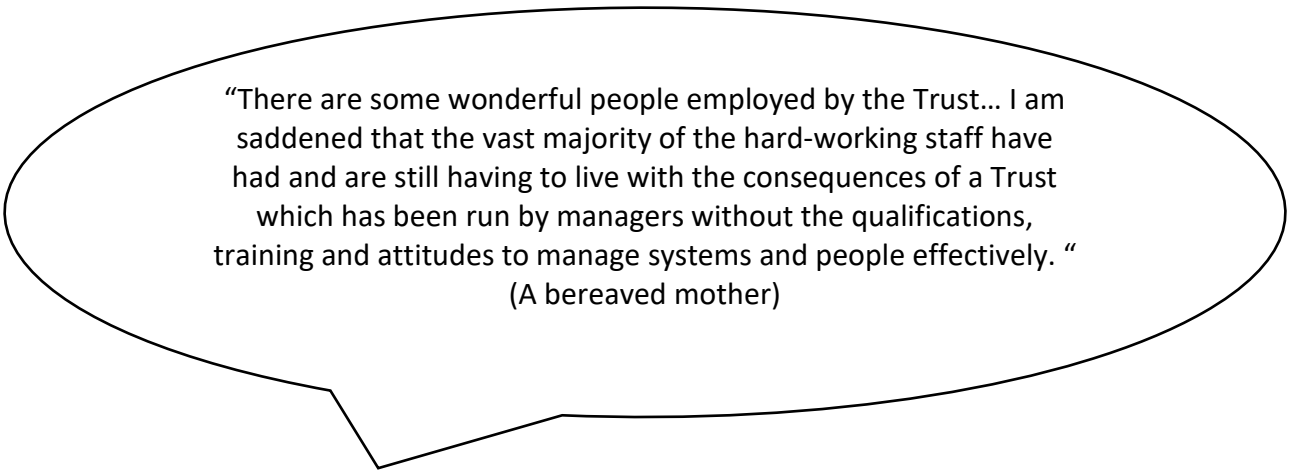
And, in the September 2022 board papers, the 2021 staff survey data was presented. It highlighted multiple issues with the culture of the organisation, for example:

"*The data available shows that bullying and harassment is taking place within the Trust and this includes instances of a lack of respect and unhealthy behaviours from colleagues, managers and service users. Although not everyone exhibits these behaviours, and there is evidence of a downward trend, the scale of the problem suggests that it is still widely tolerated*" (p 44).

Consequently, 69.6% of staff reported not feeling safe or confident to "*raise unsafe clinical practice*" (p139 and 158). When compared to other trusts NSFT performs significantly poorly and the table which compares the top and bottom 5 scores presented on page 144 of the board papers show large discrepancies:

"Of real concern in this year's staff survey results is the significant decrease in the percentage of respondents that feel the trust acts on concerns raised by service users or that secure to raise concerns about clinical practice. Not only are these scores being most declined, but they also feature in the bottom 5 scores and are significantly lower than the national average" (p145).

Bereaved families and campaigners observe all too often the toxic culture and they sometimes hesitate to make justified complaints because they do not want front-line staff blamed for system failings.



We wonder if staff felt able to raise their concerns? If not, this is a feature of 'organisational silence' – where people know the truth about certain issues but feel unable to speak out and therefore within the organisation 'very little' is said (Jones and Kelly, 2013).

With so many people working hard within and outside of NSFT to improve the culture and to set conditions where it is easier to do the right thing, it is concerning that these embedded problems with mortality data have been revealed. We wonder if this reflects habitual, rather than critically reflective, behaviours from some key individuals who have a strong unconscious bias. We noticed that in an outstanding trust Sheffield Health and Social Care NHS Foundation Trust they set board agendas with a standing item of reflecting on unconscious bias and any preferences that influence decisions. Our bias means we are sensitive to deaths associated to NSFT and associated recurring themes. We acknowledge this

and recognise that a counter-balance from a wider systemic perspective is needed. However, from the outside we would question if the whole system has succumbed to an unconscious bias of unquestioningly trusting the data and the decision making about including and categorising deaths. By the 'whole system' we feel NHSE has a significant role to play in this. We think that routinely asking the question, at every level, "how might unconscious bias be influencing how we gather, interpret and use mortality data?" would be prudent.

Transparency

Throughout their report, what Grant Thornton present could be described as a lack of transparency. There is ample evidence that the documentation presented to the board obscures the mortality data. In turn, the public, external stakeholders, and monitoring bodies remain ignorant of how many have lost their lives. As citizens, it is very difficult to gain access to mortality data nationally because the systems keep changing and often data is not accessible to us. The lack of challenge from ICBs, the CQC, and NHS England about missing, inaccurate, or confusing data leads us to question whether obscuring mortality data is a failure of wider system governance.

The failure to be aware of and respond to alarms being raised has parallels with the Mid Staffordshire scandal. The report into that inquiry stated that rather than knowingly contributing or condoning poor practice it was more likely those in the system:

> *"… were not being sufficiently sensitive to signs of which they were aware with regard to their implications for patient safety and the delivery of fundamental standards of care"* (Francis report, 2013 point 71).

An observable indicator of NSFT's lack of transparency is the way investigations and reviews are mentioned in board papers but there is no published subsequent exploration by or accountability to the board. For example, in the September 2021 board papers it states that NSFT had commissioned an independent review of its response to a number of unexpected deaths within Children, Families and Young People's (CFYP) services. As members of the public, we are unable to access any report arising from this review, neither can we see the full findings reported in board papers. In September 2021's Board minutes the following is reported from the Quality Assurance Committee (25th August 2021):

> *CFYP External Review*
>
> *"The Trust had commissioned an independent review of its response to a number of unexpected deaths during the Covid pandemic, in addition to the usual Serious Incident process. The Committee discussed the learning and were assured that the Trust had responded well to the review and recommendations for improvements. Most are completed and the Quality Committee will continue to monitor the remaining. The right leadership was now in place within the CFYP teams following recruitment, training and coaching programmes and an oversight assurance group was being established for ongoing scrutiny and assurance".*

All we can see from the minutes is that "*the Board noted all reports*" which does not give an indication about whether the Board actually saw any details regarding, or findings from, the review into this cluster of deaths. Patient deaths are the most serious NHS 'never' events and

it is not acceptable for investigations into unexpected deaths to be held behind closed doors and for findings not to be accessible.

Not reporting back on reviews into deaths has a long history at NSFT. Verita (2016) cited examples of reports into deaths that the board did not follow up:

- March 2012 - the director of nursing was asked to look at an increase in unexpected deaths in the community. No further updates or actions were minuted (Verita, page 53).

- December 2013 – A Community serious incidents resulting in death -working party report (The working Party Report) into 20 unexpected deaths in the community *was* presented to the board (which Verita say was an exception). The board minuted there had been learning points but not what these lessons were or who was responsible for overseeing any learning or practice changes (Verita, pages 55 -56). It is of note that this report was conducted internally and its findings were largely positive and inconsistent with Verita's findings on a number of points.

- February 2014 – The director of nursing reported to the board they would be investigating 38 deaths across Norfolk Recovery Partnership. The findings were not fed back to the board but they were presented to the service governance committee (Verita, page 56). Verita say *"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"* (page 58).

- March 2014- Private board minutes state that West Norfolk CCG were commissioning an external review into deaths in the community but it was September before there was agreement to share with the public board and it was *"unclear if the report was circulated to the board"* and the *"minutes suggest that detailed discussion of the final outputs of this review were limited"* (Verita, page 58).

This lack of transparency meant we have been unable to access all the information that should have been available to us. For example, Emma Corlett put in a Freedom of Information request asking for Dr Peter Jeffries report into 20 unexpected deaths in 2014. At the end of the statutory timeframe NSFT informed her that they cannot find this.

In the 2022/23 Annual Report we found this: *"In September 2022, NHS England's Intensive Support Team completed a review of serious incident governance from care groups to the Trust Board. Their recommendations and the actions we have taken as a result are summarised in the table on the following page.*[7]*"* As an example of poor transparency, we are not entirely sure what this means. We think this is the external review referred to by Grant Thornton (p43). We are curious about why this report was neither mentioned in previous board papers or published.

It is disappointing that the trust and monitoring bodies continue to conduct reviews into deaths without reporting back in outward facing forums. We wonder why this is and also to

[7] NSFT Annual Quality Account 2022-23 pg. 83

what extent findings are shared with staff across the organisation so they can learn and change.

NSFT is not unique in commissioning reviews into deaths that seem to lead to further reviews without actions being implemented. Setting this in context, across the NHS there is a habit of repeating inquiries into the same issues without this leading to learning and, more importantly, change. Each of these is viewed in isolation rather than as part of a wider whole (over time within an organisation or across trusts) *"… seeing each inquiry as a repeat of the last carries the risk of missing opportunities to learn more specific lessons arising from the different inquiries"* (Goodwin, 2019 p 208). Even when reviews lead to patient safety alerts trusts can be slow to comply and implement actions and some will 'forget' what they should be doing (Cousins, 2020). There seems to be organisational, systemic and structural amnesia which is compounded by changes in personnel. Reading Grant Thornton's report, we felt that we had seen and heard all this before. We suggest that NHS England, the Department for Health and Social Care and our government have, over many decades, enabled and perpetuated this practice of reviews and inquiries that do not lead to accountability and improvement.

Duty of Candour

> *"… for all the fine words printed and spoken about candour, and willingness to remedy wrongs, there lurks within the system an institutional instinct which, under pressure, will prefer concealment, formulaic responses and avoidance of public criticism."* (Francis, 2013)

This statutory Duty of Candour (DoC) is *"now seen as a crucial, underpinning aspect of a safe, open and transparent culture"* (CQC, 2021). Certainly, NSFT has committed in its policies to exercising a DoC. However, if they do not know who has died under their care and management, they will not know which families to it exercise it to.

Bereaved relatives would find it more credible when they witness openness, transparency and candour in the way the trust were to present all their shortcomings for public scrutiny. One could argue that those preparing mortality data for internal and external scrutiny need to exercise a duty of candour.

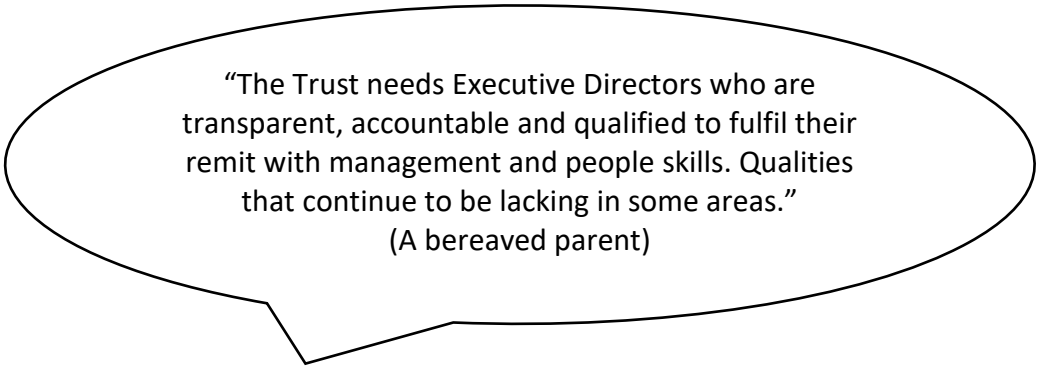
Accountability

In this section we will consider issues of internal and external accountability. Whilst NSFT must, in our view, accept responsibility for its inadequate recording and reporting processes, the wider system should also be held accountable. Had the national problems in mortality data been addressed, national consistent criteria and processes set, and commissioners, monitoring, and regulatory bodies performed due diligence, then these issues would have been picked up and addressed years ago. Sir Robert Francis cites similar system failings:

> *"When examining what went wrong in the case of a systems failure … the temptation of offering up scapegoats is a dangerous one which must be resisted. To do this would be to create the fiction that the behaviour of one person, a small group of people, would have made all the difference … There was a combination of factors, of deficiencies throughout the complexity that is the NHS, which produced the vacuum*

in which the running of the Trust was allowed to deteriorate" (Francis report, 2013 point 110).

However, INQUEST (2016) say that disciplinary action is not robust enough (p5) and when there is action, *"too often blame is focussed on junior level staff with insufficient action on corporate level…"* (p13).



The concepts of blame and censure are often conflated. Kelsey (2017) suggests that professionals and organisations *should* be blamed if they have made errors because they should be held accountable and take responsibility, however, they should not be harshly criticised for actions made in good faith or due to *"unavoidable human or systemic error"* (p51). A 'just culture' rather than a 'blame culture' recognises that harms are rarely down to individuals and that a restorative approach can underpin learning and remedial action (Cribb et al, 2021). There needs to be accountability in the context of the system as a whole because it is hard to class the errors in mortality data as entirely unavoidable given the repeated concerns raised or the responsibility of scrutineers to notice and address.

The bereaved families no longer have faith in the 'learning lessons' rhetoric. Many of those we represent *do* want individuals held accountable, perhaps because some of the same individuals repeatedly act in ways that are unacceptable to those left behind. There are only so many times they can hear the same assurances from the same people, about the same things, and believe them.

We too have brought our concerns to different people's attention and they have thanked us for it but continued without change. Rather than apportioning blame, we want to see a restoration of public and staff confidence via honesty, some demonstrable change, and a focus on repairing the damage arising from poor mortality data. This can only be achieved through greater transparency and genuine co-production.

Over the last decade, many people, organisations, quangos, and initiatives have come and gone but some things remain persistently problematic. There is the potential for parts of the system to try and slough off responsibility or even start blaming each other as a response to the findings in the report. This will only lead to further inertia. We have already observed this phenomenon in the delay between Grant Thornton completing their report in February and publication at the end of June which we are told is due to checking for 'factual accuracy'. We question why this checking process took longer than compiling the report. From the information available to us, we believe the delay was in part due to organisations within the system defending their positions. This has to stop.

We observed this again when NSFT's CEO deflected blame for NSFT's poor mortality data on to GPs and partners in media reports. The whole system needs to stop looking for the things it wants to disown and start looking for the things it should collectively own and urgently address.

Internal leadership and governance issues at NSFT

The April 2022 CQC report states:

> *"Leaders operated governance processes throughout the service and with partner organisations. However, our findings from our core service inspections identified governance processes in place failed to identify or address all risks leading to significant patient safety concerns"* (P25).

The NQB lays down standards and expectations for those responsible for leadership and governance with regards to mortality.

> *"Mortality governance should be a key priority for Trust boards. Executives and nonexecutive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge"* (NQB, 2017 p8).

The role of non-executive directors includes:

> *"Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support. For example, be curious about the accuracy of data and understand how it is generated; who is generating it, how are they doing this, is the approach consistent across the Trust …"* (NQB guidance p 24).

In addition, they should ensure that: *"…information presented in board papers is fit for publication i.e. it is meaningful, accurate, timely, proportionate and supports improvement*" (NQB p25). From the evidence presented in the Grant Thornton report and our search for triangulating evidence it seems the non-executive directors and the Council of Governors have not been performing some of their fundamental duties.

More curiosity and challenge is required

> *"Whilst data is presented in board reports there is limited evidence of interrogation into the data on either a routine or areas of concern basis."* (GT report p35)

A lack of curiosity and challenge from the board around mortality figures is a long-standing problem. In 2016, the Verita report stated that although unexpected deaths were routinely reported to the board there was *"…little evidence in board minutes of action beyond this to explore themes or lessons"* Verita, p 11). They recommended *"…more detailed discussion at board meetings about unexpected deaths to ensure that learning is being applied across the trust".* Grant Thornton's report provides detailed evidence that demonstrates mortality governance is still not a priority for NSFT's board. The board reports contain minimal evidence

of interrogation of data to investigate peaks in mortality or understand themes in the wider data.

Verita (2016) recommendation 7 (page 19) states: *"The trust board should develop its role beyond monitoring unexpected deaths"* and it lists 6 points relating to learning and outcomes including - *"seeking assurance that learning flows from 'ward to board' and back".* It is clear from Grant Thornton's report that 7 years later this is still an issue.

To change this embedded behaviour will, in our opinion, require more than the introduction of a new dashboard or renaming a committee. It requires someone with sufficient understanding of the trust's processes and personnel, who has a willingness to explore why this is such a deep-rooted problem and the courage to challenge and to undertake robust and regular reviews. A study, that looked at how hospital boards implemented the recommendations of the Francis report, concluded that a *"restless board"* that *"seeks constantly to find out more, benchmark itself, do better, and check on prior concerns and actions"* is needed (Smith and Mannion, 2018). Our observations over the last decade, and the evidence we present in this report, are not reflective of a 'restless board'.

The Healthy NHS Board Principles for Good Governance (2013) highlight the key role in scrutinising patient safety. *"Effective scrutiny relies primarily on the provision of clear, comprehensible summary information to the board"* (Verita, 2016, page 53). The concerns Verita raised in 2016 about the board's lack of examination and challenge on mortality data mirror Grant Thornton's findings in a way that is deeply concerning. Nothing seems to have changed.

> "*Unexpected deaths are routinely reported to the board but the board minutes suggest little discussion about them takes place*" (Verita, page 62).

Our examination of board papers over the last decade shows a long-standing acceptance of the numbers presented, even though the methodology and the 'ball park' figures fluctuate wildly, without this generating deeper discussion, monitoring, or learning. Questions that still need to be answered are:

- The trust made commitments to Verita about its plans to address these issues but these did not bring about the necessary change, why didn't this happen?
- Why has poor practice around mortality been allowed to continue through successive board memberships?
- What needs to happen for the board to substantially change in their attitudes and behaviours towards mortality?
- If there are any positive changes, how will they be sustained?
- How will the public know that mortality data and scrutiny is accurate and being used for learning?

Verita reviewed NSFT board papers from 2012 -2015 to examine board oversight of unexpected deaths. We have examined all the board papers since. Therefore, we are confident that although there have been many changes, and significant fluctuations in quality, the acceptance of poor quality mortality data and limited scrutiny of deaths associated with

the trust is consistent. Nearly every report we looked at was riddled with anomalies that should have alerted readers to the way data is presented, even in some cases manipulated.

For example, In NSFT's 2022 Annual Report they state: "*There are 101 cases where cause of death is known to be by patient safety incident"* (p59). In the following paragraph, it states that of 190 deaths with no known cause: *"101 are potentially safety incidents…".* Three paragraphs later, the report says: *"There were no cases of a patient death during this reporting period which was judged to be more likely than not due to problems in the care provided to the patient".* It is worth noting that in this reporting period April 2021 – March 2022 the Coroner issued 5 Prevention of Future Deaths Reports: Terence Tuttle, Joshua Sahota, Mary Bush, Sheila Steggles, and Theo Brennan-Hulme.

In 2022, a bereaved mother from the above cohort came with us to meet MPs to express our concerns over the deaths and the way NSFT seemed to have lost count. Her utter devastation about her son's avoidable death was heart-rending to witness. It is simply untrue that no patients died due to problems in the care provided to the patient. An unquantifiable number died, some of whom will have been due to unsafe care. The PFDs bear witness to that. The arrogance and abdication of responsibility that sits behind inadequate mortality data, and the minimising of statistics reported publicly, is unacceptable and it disrespects those who have died and their families.

The Council of Governors public papers, including meeting minutes, do not demonstrate any evidence of detailed discussions or exploration of data in relation to mortality. The October 2022 papers contain comments about too many lives lost and asking for assurance. However, there is no forensic analysis or evidence of holding to account. Similarly, the questions asked by governors at the public board do not demonstrate understanding of the board papers of the issues that they raise in relation to mortality and the corresponding data. The Governor Improvement Plan has a specific section on improving the way they hold to account but, sadly, the actions which underpin this would not result in more robust challenge or analysis.

Overall, we feel that the Board of Directors and the Council of Governors show a low level of 'situational awareness' about mortality at the trust. Situational awareness is defined as *"knowing what is going on around you"* and a loss of it is *"thought to be fundamental to many types of human error"* (Kelsey, 2017 p 133). We wonder if governance on mortality is poor because people are too reliant on, or accepting of, those responsible for gathering, recording and presenting data over the last decade. There has not been sufficient curiosity or challenge or awareness of what is going on, why this matters, and what needs to happen.

Mortality data is over-shadowed by patient safety data

Grant Thornton's report identifies that the board reports focus on patient safety incidents and inpatient deaths and our examination of board papers corroborates this. In recent board papers there are 'risk registers' but mortality is overshadowed by patient safety. NSFT link their risk register to 'risk appetites'. It would seem there has been little appetite to explore and address the risks posed by mortality data management. This is consistent with a general low level of interrogation of mortality information by the board. *"Board reports reviewed as part of this report contain minimal evidence of interrogation of data to investigate peaks in mortality or understand areas of interest in the wider data"* (GT report p32). If the board and governors do not have the capability or capacity to understand what is being presented to

them, they cannot effectively challenge. We, and other campaigners, could spot anomalies and, with our appetite to check and challenge, we have raised this regularly.

However, the CQC do not share our concerns:

> *"Since the last inspection the trust had progressed work to improve the availability, quality and presentation of data. The performance function was being strengthened and had been moved from the finance to the operations team. The trust had worked with NHS England to refresh the use of statistical process control to present data so it clearly showed trends over time for the Integrated Quality and Performance Board report and other Board papers; and to strengthen the dashboards used for care groups"* (CQC 2023, p20).

Looking at the last 7 months board papers, it is difficult to see the impact of the input of NHS England, who have been supporting the trust since September 2022 to present mortality data, because the January and April 2023 papers continue to contain minimal and confusing mortality data. As previously mentioned, there continues to be changes in methodology. The May 2023 papers contain no mortality data at all with the exception of reporting that there had been no Prevention of Future Death reports.

No clear lines of accountability

Through Grant Thornton's report a thread of complex and unclear lines of accountability, with regards to the gathering, recording and reporting of mortality data, is evident.

> *"The Trust's oversight over the end-to-end process of mortality reporting requires improvement and there are inadequate controls to ensure the data reported accurately reflects the service's understanding of their patients"* (GT report p42).

In their 2023 inspection report, the CQC stated:

> *"The non-executive directors worked together attending more than just their main sub-committee of the Board to ensure issues that extended across more than 1 committee were considered in a joined-up manner"* (CQC Page 11).

We question the CQC's judgement on how joined up mortality governance is because their views are at odds with Grant Thornton's findings. They suggest the way sub-committees work together is complex and at times unaligned: *"The governance over mortality reporting at the Trust is complicated and straddles a number of corporate functions*" (GT report p42) and the trust has used similar but different names for committees which adds to the confusion. In fact, the Trust do have a number of similar but different names for committees. For example, the 'patient safety incident group' and the 'patient safety incidents and mortality review group' and these seem to continually morph into similar sounding groups and sub groups. Grant Thornton wrote:

> *"Internally, whilst there is a documented line for reporting through sub-committees into the board, members of staff interviewed by Grant Thornton reflected that they felt processes were not clear"* (GT report p32).

The complex web of committees that are presented as a flow chart in Appendix I (GT report p59) graphically illustrate how confusing the oversight and governance of mortality data is. It reminds us of the 'pit of inaction' (Aldridge cited in Aldridge and Corlett, 2023) which graphically shows the way sub-committees can becoming a self-perpetuating cycle of investigation, delegation, reporting back highlights, and generating reports that no one reads.

It is not clear how the board are meeting their responsibilities but there is a helpful list of who is accountable for mortality data at NSFT with the "*overall responsibility for policy implementation"* sitting with the CEO (GT report p42). From the CQC report it looks as though community deaths have been the responsibility of the finance director. NSFT had reassured the CQC that governance of mortality data was moved away from finance to clinical directors. In the action plan in Grant Thornton's report (pages 10-16) the Chief Finance Officer as the Executive Lead for 7 of the 16 recommendations. Some of these actions do not seem to be about finance but about training, data, data sharing and other things which would appear to be outside the remit of a Finance Director. This does not sit well with bereaved relatives.

The CQC say that having a *"specific person, at a reasonably high level in the trust, is key to driving the work forwards"* (CQC, 2019 p 13) and that good practice includes the appointment of a medical examiner (p16). Grant Thornton describe how plans to appoint a medical examiner are in place to oversee mortality data. However, NSFT's Learning from Deaths Policy (last updated via a full review in January 2023) lists 'Medical Examiner' in the list of roles and responsibilities for the board and details the medical examiner's duties (NSFT, p4). May's 2023 board papers mention the *"introduction of the Medical Examiner system" (*p154). We are genuinely puzzled – does NSFT have a medical examiner or not?

Lack of oversight and action from regulatory and monitoring bodies

> *"We weren't able to identify any trust that demonstrated good practice across all aspects of identifying, reviewing and investigating deaths, and ensuring that learning is implemented" (*CQC, 2017).

We are not in a position to establish if any trusts are demonstrating good practice now. It is unclear how the Department of Health and Social Care are discharging their duties to ensure the whole system is functioning effectively with regard to identifying patient deaths and using this data to underpin patient safety.

Something that concerns us is the almost invisibility of mortality within the trust's BAFs (Board Assurance Framework) that are presented to the board and externally to evidence risks and improvements. For example, in March 2023's BAF the only reference to mortality is in relation to suicide awareness and in May 2023's BAF there is no mention of mortality, other than 'learning from deaths' being an action and a vague reference to 'unexpected deaths' being an outcome indicator. We are surprised that there is not a category on mortality. This oversight sends a message to bereaved relatives that deaths are not important to NSFT or the wider system.

Throughout the hierarchical structure of the NHS, organisations have their risk registers and Board Assurance Frameworks (or their equivalent). We are perplexed that mortality data and

monitoring death rates at NSFT do not seem to feature in these. Neither can we find any form of scrutiny of mortality in either of the ICB's published board papers. This reflects a wider system failing in our opinion.

"Families express a lot of anger about the inadequate role of the CQC…" (INQUEST 2016, p12). Bereaved families are angry with the organisations responsible for regulation and scrutiny because they feel concerns are repeatedly raised about mortality and ignored and therefore problems continue. Bereaved families are left feeling that, at best, no one cares about the deaths of people with mental illness and, at worst, that this is state-sanctioned 'deathmaking' as defined by Wolfensberger.

" It's eugenics of the 21st Century because we don't want the mentally ill in our communities"
(A bereaved sister)

Integrated Care Boards

The NQB outlines the role of commissioners in managing mortalities:

> *"Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services"* (NQB 2017 p22).
>
> *"Commissioners are accountable for quality assuring the robustness of providers' systems so that providers develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified"* (NQB 2017 p23).

For the majority of the last decade Clinical Commissioning Groups (CCGs) rather than the ICBs were responsible. In Norfolk and Suffolk there were several CCGs. Investigation into mortality was undertaken in small geographical areas which meant that oversight of NSFT as a whole was more difficult. The inception of the ICBs offers the opportunity to do things differently, particularly if they work together, and get to grips with mental health related mortality in order to commission the most effective services.

We agree with Grant Thornton that there are opportunities to learn from their review and for NSFT to work with their partners to understand the underlying issues that contribute to deaths (GT report p40). The ICBs will need to coordinate how they respond to the issues raised by Grant Thornton. *"The ICB should support the trust to ensure appropriate plans and resources are in place… and to hold the Trust to account for the plans it sets"* (GT report p44). Three areas that Grant Thornton identified for learning and information sharing were: physical health, public health and inequalities, and service access and availability.

Grant Thornton go on to set out recommendations about the areas the ICBs should focus on when supporting NSFT (p40). These are: senior oversight, data quality and monitoring, documentation, and information security.

We suggest that the ICBs need to work with Public Health to explore in depth mental health related mortality data. There must be discrepancies that should be raising alarm. Some questions the ICBs might want to explore include:

- How many people are dying due to suicide, drug/alcohol related deaths, with serious mental illnesses who are not under the care of NSFT? How does this compare to national figures and might it reflect gaps in services?
- Are there clusters of deaths in particular areas and how does this correlate to NSFT's mortality data?
- Are there specific issues such as deaths on waiting lists or following discharge that might be addressed via commissioning?
- How might all partners in the system improve their information sharing and understanding of cause of death when a patient dies?
- How might analysis of mortality data be used to identify and learn from themes? For example, where deaths occur in the gap between GPs and NSFT.

The ICB non-executive directors have an important role to play in pushing back to NHSE, the CQC and Department of Health and Social Care to make the necessary policy changes to ensure that going forward deaths are accounted for and scrutinised, mortality data is accurate, reliable and supports learning and improvement, and that they produce updated guidance.

We do not believe that point 15 of the action plan (p15), *"establish a clear improvement plan to address the issues identified in this report, and report progress to a [NSFT] board committee"* is robust enough. We implore the ICBs to take a more active role in ensuring this (of the multiple improvement plans relating to NSFT) is implemented.

Care Quality Commission

The CQC highlighted the scale and depth of poor recording and reporting of mortality data nationally (CQC, 2017). They made a number of recommendations which specifically cited mental health: *"CQC will continue to be actively involved in translating these recommendations into actions..."* (CQC, 2017 p11). They went on to state the: *"CQC will also review how learning from death is documented in inspection reports"* (p11). This aligns to the National Quality Board England *National Guidance Learning from Deaths* (2017) which states:

> *"The Care Quality Commission will strengthen its assessment of providers learning from deaths including the management and processes to review and investigate deaths and engage families and carers in relation to these processes"* (NQB, 2017 p7).

In 2019, the CQC reported on how trusts were progressing the learning from deaths agenda since the NQB guidelines were introduced. They undertook case studies for 3 well led trusts. One of which was Norfolk Community Health and Care NHS Trust (NCH&C) who were at that time rated 'outstanding' (CQC, 2019 pages 23-24). By 2018, NCH&C already had processes in place where deaths were all reviewed by a doctor and senior nurse to decide which deaths to escalate. They undertook thematic reviews of all deaths quarterly to look for learning and further review. Unlike NSFT, who do not have clinically-led categorising of deaths and have processes that seem to minimise how many deaths they want to own, NCH&C were actively

seeking to review more deaths because they did not wish to miss the learning opportunities. This is a good example of a trust with a healthy learning culture. We are aware that NCH&C lost their outstanding CQC rating and we have no information about the way they currently handle their mortality data. However, we feel the Norfolk and Waveney ICB are well placed to comment on this with a view to deciding if NSFT could benefit from learning from NCH&C.

The enablers and barriers to good practice detailed by the CQC (2019, p9) are all issues that have been raised in inspections of NSFT. Therefore, we would have expected the CQC to anticipate NSFT might not be performing well with regard to mortality. Since 2016, the CQC have routinely inspected NSFT 5 times plus many inspections of individual services. In 3 out 5 they mention mortality /death. The chronology of CQC comments on mortality present a stark and concerning picture:

2016: They found a number of incidents across the trust that had not led to learning these had resulted in the Verita investigation.

2017: they said "…*ensure that the recommendations of the* [Verita] *report into unexpected deaths at the trust are fully implemented and learnt from*". And, in the 'Are services safe?' section, they say "…*the* [Verita] *report made 13 recommendations, including that there needed to be more detailed and informed discussion at board meetings about unexpected deaths and more cohesive governance structures to ensure that learning was being applied across the trust*". And in the 'Are services well led?' section: "*We judged that there was a lack of grip around some serious issues that had been identified over the past two inspections … we were particularly concerned that the information and learning from deaths within the trust had not been given adequate focus. Despite several reports there was a lack of traction within the trust to affect change in practices based on findings from the learning following these serious incidents".* This could epitomise Grant Thornton's findings 7 years later.

2022: Within discussion about mortality and patient safety it states: "*The board and senior staff expressed confidence in the quality of the data and welcomed challenge*". And, "*Effective systems were in place to identify and learn from unanticipated deaths*". We note the term 'unanticipated' is used here which is different from the terms used and cited by Grant Thornton

2023: In their most recent inspection, there is zero mention of mortality or zero mention of death. This is disappointing because we would have hoped the CQC would be more robust in checking that NSFT had actually done what they said and, if so that they had sustained any changes. This is particularly disconcerting because they were inspecting at the same time as Grant Thornton were conducting their audit of mortality.

It is of note that the CQC do not report over consistent date ranges, or use consistent terminology, across their reports (see Appendix 4). We would deduce that they are drawing on NSFT's chaotic and flawed data. If there is to be any hope of the CQC holding NSFT to account there has to be consistency in the way both NSFT and the CQC report mortality.

The 2017 NQB guidance (p52) states:

> *"Inspectors will use new key lines of enquiry in relation to safety and governance, set out in the Care Quality Commission's assessment framework, to assess learning from deaths, collect evidence and identify good practice. Where specific concerns are identified, the Care Quality Commission can use its powers to take action with individual providers and will report its findings of good and poor progress in individual inspection reports or national publications to help encourage improvement"* (NQB 2017 P52).

And

> *"As the revised inspection regime of the Care Quality Commission will assess providers' ability to learn from deaths as a key component of high quality care, work to address this will be factored into NHS Improvement's work to support providers in achieving good or outstanding Care Quality Commission care ratings. Regional teams will work with providers, their commissioners and NHS England to identify areas where improvements can be made and the strategies which can help deliver the change required."*

We are concerned that despite their responsibilities to inspect and identify issues the CQC seem to have largely missed the flaws in the way mortality data is gathered and reported on. The following quotes below, from page 6 of the CQC full inspection of NSFT (15th January 2020), raise some concerns about level of CQC scrutiny because it contrasts with Grant Thornton's findings:

> "*The trust had improved its approach to learning from and managing serious incidents as a result of feedback from families and staff. Trust committees and the trust board had sight of incident data. The trust took proactive steps to address themes identified and improve ways to share learning across services. A new serious incident scrutiny panel and serious incident team had been created to report findings from investigations to the board. The trust recognised there was still work to be done to embed and improve this process further".*

And

> *"The trust collected reliable data and analysed it. This was a significant improvement from the last inspection. Staff across most services could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Staff submitted data or notifications to external organisations as required. New ways of monitoring and addressing waiting lists had been implemented with evidence that many lists had reduced. This meant leaders were able to understand what was happening in their organisation and act when needed*."

However, sometimes the CQC did make observations that align with Grant Thornton's findings. For example, in their 22nd January 2021 report they state:

> *"The trust had six serious incidents resulting in the death of a patient between January and September 2020 with a further death reported the week prior to inspection. Staff in both Great Yarmouth and Waveney and West Suffolk teams told us that they did not routinely receive feedback about the outcomes or learning from incidents" (*p3).

This raises a 'so what' question. If NSFT were collecting reliable data in 2020, but the CQC didn't check if the improvements were sustained in 2021, then the NSFT pattern of improving for only short time periods went unchallenged. The repeated relapsing of improvements is a feature of NSFT's in and out of 'special measures. Therefore, it was even more imperative for CQC to check back on their concerns in every subsequent inspection.

National Quality Board

Most trusts follow the NQB (2017) mortality guidance on mortality and the Mazar's (2015) report but there *"…is no single national document which offers a clear framework and supporting terminology…"* (p19). The NQB have not updated guidance since 2017 which is concerning given the scale of problems with mortality data they and others document. The NQB is part of NHS England.

NHS England

Within the layers of bureaucracy, that caused or perpetuated the conditions that have led to NSFT being able to get into, and seemingly unable to get out of, such a serious muddle with mortality data, NHSE play a significant role. There is an abundance of evidence from numerous reports into deaths across the NHS in the last decade that issues such as no agreed definitions or processes and insufficient monitoring or challenge of mortality data they collect (including data that is not submitted as required) to support our opinion that NHSE are providing weak leadership.

The 2022/23 guidance from NHSE in respect of how trusts should present annual reports has zero mention of mortality or Prevention of Future Death reports. Given that patient safety and learning from incidents is stated as a priority for NHSE, it is somewhat curious that they appear to feel it unimportant enough to be included in annual Quality Accounts. [8]

Trusts, particularly those like NSFT who are in and out of special measures, require strong consistent guidance and support. NHSE need to model what good looks like and set the conditions for trusts to know what they need to do and how they should do it. They should provide ongoing support and challenge to ensure improvements are both made and sustained. From our perspective mortality is not prioritised by NHSE and their example does not inspire confidence or support trusts to do the right things. The intervention of government and the Department for Health and Social Care to demand coherent and coordinated policies that applies across the NHS is long overdue.

In their 2019 Patient Safety Strategy NHSE state:

> *"We are changing the underlying taxonomy of the data we collect, so it is better suited to learning, more appropriate for analysis and more user-friendly to people making reports. We are balancing reducing the time it takes to input information with*

[8] NHS Foundation Trust Annual Reporting Manual 2022-23

collecting data that provides insight about the issues we need to record and what might be done to improve safety" (p23).

It seems to us critical that mortality data is included in these changes in ways that illuminate rather than minimise who is dying and why, and to make it impossible for NHS mortality data to be distilled into statistics that exclude too many deaths. Whilst we understand, and agree with, an approach of serious incident review quality over quantity, we question NHSE's solution to the problem of trusts being overwhelmed by the numbers of deaths and consequently unable to keep up with investigating them, being to only investigate a sample. Surely, what is needed is to concentrate on reducing mortality so that the numbers dying and requiring review are more manageable? In our opinion, this reflects the normalising of patient deaths rather than a determination to reduce mortality.

NHS England's website says that they ask themselves questions to evaluate the quality of data, these relate to consistency, accuracy, timeliness, efficiency, validity and completeness. Given how many issues Grant Thornton uncovered, we wonder how effectively NHS England had been asking questions about the quality of mortality data generated by NSFT.

Something we find hard to understand is the way NSFT, and other trusts, can report to NHSE statistics that should raise concerns, or even not report their data at all, but this is seemingly not noticed or addressed. We wonder if anyone reads annual reports or looks at NRLS figures to critically analyse mortality data within them. This seems consistent with the 'deaf effect' which is when decision makers and those holding power do not do not hear (by ignoring or over-ruling) 'bad news' and they carry on with a 'failing course of action' (Cuellar,2009 cited in Jones and Kelly, 2013).The bereaved families feel unheard and unheeded, not just by NSFT but by NHSE and the wider system, through their deafening silence.

We looked at the Annual Reports that the trust submitted to NHS England and been shocked by some of the data presented within them that seems to have been accepted without question. We compared the sections on mortality in the last two annual reports:

April 2021- March 2022	**April 2022 -March 2023**
1929 people died within 6 months of contact with NSFT.	2864 people died within 6 months of contact with NSFT
The 'substantial increase' over last 12 months reflected the "impact of COVID 19. NB: The reported peak in deaths January 2021 in NSFT's data.	No mention or explanation of the increase in deaths (an additional 935). NB: No quarter is as low as the highest quarter the previous year.
Of those deaths - 23 patient safety investigations and 12 structured judgement reviews	15 deaths where coroner has ruled 'suicide' or 'took own life'. 12 patient safety investigations relating to deaths and 12 structured judgement reviews. 5 thematic reviews and 16 'after action reviews'.
	Key theme from reviews '*gaps in access to service delivery'.*
94% deaths are 'natural causes'.	No percentage given for 'natural causes'

Other than age and gender, no mention in demographic breakdown of ethnicity or protected characteristics	Other than age and gender, no mention in demographic breakdown of ethnicity or protected characteristics
No mention of Prevention of Future Deaths reports. NB: There were 5 on Ministry of Justice website for this period	There have been 3 Prevention of Deaths reports. NB: There are 3 on Ministry of Justice website for this period.
	No mention of Grant Thornton's mortality review. Comment about working towards appointment of a medical examiner officer

Please note: We have not had time to fully analyse the 2022/23 Annual Report because it was late being published (3rd July 2023). We do note there is significantly more detail about mortality than usual however it still does not tell bereaved families and the public what they want to know.

NHS Digital have made a number of national recommendations about the reporting of mortality data (2020). It would help trusts to do the right thing if the processes were set out clearly from above and the recommended improvements were made.

In Grant Thornton's report they stated that NHS England had conducted an external review of patient safety and learning from deaths and mortality. However, it was not clear when this happened, why, and what else they recommended (p43). On page 43 (GT report) it states:

> *"This issue [meaning unclear] was highlighted by an external review by NHSE around Patient Safety Incidents. It was subsequently noted within the Trust that mortality had been lost sight of in the Patient Safety Review Group. This has since been renamed, in September 2022, the Safety and Mortality Committee, with an aim to split its focus between, on the one hand, patient safety incidents and, on the other hand, the impact that the Trust's care and treatment has on deaths in the community and inpatient populations. Grant Thornton has not seen minutes of subsequent meetings to measure progress against this aim but understand that this group now meets with new Terms of Reference and workplans".*

We are very concerned that the Patient Safety Review group had 'lost sight' of mortality. We can see that from recent board papers there does seem to be more detail and focus on patient safety and on inpatient deaths and we can see that different sub-committees are responsible. However, the patient safety team review some deaths (which are reported to NRLS) and the patient safety team are responsible for overseeing that all deaths are reported on the incident reporting system (NSFT, 2023 p 7). NSFT state in their Annual Report 2022 that NRLS figures are only deaths by suspected suicide which are reported to the system. They, correctly, state that the figures reported to the Strategic Executive Information System (which allows users to report and view, depending on access rights, serious untoward incidents) figures will be different and include all forms of unexpected death.

We are finding it hard to conclude governance is strong not poor from the evidence within Grant Thornton's report. We recognise that inpatient deaths might be more accurate because the fundamentals of the data journey are more likely to be correct

It states in the Grant Thornton report that:

> *"The Trust has been working with NHS England since September 2022 to improve its processes, particularly in relation to mortality … The recommendations from this report will support improvement by providing focus and clarity on issues impacting on data recording"* (p5).

It is not clear what this is referring to. We wonder if it is the *Better Tomorrow* quality improvement plan referred to on page 8 of Grant Thornton's report.

Better Tomorrow

The Grant Thornton report makes some statements about the *Better Tomorrow* initiative and how this will be a key part of improving mortality data quality. However, this is not backed up with any detail. We welcome this support for NSFT, which we assume might be part of the sector 4 intensive recovery support plans.

It is quite difficult for those external to the NHS to get any information about the *Better Tomorrow* initiative. Therefore, to assist lay readers of our response, we will summarise their aims. Our understanding of the *Better Tomorrow* project is that the focus is on *"learning from deaths, learning for lives"* and using mortality data to inform improvement. They state that *"mortality metrics are only smoke signals to be understood in a wider context"* and that data should be considered by the whole system. *Better Tomorrow* best practice requires:

- ICBs to work closely with partners to share information and learning by sharing intelligence to identify themes and opportunities to prevent future deaths. We are therefore curious about how the ICBs are involved in *Better Tomorrow's* work with NSFT and what the resulting improvements are.

- Board level leadership that is consistent, uses mortality data to inform care, considers data capture and accuracy, seeks gaps in information, understands trust methodologies, and work with other trusts and partners.

The *Better Tomorrow* project does seem to be exploring more meaningful ways of mental health trusts categorising and presenting mortality data. From the information available to us, it looks like *Better Tomorrow*'s focus is on using mortality data to identify spikes in mortality, to steer investigation and learning, rather than in the data capture and quality per se. We can see from Grant Thornton's report that NSFT are planning to use Seagry consultancy to help with this aspect.

We cannot find any information suggesting that *Better Tomorrow* will be recommending consistent definitions and approaches across trusts which is disappointing and potentially ineffective. Without a consistent approach it will remain impossible to compare trusts on a like for like basis.

Until the May 2023 Board papers were released, we did not have any information about *Better Tomorrow* input at NSFT. However, this is just a single point without explanation. We checked board papers back to September 2021 and could not find mention of NHS England undertaking this work. In the April 2023 board papers it states that there had been a deep

dive review of Trust learning from deaths during quarter 2 of 2022/23 and the Better Tomorrow Quality Planning process complete during quarter 4. However, we have been unable to find any mention of these in the board papers between March 2022 and April 2023.

We do not share Grant Thornton's optimism that *Better Tomorrow* will in itself be able to prompt the level of change required to address the difficulties in mortality data at NSFT which we believe reflects a deep organisational and system malaise. Additionally, whatever the *Better Tomorrow* plans are to focus on the "process of reviewing deaths" (p8) will be limited in their effectiveness and usefulness because, as we outlined in the data journey section, not all deaths are included or categorised correctly. If the raw data at the beginning is incorrect then it can never represent a true picture however well it is analysed and presented.

National Recording and Learning System (NRLS)

Over the last few years we have been tracking the mortality data that NSFT submit nationally that is available to us. Caroline Aldridge shared with Grant Thornton that there was missing data for NSFT on the NRLS website in some months. These included missing data from April - September 2017 and April 2019 to January 2022. On 1st July we checked NRLS and found no data had been uploaded for 6 of the previous 12 months. The last two are January, and February 2023 but the others are March, June, July and December 2022.

By comparison, Sheffield Health and Social Care NHS Foundation Trust has reported deaths for every month during the same time period except December 2022 and East London NHS Foundation Trust has reported deaths for every month during the time period.

In their April 2022 report, the CQC state: *"The trust [NSFT] was rated 'worst' for consistency of reporting to the National Reporting and Learning System (October 2018 to– March 2019), which showed a downward trend when compared to the previous period"* which leads us to wonder if, despite having this highlighted, NSFT had continued to be inconsistent reporters. Had we time, we would compare this to other trusts to see whether they upload in a timely way. It is a concern to us that this omission went seemingly unnoticed or challenged by Non-executive directors, Governors and commissioners. We are wondering if the data was added retrospectively as a result of the issue of missing data being flagged up by Grant Thornton. If so, we feel this should have been made explicitly clear.

We noticed that there was a steady increase in NSFT's 6 monthly reported deaths to NRLS from single figures in 2014/15 to 25-35 each 6 months in 2016 - March 2019. Then, following the gaps where no data was recorded things revert to mainly single figures or even zero. We cannot find any explanation for this, which might be because we only have public access. Something else we noticed is the way NRLS figures changed over time on their webpage which is very hard to keep track of. We feel that it is important that any under-reporting to NRLS is investigated and explained. Again, we are curious why no one seemed to have noticed or challenged these things.

There was no mention of NRLS in the report. This is interesting and of concern because it is often the NRLS figures (which are a small sub-sample of the deaths attributable to the trust) that are often quoted in board papers. It raises questions about why this key information relating to mortality data has been omitted from this mortality review. Did Grant Thornton

fail to look at this as part of the review, or did they look and decide it was not relevant? In either case this brings in to question the thoroughness of this audit.

NHS improvement[9] has repeatedly and clearly stated that *"regular and timely reporting to the NRLS will help reduce the likelihood of your organisation being flagged as potentially under-reporting".* They further state that *"deaths and severe harms should be reported within two working days".* It is clear NSFT frequently falls well short of this standard. For example, NHS Improvement data shows that during the period October 2018 to March 2019 50% of NSFT incidents were reported after 145 days, and 5% after 190 days. In fact, the best that they have achieved in recent years is April 2016-September 2016 when 50% of incidents were reported after 28 days, and 5% after 51 days.

We are curious why NHSE are not more proactive in exploring data quality and bias because they know it is an issue:

> *"Patient safety incident data in general is prone to reporting error and bias and NRLS data is no exception to this. Error and bias will affect the number, type and temporality of reported incidents and how the data is interpreted. Users must also remember that as the number of incidents reported reflects reporting culture rather than the definitive number of patient safety incidents occurring"* (NHS England, 2018b p16).

This seems even more important when a trust is rated 'inadequate' or 'requires improvement'.

NHS Improvement remind NHS Trusts that the thresholds for under-reporting are unlikely to be triggered by being a 'safer' trust; therefore a red '*potential under-reporting' indicator should be investigated and issues relating to your local reporting processes and data explored*". So, the warning signs to NSFT and commissioners were there in plain sight. We have neither the time nor resources to find every single notification and submission on this issue, but a quick search easily found 3 submissions that were flagged 'red'. At best, they reported 97.4 incidents per 1000 bed days (April-September 2017) and by October 2019-March 2020 this had reduced to 65.88 incidents per 1000 bed days and this was flagged as a red risk for potential under-reporting.

The distillation by design of mortality data is a feature of the data presented by NRLS. Only those deaths that have a serious incident review are included. This naturally reflects the individual and subjective processes and cultures of trusts who decide this. Therefore, NRLS data has never matched the data within the trust's annual quality reports that are published by NHSE. This anomaly needs to be addressed as it misleads the public. We feel that nationally mortality data should reflect the gross number of deaths.

[9] NHS Improvement send notifications to trusts regarding how they are meeting key performance indicators and flagging any potential risks in 'How to understand and improve your patient safety incident report to the National Reporting and Learning System (NRLS)'.

Independent scrutiny

As well as the organisations mentioned in Grant Thornton's report who are responsible for scrutinising NSFT, there are other statutory or voluntary organisations who have a role in calling NSFT to account.

Local Authority Health and Scrutiny Committees (HOSCs)

According to the Suffolk County Council website - "*The Health Scrutiny Committee is responsible for scrutinising wellbeing and health services across the county*."

And:

> "*The Norfolk Health Overview and Scrutiny Committee considers all matters relating to the needs, health and health related services of the population of Norfolk. It scrutinises services that have an impact on the health of Norfolk's citizens and challenges the outcomes of interventions designed to support the health of Norfolk people*."

Throughout the last decade concerns about patient safety and deaths have been brought before Norfolk's HOSC. They have attempted to call NSFT to account and to drill down into concerns. However, what Grant Thornton's report reveals is that they, like all external bodies, will not have accurate and reliable data to inform them.

Emma Corlett has been a member, or substitute member, of NHOSC since 2013. She has reviewed the minutes of every Health Scrutiny Committee meeting that NSFT and commissioners responsible for mental health have reported to since 2013. She has also reviewed the NHSOC briefings that are circulated to committee members between meetings.

While some of the scrutiny has been around the broader safety and culture issues as identified in the NHS staff survey and CQC inspection reports, the minutes relating to mortality provide further evidence of a system that has not and is not consistently or accurately collating or analysing information.

It also evident that assurance has been provided to Councillors at committee when there is an absence of objective evidence to support those assurances. Many of the problems and themes identified in the Grant Thornton audit are issues that NSFT and the wider system claim to have addressed or to already have good governance and oversight arrangements in place.

Where appropriate we have viewed the video footage to ensure for factual accuracy. In September 2022 the Deputy CEO in responded to question about death numbers and why all of the recommendations of the Verita review not been implemented. She said:

> *"I'm going to give some push back. It's not that we don't know the rates. It's that there is a disagreement with the rates. The agreement is therefore that NSFT will be party to an independent review of mortality data. The ToR, the commissioning is happening by the ICBs and we will supply the information requested. We are not attempting to interfere with the ToR or findings of that review. So that's the situation. It's not that we don't know, it's that there is a difference of opinion so we are taking a different approach and this review will provide a single version of the truth on deaths in our trust".*

The part of the question about why Verita recommendations had not been implemented remained unanswered.

What is shocking is how many times the HOSC have asked specific questions about recurring issues (deaths, waiting lists, unsafe discharges, poor systems etc) and been assured by NSFT that changes have been made or planned. And for those assurances to be proven false. Other, more general assurances relating to the demand on local mental health services and capacity to meet that demand have been made. Again, we cannot find objective evidence to support those assurances or any meaningful action by the wider system to address those issues when assurances proved false. These system-wide demand and capacity problems should have acted as a further major alarm to the wider system because of their very obvious risk to safety. This does beg the question of who follows things up and where the accountability lies. It feels like there is a system wide amnesia that asks the questions but promptly forgets to check.

We have been unable to find any scrutiny of NSFT by the Suffolk HOSC of any concerns relating to mortality or number of deaths. We would like to see Suffolk HOSC adopt a similar approach to scrutinising NSFT as Norfolk HOSC. The issue of mortality is very important and we feel the HOSCs should work together in regularly questioning and challenging on deaths associated with NSFT and the ICBs in terms of mental health related deaths across our counties that might be a result of gaps in services. We would like the HOSCs to be persistent in following up the issues raised by Grant Thornton's report and our response.

Healthwatch

The functions of local Healthwatch are: to gather and represent the views of people who use services and share these with commissioners and scrutineers; make recommendations about service improvements; promote the involvement of people with lived experience within all levels of the health system; feed user views into Healthwatch England and advise them and the CQC about areas of concern.

In response to the Verita report in 2016, Andy Yacoub, Healthwatch Suffolk CEO, said:

> "*The figures reported by the BBC appear shocking and we urge the Trust to take immediate steps to implement the recommendations outlined in the Verita report. With improved internal reporting, we would hope that the reasons for the increased numbers of unexpected deaths could be better understood, with clear remedial actions taken wherever possible … We will be making enquiries of the Trust to monitor its progress towards implementing the learning from this report and the experiences of service users and their families.*"

We have been unable to find any reports after this date which demonstrate the monitoring of NSFT's progress on this or in relation to mortality or unexpected deaths. Given their proactive approach to improving services it was surprising that they were not involved in the Grant Thornton SoR or interviewed as a key stakeholder.

Healthwatch Suffolk issued a statement following the publication of Grant Thornton's report which was critical of the findings, the action plan, and the way it had been produced. Andy Yacoub, CEO at Healthwatch Suffolk said this on social media:

> *"In my mind, an audit report (and the accompanying news releases) of this magnitude, sensitivity, and importance of the one the mortality, published earlier this week, is of less interest than:*

(a) What lies behind it (it was conceived, commissioned and produced without the involvement or knowledge of, people with lived experience; and
(b) the immediate and future impacts from the action plan (also produced without the input of people with lived experience) and its 16 recommendations i.e. outcomes

We completely agree.

There is no mention of the mortality review on Healthwatch Norfolk's website and we are not aware of them issuing any statements. We have been unable to find any reports or statements in relation to the Verita report, mortality or unexpected deaths on the Healthwatch Norfolk website. We note, without conclusion, the differences between Norfolk and Suffolk Healthwatch organisations.

Campaign to Save Norfolk and Suffolk Mental Health Services (the Campaign)
Since its inception in 2013, the Campaign have raised concerns about patient deaths at NSFT via its website and through letters to the trust, the CQC, NHSE&I, MPs. and others. They have also repeatedly raised the poor quality of data presented in board papers that at times render the content meaningless. We could cite numerous documents where the things highlighted by Grant Thornton have been previously raised by campaigners. This review by Grant Thornton arose as a direct result of campaigners presenting their concerns about the deaths and the way NSFT seemed to have lost count of these to a group of interested MPs in London in July 2022. Something has gone seriously adrift when campaigners need to flag up deaths because the system fails to notice what is in front of them or heed the warnings of concerned citizens and frontline staff.

Suffolk User Forum (SUF)
The functions of SUF include: gathering people's feedback and enabling an active user voice in the commissioning and delivery of mental health services, facilitating coproduction, and influencing decision making, valuing lived experience as an essential resource for service improvement. SUF receive core funding from the Mental Health Pooled Fund, to be a strategic partner with Suffolk County Council and NHS commissioners to ensure that the voices of people with mental health and wellbeing needs are at the heart of service planning, delivery, improvements and commissioning.

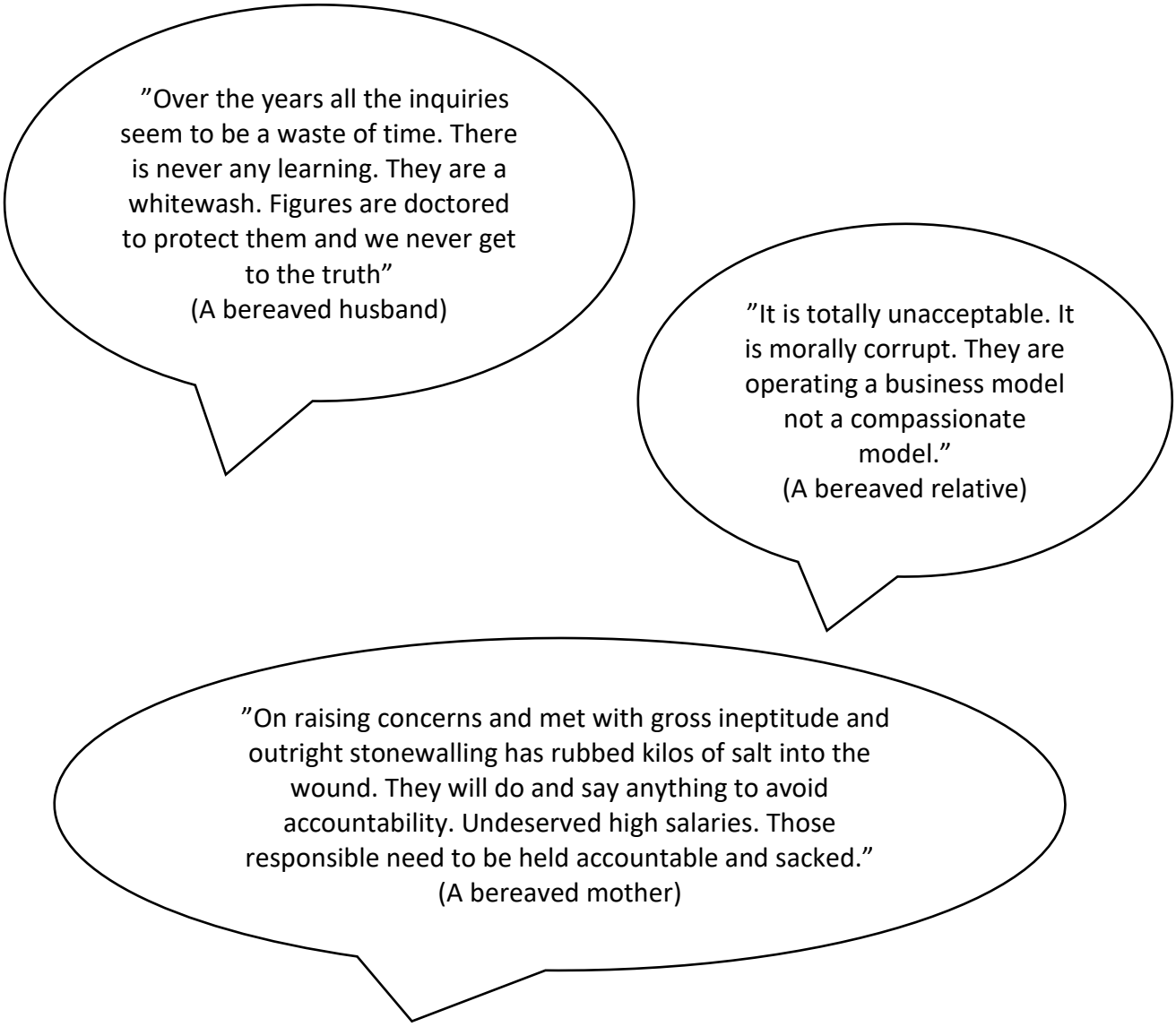
We were unable to find any explicit sections in feedback reports on the SUF website which provides experiences related to mortality, or any form of challenge to the system about mortality. This appeared to indicate that SUF are not aware of any of the issues cited in this report and would appear to be a gap in their role as strategic partners. However, SUF were quick to issue a statement supporting NSFT's challenge to the media about perceived misreporting of the Grant Thornton report. This was disappointing and left us wondering if their impartiality has been compromised.

Why the findings in the mortality review matter

In this section, we consider some of the concerns arising from Grant Thornton's findings. The poor mortality data might be contributing to deaths because without themes and trends being identified and analysed, no remedial or reparative action can be taken. NSFT and the wider system have a duty to acknowledge and address these things.

Bereaved families' view

The impact on bereaved families who read Grant Thornton's report will be powerful and painful because the contents are shocking and show disrespect to service-users who lose their lives. Every life lost **must** matter. Bereaved families typically want there to be learning from a death of a loved one because it might prevent similar deaths. It is unlikely learning can occur if deaths are not even accounted for and the reasons why they have died are understood.



Healthcare Safety Investigation Branch Inspection (HSIB)

In our opinion, the issues are serious enough to merit a Healthcare Safety Investigation Branch investigation. The HSIB decide whether to investigate based on three criteria - impact, risk, and learning potential. We believe that people dying under the care and management of a trust and clinical staff not having mortality data to use to learn from and prevent further deaths demonstrates impact, risk and potential for learning.

In terms of satisfying the HSIB criteria for a national investigation, we know from similar issues in Essex and from the lack of national guidance on mortality recording and reporting that this

is likely to be a national issue. In Essex they have struggled to identify how many inpatient deaths there have been over a 20-year period, currently this stands at around 2,000[10]. From the Grant Thornton report it seems that NSFT would find it even harder to identify how many inpatient deaths there have been.

The HSIB recently undertook a national investigation around assessing risk in mental health that was called by a relative which is relevant to the issue Grant Thornton raised about numbers who die within one month of an appointment. We feel that unsafe discharges indicated by the statistics presented by Grant Thornton merits a similar level of investigation. We will be sending a copy of our response to the HSIB and asking them to investigate. We would like to see the wider system do the right thing and support our request for the HSIB to investigate.

In October 2023 HSIB will officially become the Health Services Safety Investigations Body (HSSIB). The HSSIB will have increased powers and will become a fully independent non-departmental public body, commonly known as an arm's length body (ALB), of the DHSC.

Are the issues so serious that the Health and Safety Executive (HSE) should be called in?
With Grant Thornton being unable to definitively say how many people have died, and why, it is impossible to determine how many deaths were avoidable. The report states repeatedly that the mortality data quality is so low that it cannot be used for learning. This feels like a health and safety issue on a corporate scale.

An example, and there may be others, where the lack of scrutiny, learning and action from mortality data has contributed to deaths is inpatient deaths by fixed point ligature. The CQC flagged these up as a risk in all their inspections and at times flagging up that they were repeatedly identifying the same ligature points because the necessary remedial action had not taken place. In April 2022, the CQC once again raised the issue in their full inspection report: *"The trust did not ensure staff were aware of ligature assessments or mitigated or removed ligature points effectively to maintain patient safety"* (p3). In January's 2023 board papers there was yet another discussion and plan to remedy fixed ligature points. In the same papers a death by 'fixed point ligature' is mentioned. In February 2023, NSFT's Chair's report to the performance and finance committee states that "*ligature removal was underway"*. In May 2023's Board Assurance Framework on the addressing of ligature points risks on wards is described as work in progress. The theme since 2015 seems to be identification of ligature points, followed by plans and some action, but never completion of the work. There is a precedent of the HSE prosecuting a trust for failing to remove the known risks of ligature points on a ward and further deaths occurring. It would be prudent for the ICBs and/or CQC to ask the Health and Safety Executive to offer a view of whether this merits investigation.

Under-assessing risk is an issue that has come up in Prevention of Future Deaths reports and media accounts of inquests. We also wonder if the 1953 patients who died within 1 month of discharge in a 42-month period (potentially evidencing unsafe discharges) would also meet the HSE threshold (Figures from GT report p38).

[10] https://www.medscape.co.uk/viewarticle/number-deaths-be-investigated-mental-health-inquiry-rises-2023a10000qx?src=WNL_ukmdpls_230114_mscpedit_gen&uac=459011MV&impID=5083353&faf=1&sso=true

Comparison with other trusts and localities

How NSFT compares to other trusts

In 2016, Verita highlighted similar difficulties regarding mortality data and they gave a credible and clear rationale about why the data was unreliable. However, they did some in-depth analysis to draw comparisons by looking at particular aspects. We do not have the resources to replicate their methodology.

Identifying excess deaths

The SoR the ICBs issued to Grant Thornton (point v) states: *"Considering if there is any appropriate mechanism for establishing 'excess deaths' as context to crude mortality…".* This fundamental question remains largely unanswered in Grant Thornton's report. However, they do make a number of references about why making comparisons with other trusts and national data is important but difficult given the quality of NSFT's mortality data.

We have picked some indicators that Verita used to give an insight into the current situation. Please bear in mind that any comparison will be skewed because NSFT's raw data is fundamentally flawed.

- In 2019, ONS statistics cited Norfolk as having the fastest increase in suicide rates in the country. This was despite the suicide prevention initiatives that had started since the Verita report.
- Deaths due to drugs and alcohol: The Verita report discussed how the 'unexpected deaths' at NSFT seemed higher because unlike some trusts they offered a drug and alcohol service. This narrative was one that had been used by NSFT for some time. In 2013 the then Director of Nursing told the EDP *"the majority of deaths were of patients using [NSFT] drug and alcohol services"*[11]. Chief Executive Michael Scott told NHOSC on 16 September 2016 *"deaths due to drugs and alcohol misuse made up for approximately 30% of suicidal and unexpected deaths reported by NSFT".* In April 2018, drug and alcohol services were out-sourced and if this reasoning was correct, deaths attributable to the trust should have dropped. They did not. Having a dual diagnosis increases the risk of dying and the Verita report cited people (particularly men) as being the most likely to die. We know from media reports into inquests that drug or alcohol related deaths often cite 'long history of mental health problems' or 'known to mental health services'.

We looked at data produced by partner agencies within Norfolk and Suffolk to see their statistics on mental health.

- Norfolk County Council's, *How does health vary by place Norfolk* (2022) report draws on ONS Health Index to compare aspects of health that are better or worse compared to England. Their graph (p14) illustrates that 'mental health' is markedly worse but overall deaths (for any health reason) are a bit better. However, 'avoidable deaths and early deaths from all causes' (which are likely to include some mental health related deaths) are in the worst fifth in King's Lynn, Norwich, Thetford, Hemsby and Great Yarmouth, and the second worst fifth in some other areas of Norfolk.
- In 2019, the Norfolk's Clinical Commissioning Group reported on physical health and severe mental illness (Great Yarmouth and Waveney et al CCGs, 2019). They state that

11

> two thirds of the population with a serious mental illness living in Norfolk and Waveney STP are dying from physical illnesses that can be prevented.

From triangulating data to national statistics, we can see NSFT have higher death rates in some respects but, thankfully, not alarmingly so.

Lack of learning from data

The never-ending stream of promises to bereaved families and others about learning lessons have been repeatedly broken. We believe that if sufficient care and attention had been paid to the mortality data, and due diligence been undertaken by those responsible for monitoring, scrutinising, and calling to account, there could have been learning that would have supported action and prevented some deaths.

NHS England states:

> "*Quality data plays a role in improving services and decision making, as well as being able to identify trends and patterns, draw comparisons, predict future events and outcomes, and evaluate services*" (www.nhsengland.nhs.uk).

On their website. NSFT have publicised their 2021 Safety Strategy[12] which states that: *"We will continue to embed, maintain and improve structures, processes and roles that enhance safety. A continual focus on the person, and human stories related to safety …"* (p3) and a core component is *"Systems that enable identification, monitoring, escalation, oversight and mitigation of risks from ward to board"* (p3). However, mortality data and learning from deaths are not mentioned within the strategy, with the exception of 'unexpected deaths' being one of the outcome measures. Fundamental flaws in this strategy are the implicit assumptions that the structures and processes are sound and that the data can be relied upon.

Grant Thornton highlight that NSFT's mortality data is not conducive to learning because there is no clear conversion from mortality statistics to understanding care: *"There is limited evidence of community death themes or learning beyond the expected and unexpected categorisation of death stage"* (GT report p35). As this categorisation is poor in first place it is questionable how useful any learning would be.

> *"During the review two senior clinical leaders stated that members of the Trust's clinical staff have limited faith in their data and do not use or analyse it in a structured manner"* (GT report p37).

This means that the data does not do what staff want or need it to do. Frankly, if the data does not provide clinicians with what they need to inform their practice it is of limited use.

Using, or rather not using, mortality data for learning is a longstanding problem. The Verita report cited NSFT as ranking 223/230 trusts in the Learning from mistakes league table. They stated *"…our work tends to reinforce this conclusion, in view of whole board examination of learning from unexpected deaths"* (Verita p 61). As far as we can see no further league tables

[12] https://www.nsft.nhs.uk/download.cfm?doc=docm93jijm4n1964.pdf&ver=3065

were produced by the Department of Health and Social Care so we were unable to track whether NSFT improved or deteriorated using this measure.

We are very concerned about how learning from deaths and tracking the implementation of recommendations from PFDs is managed at NSFT. We know from campaigners Freedom of Information (FOI) requests to NSFT that the trust might be struggling to keep tabs of who was issued an FOI let alone the recommendations. The first FOI requesting PFDs was returned but a PFD missing from 2014. A more recent follow up FOI response had a name on the list that, as far as we can tell, did not receive a PFD (this is a data protection breach).

Significantly, current and past Learning from Deaths policies do not make any mention of PFDs. This omission is concerning because PFD recommendations are learning points. A purpose of PFDs is to answer key questions: How did this person die? Was it a death that could have been prevented? What lessons can we learn? Are there things that can be done so that similar deaths can be avoided? (The Law and Policy Blog, 2023).

"There is little wider point in coroners conducting their inquiries and making recommendations if nothing comes of the lessons that have been identified." However, the lack of follow up, implementation of recommendations, and monitoring of those, is a national problem - *"In essence, the lack of any body (and, indeed, anybody) being responsible for monitoring what happens to coroners' recommendations robs the coronial system of any wider efficacy*" (The Law and Policy Blog, 2023).

It is as if, within the patient safety and mortality systems at NSFT, they have lost sight of PFDs. If so, this is appalling.

We note in Grant Thornton's report that NSFT *"attends public health and inequalities forums"* (p37). In our opinion, attendance is not sufficient. It is engagement, and acting upon what has been heard and learnt from partners, that matters. This is particularly true in an era of Teams meetings where logging in can constitute attendance. We can see no evidence in Grant Thornton's report of any outcomes or impact of NSFT's attendance and therefore do not accept that it is reasonable to cite it as evidence of how they are addressing the fundamental flaws in their processes.

A lack of learning is a national issue. The Parliamentary and Health Service Ombudsman (2014) reviewed the quality of complaints and investigations into avoidable harm. They say: *"…learning from investigations appears to be trapped in high level meetings…"* and learning across organisations is reliant on *"goodwill and personalities"* and *"cross organisational learning tends to be led by the willing few rather than something that is widespread practice across the NHS"* (p8). We are curious about where within NSFT the data and any learning is trapped.

Within the Grant Thornton report it is clear that the data collected does not have enough specificity to be used to identify and address themes. We already knew this because we had spotted a theme from Prevention of Future Deaths reports and media articles on inquests that people were dying on NSFT's waiting lists. Dying while waiting for services is a theme of Caroline Aldridge's book about her son who died waiting for an appointment, *He Died Waiting*

*(*2020), and the book she co-edited with Emma Corlett, *They Died Waiting* (2023), which is a collection of other people's lived experiences.

Over the last few years, the Norfolk and Suffolk campaigners have put in a number of Freedom of Information request to NSFT regarding deaths. The majority of these were refused. On 13th December 2021 they put in an FOI for NSFT to provide the numbers of 'unexpected deaths' between 2019 to 2021 (including those on waiting lists). This was refused under Section 22 with a rationale that all the information would be in a paper being written by Dr Dalton about Mortality and Learning from Deaths and that the trust had checked that all the information requested in the FOI would be in the report. The published report did not contain information about waiting lists. In February 2022 campaigners requested the missing information and were told this would be responded to but a fee might be payable. To date this information has not been provided. Having read Grant Thornton's report it seems likely that the reason the information about deaths on waiting lists (which would be vital information) was not provided is that NSFT do not gather, or if they do cannot retrieve, this information.

The CQC has repeatedly criticised the trust for its management of waiting lists. In terms of learning and using data to improve services it would be helpful that any improved systems captured this data.

There are several references in Grant Thornton's report that suggest a lack of analysis and learning which means that further investigation is needed because the data has revealed serious issues. We shall explore four of these in the next section.

Covid masking deaths

Grant Thornton describe how NSFT attempted to evaluate the impact of Covid-19 on their mortality figures, the Trust *"…reached the conclusion that 'people who were in contact with NSFT's services were disproportionately affected, compared to the whole population [of Norfolk and Suffolk]",* however, the analysis did not adequately explore the reasons (p35). This is an example of the way not just NSFT but the wider system, are not interrogating mortality data to explore trends.

We looked at NSFT's Board Assurance Framework: On 28th January 2021, they identify the risk of *"…loss of life in service users, carers and staff…"* due to Covid but there is no mention in the controls, assurances and actions sections that states how they are recording these deaths and what would be indicators of the risk increasing (point 4.3).

Compounding the issues surrounding the spike in deaths in January 2021 (discussed on pages 33 and 35 of GT report) is the categorisation of deaths. Grant Thornton suggest that deaths from Covid may have been categorised as 'Natural- non-specific cause' and that Covid might not have been captured as a cause of death. Some deaths during the pandemic were connected to Covid, but not from having the disease. For example, we discovered in board papers that there had been a cluster of deaths in Children Families and Young People services that merited a review.

Unsafe discharges

On 8th and 22nd November 2022, we, and others, met with the ICBs, NSFT, and NHSE to share our concerns about the safety and effectiveness of NSFT. One of the issues we raised was unsafe discharges. We know from deaths reported in the media and from our observations that this is a recurring theme. Similarly, there have been Prevention of Future Deaths reports about unsafe discharges. Unsafe discharges are a longstanding problem at NSFT. 'Discharge with insufficient care package' was one of the top 5 causes of complaint reported in NSFT's 2022 Annual Report. Deaths following discharge are very difficult for bereaved relatives to accept.

"When NSFT are there to support those with mental health to continue life, I find it perplexing that the service does not keep a close eye on the mortality rate of those under their care and within a period of time of discharge. How can the service know it's effectiveness if it is not seeking to understand how those with mental health issues are responding to the treatment/care plans they are given?"
(A bereaved mother)

The Verita (2016) report highlighted serious shortcomings with discharges (p43) and in "*a few cases"* the poor practice they highlighted *"…were considered to have contributed to or caused the unexpected death"* (p43). Verita (who reviewed 126 serious incident reports) found examples of poor practice around discharges (page 43). These included: no 'proper' discharge plan; discharge without care plan, CPA or updated risk assessment; limited or no liaison with GPs; discharge from CRHT without face-to-face meeting with the service-user; unclear rationale for discharge; and no crisis plan in place. These issues have featured repeatedly in Prevention of Future Death reports and media reports of inquests. It is devastating for bereaved families who have subsequently lost their loved ones to know that the trust had been informed of these failings but continued with unsafe discharge practice. What the Grant Thornton report demonstrates is that a barrier to learning from deaths in these circumstances is the poor quality mortality data that does not even provide reliable and accurate basic information on deaths.

In their Annual Report 2022, NSFT state they use tools to "*alert for 'red flag' concerns such as recent discharge from a mental health unit or contact with crisis services".* Given Grant Thornton's findings and the number of deaths we observe, it seems this system is not effective enough. Grant Thornton's analysis indicates that there might be links between discharges and deaths but cannot elucidate due to the quality of the mortality data. We agree.

Grant Thornton describe less clarity about community/out-of-hospital deaths. This might reflect that under NQB guidelines reporting inpatient deaths are mandatory but community

deaths are not. This is a national problem and community deaths commonly do not have "*any notification or appropriate investigation or inquest"* (INQUEST, 2016 p3).

We are concerned about the 278 patients whose date of death and discharge are the same (GT report p38). There is no clarity in Grant Thornton's report about what this means. It could be that 278 patients were discharged then died on the same day (which would be horrific), or that the death notification triggered being discharged, or a mix of both. In a statement correcting the media for inaccurately reporting this figure, an explanation was given that was ambiguously worded and seems to imply all 278 were discharged on date of death as an administrative process. We were not convinced. It is deeply worrying that there does not seem to be a way of clarifying this.

Grant Thornton flag up the high numbers of deaths within one month of discharge (p38). In the period April 2019 – September 2022:

> *"1953 patients whose death is considered under the management and care of the Trust the date of death is within one month of discharge … Given the large number of patients who die within a month of discharge from the Trust's services, more work is needed to understand this cohort. Having an accurate cause of death will be crucial so the Trust can understand if it could have acted differently…"* (GT report p38).

The difficulty in a piece of work exploring this cohort is that NSFT do not know the causes of death for many of their patients. Nevertheless, we believe that a robust attempt should be made to interrogate this data.

On page 39 (GT report) it states that 37% of deaths (some 3261 people) between April 2019 and September 2022 had a *"discharge date recorded after the date of death"*. If so, 63% (5552 people) of those who died did so following their discharge from services. This means 8813 people died in this 3.5 year period.

The issue of identifying when patients who are discharged from services die, is a national issue*:*

> *"There is no consistent process or method for NHS trusts to record when recent patients die after they have been discharged from the care of the service, either from an inpatient service or from receiving services in the community"* (CQC, 2016 p9).

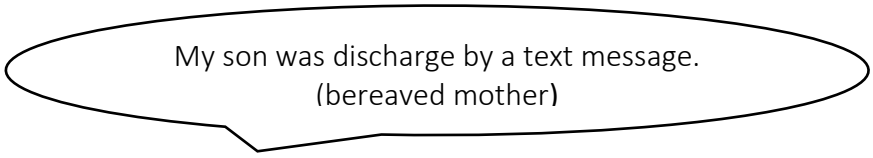
We are curious about why nobody in the system has noticed or addressed deaths following discharge from services because so many are publicly reported. Anecdotally, we know these kinds of deaths relentlessly occur and in recent weeks we have been told of several such deaths.

Lack of follow-up of at-risk patients

The chart on page 38 [Figure 5] indicates that of approximately 5,400 patients who died in the 41 month period examined, almost 2000 died within one month of discharge. Grant Thornton state that "more work is needed to understand this cohort, ensure this data is accurate and act on any learning". We assert that this could indicate a lack of oversight and follow-up of at-risk patients by the Trust, and any further work around this cohort should have

robust oversight by the ICBs. It was equally concerning that almost 7% of deaths in the cohort examined had "not been seen for a number of years", with 2% "where the patient had not been seen for over 2 years". This is a clear example of the Trust not even being able to accurately identify patients for inclusion by its own stated criteria (under the care of or within six months of discharge). It is currently impossible to determine how many of those deaths were people who had in fact been discharged from services and their records not updated accordingly, and how many were of people who still required further clinical input but had 'slipped through the net'.

We have been given examples by people using services and bereaved families of people languishing in services but not actually being seen during prolonged gaps between one care co-ordinator leaving and being reallocated to another, or of being discharged after months of not being seen with no discussion or face to face clinical assessment.



It is our sense that particularly in adult and youth community teams' caseloads were overwhelming and there was not good oversight of those 'team held' cases where a member of staff left their job and there was simply no-one to allocate their care to. For example, the CQC found objective evidence of wholesale removal of 300 young people from awaiting allocation lists for non-clinical reasons within Youth Services[13].

We know from inquests and media reports that inadequate risk assessments have led to many deaths. Two recent examples are Alan Hunter (2020) and Faisal Mohammed (Rowan) Al-Dossary (2021).

Despite many months of checking the report for factual accuracy the data and discussion about dates of death and discharge it is impossible to penetrate the ambiguity. Although we know much of the data is meaningless, this stark information must be further assessed, analysed and acted upon.

The police are often involved in mental health related deaths because they attend and investigate. In Zoe Billingham's (former HM Inspector of Constabulary) foreword to the HMI CFRS (2018) report *Policing and mental health: picking up the pieces*, she describes how it is often the police who are called on when there is a mental health crisis. We notice that within the literature, processes, policies, and information about deaths connected to the NHS there is almost no mention of how the police might provide or use mortality data. With the new mental health collaboratives being stood up in Norfolk and Suffolk, it might make sense to include the police in action plans. We would hope that with her understanding of managing mental health risk from both a police and mental health trust perspective, Zoe Billingham is well placed to build connections. Critical to this will be having accurate mortality data. Adding to the urgency of establishing accurate NSFT attributable death data is the news that the

13 https://www.edp24.co.uk/news/local-council/20750426.mental-health-trust-admits-discharge-300-young-people-waiting-list-decision/

Metropolitan Police will soon be refusing to attend mental health emergencies.[14] Subsequently, his strategy was adopted in Norfolk and Suffolk. It will be extremely difficult to identify any excess deaths that could occur because the baseline data is flawed.

The importance of coroners

Across NHS trusts:

> *"There remains too much subjectivity in the system and too much room for error, for example, highlighted by revelations that large numbers of mental health deaths are not being reported to coroners. We simply don't know how many deaths are going below the radar"* (INQUEST 2016 p4).

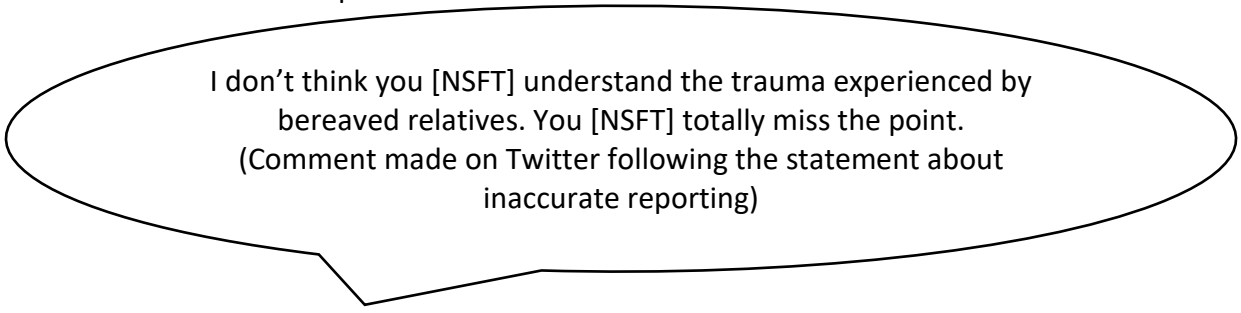
Grant Thornton do not specify the processes by which NSFT are reporting deaths to the coroners, although by implication it is likely some might be missed.

Grant Thornton did not comment of how NSFT record and report on Prevention of Future Deaths reports issued by coroners. From the evidence presented by Grant Thornton about mortality data we cannot assume that there are good processes in place for this. We would like assurance that there is an effective system for managing and using this data for learning and that oversight from NSFT's board and the ICBs will be much stronger.

Harm upon harm

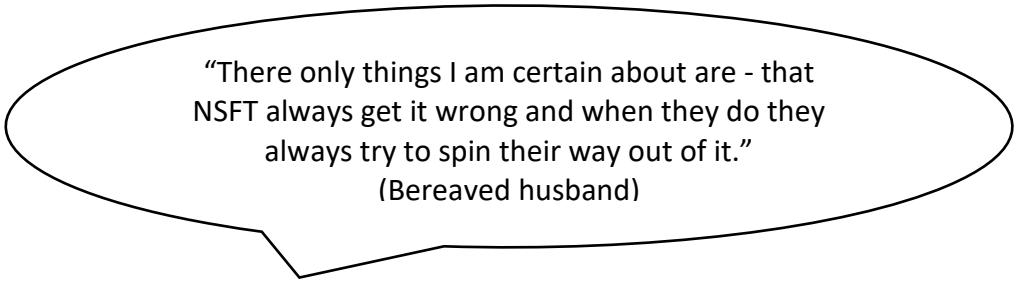
We have been appalled by NSFT's responses following the publication of the report. The toll on bereaved has been immense. It was not helped by a communications team who acted without compassion or thought for the families. The swiftness with which they issued subsequent statements (which were not shared with us in advance so we could warn families) has exacerbated their grief and trauma. If ever there was a time when NSFT needed to be understanding, absorb criticism, supportive and gentle it was in the immediate period after publishing such an emotionally-loaded and devastating report. What was communicated to families was that statements from the CEO and Chair were tightly scripted and the statements were all designed to try and make things look better than they are. It is difficult to find words to adequately express how families felt.

Rather than reassure, the issuing of definitive death numbers and tetchy statements correcting the media for quoting verbatim the report, confirms that NSFT still do not seem to grasp their data is fundamentally flawed and that they continue to manipulate statistics in a misguided attempt to minimise how many deaths there have been. There is an irony in NSFT seizing on an opportunity to criticise others for inaccurate recording. The inappropriateness of this was obvious to the public.



[14] https://www.bbc.co.uk/news/uk-65741824

The dangers of certainty



It is well recognised in health and social care that professionals and organisations certainty is unlikely due to the nuances and complexities of working with people. Indeed, in the field of social work certainty and unsafe practice are considered as 'bed fellows'. The key to embrace working with uncertainty by being critically reflective and seeking to understand context (Fook,2016). Fook asserts we need to accept and manage uncertainty because:

> "*One of the major dilemmas posed for modern current practice is the difficulty of acting effectively, through using learning from past experience, when the new situations we encounter are unpredictable and uncertain"* (p190).

What we have observed over the last decade is leaders at NSFT declare certainties whilst presiding over chaos. There seems a lack of critical reflection and an integral arrogance that fails to fully comprehend both the seriousness of failings, or the impossibility of simple and/or certain remedies. Therefore, we were not impressed to hear the Deputy CEO talk at NHOSC of finding a 'single version of the truth' with regards to death numbers. We knew that even in an outstanding trust this would be impossible because the national guidance and criteria being changeable and unclear. Every part of the mortality data processes rely, in some part, on humans making a judgement or taking appropriate actions.

Even in the face of the evidence presented in the Grant Thornton report, NSFT persisted in the belief they could be certain of some of their data. In their statement in response to the mortality review on 28th June 2023, the CEO states:

> *"We have certainty on the number of deaths related to incidents and suicides; firstly, because they correlate with and are verified by the coroners' data; secondly, because they correlate with real-time recording by local authority public health teams, and thirdly, because Grant Thornton have found strong governance around the recording and reporting of all patient safety incident deaths and suicides."*

We would counter:

Firstly, that there is evidence that there is variation between coroners about where the thresholds are for this (Gunnell et al, 2013). In 2020, the standard of proof (from beyond reasonable doubt to a balance of probabilities) for ruling a death as suicide was changed[15] so

[15] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/changeinthestandardofproofusedbycoronersandtheimpactonsuicidedeathregistrationsdatainenglandandwales/2020-12-08

looking retrospectively across 5 years means that it will be difficult to compare between years. Despite the change, within NSFT's catchment area the different coroners are more or less likely to come to this conclusion and/or issue a PFD. For example, one of the Norfolk coroners is known to sum up by describing the act by which someone died by their own actions but qualifies this by saying *"we cannot know"* their intent to die.

Secondly, real time recording is contemporaneous and it includes suicides and suspected suicides. So, by design, data will be uncertain because it will keep changing as investigations uncover more information.

Thirdly, as detailed in the data journey section, if not every death is captured in the first place the numbers can never be 100% correct however well patient safety incidents are investigated.

We know enough to know we could never be certain of the death statistics. We were never seeking certainty or a single truth. We were seeking honesty and transparency about the processes and methodologies alongside consistent published data so we could, as concerned citizens, make informed judgements about how many people might be dying due to poor care and why.

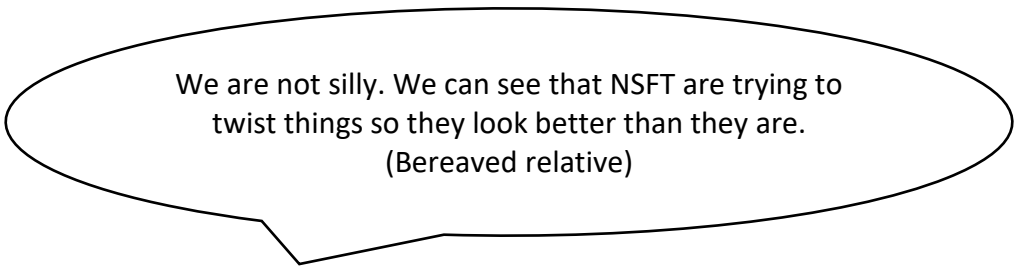
One thing is certain, those who have lost their lives are forever gone. There are thousands of bereaved families across Norfolk and Suffolk who live a version of a single the truth every day: Their loved ones are dead.

The myth of a duty of care to the public

In NSFT's statement by the CEO issued in response to Grant Thornton's report he states:

> *"We have a duty of care to our public and service users and so it is important for us today to dispel misunderstandings and assumptions that 'all deaths of those known to NSFT' equate to deaths related to poor care."*

He goes on to cite that of the 11,379 deaths, 271 were suicides and *"not all of these necessarily equate to poor care".* This seems a disingenuous response to the mortality review and, rather than offer a duty of care, it further upset those who were concerned about the death statistics.



We sometimes feel that people underestimate our understanding of mortality data. We are not silly women and we see straight through poorly conceived deflections.

We looked at the latest coroner's statistics[16] to set NSFT's mortality data in context. The issuing of PFDS was up 7% nationally but there are wide variations across the county. There are more PFDs issued in Norfolk than Suffolk (for all trusts). Coroner verdicts of 'natural causes' are up 10%. NSFT's natural causes deaths have gone from 54% to 94% since 2019 which seems disproportionate and merits investigation.

We suggest that exercising a duty of care to the public and dispelling myths should be founded on honesty.

Manipulation of mortality data

Grant Thornton's report, coupled with information provided by the CEO in media interviews, could not make it clearer that NSFT's data is 'chaotic', has gaps which means they are struggling to know how many have died, and that it is unreliable and inaccurate. Instead of admitting they have lost count of their dead, NSFT rather unwisely decided to publish some figures for the last 5 years alongside Grant Thornton's report (Appendix 3). This ill-judged decision was cited as evidence of how they are improving their transparency. Indeed, the Chair shared the link to the data within a chain of tweets promising that she will *"act and put things right"* saying *"I hope you can see that we have not tried to hide, or obfuscate, its [the report] findings".* The concerns we have regarding the newly published data are:

- Any data produced about the deaths in the last five years will be incorrect because of the basic errors in data collection outlined by Grant Thornton. NSFT do not seem to have grasped this key point.

- The decision to cover 5 years rather than the same period as Grant Thornton reported on or the 9 years that the disputed 1000 deaths related to further confuses people and makes like-for-like comparisons impossible.

- The descriptors in the table relating to these figures are ambiguously worded and even people, such as ourselves and journalists, who are familiar with mortality data struggled to understand what they meant. The use of bafflegab is not improved transparency. Plain English should be used.

- The choice of which data to be 'transparent' about are particular subsets rather than complete data sets. This gives the public the impression that things might not be so bad. For example: patient safety incident related deaths (but only those investigated); the number of prevention of future deaths (PFD) reports (but only those where the person died *and* the inquest concluded with a PFD within the 5 years; the number of suicides and 'took own life' coroner conclusions (thus excluding those who died by their own actions but their intent to die was not established); the number of suicides and 'took their own lives' coroner conclusions for inpatient deaths (thus excluding all the other inpatient deaths). We shall expand on some of these points below.

- We note that for PFDs NSFT chose to use date of death rather than date of inquest but for suicides they used date of inquest. NSFT's Chair wrote, "*We also commit to*

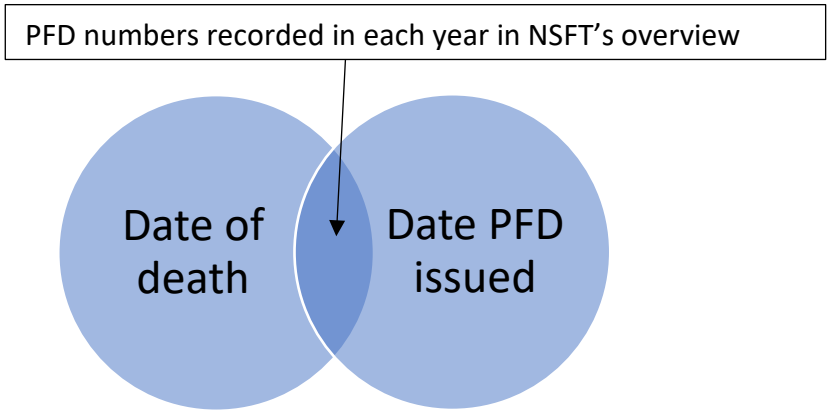
[16] https://www.gov.uk/government/statistics/coroners-statistics-2022/coroners-statistics-2022-england-and-wales#statisticians-comment

publishing a consistent set of information for the public…" The data published within this single document does not use consistent criteria.

- Grant Thornton criticised NSFT for its frequent changes of methodology without explanation, the trust committed to consistency, but the report was not a day old before they changed their methodology over a key indicator relating to mortality.

- Something that had been consistent and relatively reliable over the last decade in NSFT's data, was how they presented PFDs in their board papers and annual reports. Invariably they publish these under the date the coroner issued the PFD. This is consistent with the way PFDs are recorded on the Ministry of Justice Website and by other trusts. There have been 21 PFDs issued in the last 5 years. The figures published on 28.6.23 say 13 - these are placed under year of death. It took 2 of us 2 hours to go back into each PFD to check the dates and work out how NSFT had arrived at 13 PFDs. Whoever collated the data seems to be finding this difficult too. They have made an error (the transposing of the numbers for 2018/19 and 2020/21). By using criteria that requires both the death, and the PFD to fall within the 5 years, the trust have made it appear that there were 8 fewer PFDs in this time period. For ease, we have created at visual aid to understanding what this means:

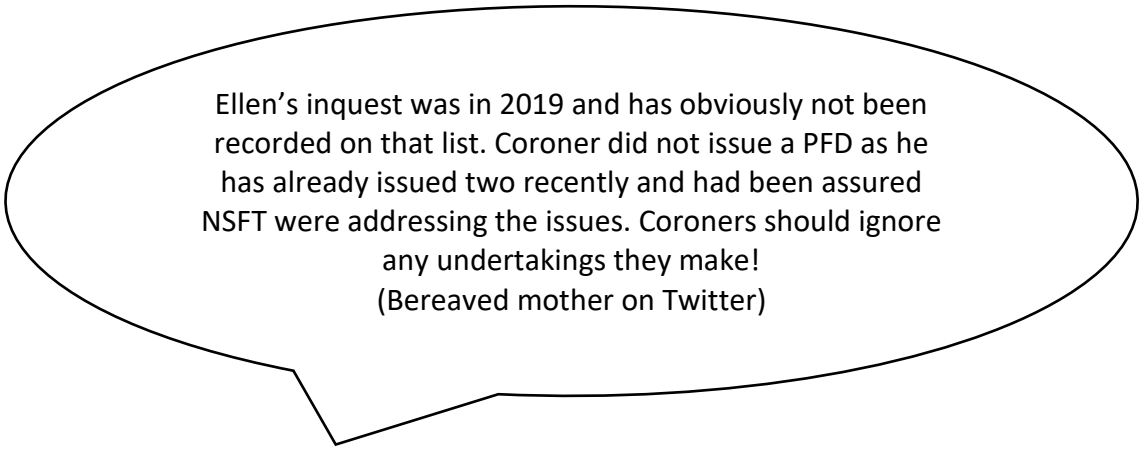
Figure 3: Diagram showing which PFDs are recorded in the Overview of NSFT's mortality data for the past 5 years.



Our interpretation of this is based on the information we have been provided with. This change in methodology means is that someone will need to die **and** have their inquest conclude (with the issuing of a PFD) within the same financial year (April-March) to be included in the trust's PFD figures in their table. Most deaths that result in PFDs are those where inquests are likely to be delayed due to adjournments. Even straightforward inquests usually occur some months after the death. Furthermore, the PFD figures will keep changing because we do not know if any PFDs will be issued for those who have died whose inquests have not concluded yet. This means the data will need to be added retrospectively to the figures published this week. It will incredibly difficult to keep track of these figures. This is not transparency.

We are not clear whether they intend to use this new methodology in their annual accounts going forward though from the 2022/23 Annual Report it seems NSFT have reverted to

reporting PFDS under in the year they were received. If they do use the, date of death and date of PFD it would mean that if someone dies in January to March of one year and there is zero chance that any PFD issued at their inquest in subsequent years would be included. If we have not fully understood or explained clearly enough how PFD data is being manipulated. This reflects how something that was easy to keep track of has been made very complicated.



- PFDs are an important part of mortality data and we were surprised this was omitted from Grant Thornton's report. They are not representative of deaths due to failings in care because often NSFT say they have already made the necessary changes, or the coroner has recently issued a PFD for similar issues, so the coroner does not issue one. The inclusion in NSFT's response to the report suggests they were looking for the smallest number of deaths to accept responsibility for (21). Showing a dexterity with statistics, that seems largely absent from their mortality data processes, they were able to present this as 13. This is a blatant misrepresentation.

- We noticed that one of the key responses to the report was a focus on suicides. The trust reassured critics that they know about **all** these deaths. By conflating suicides with other mental health deaths, they effectively exclude all the other deaths they are responsible for. For example, several of their recent PFDs have not been for suicides but for other serious failings in care such as Eliot Harris whose death was ruled unascertained. Either, NSFT do not understand that suicide deaths are not the only form of mental health death (which would be alarming) or, they do know but are deliberately focussing on a subset to present themselves in a better light.

- One area of concern for us is the number of impatient deaths we read about but have no data for. If NSFT wished to be transparent it would have been helpful to publish inpatient death numbers. Presumably, this is one data set they should have no difficulty identifying. Instead, by the use of some weasel wording, they chose to publish only inpatient deaths where the coroner had ruled suicide or took own life. This is a small subset and to those not familiar with the data it looks like there have been little or no inpatient deaths. The data presented does not even cover all of NSFT's inpatient deaths where the trust were issued with a PFD. There were 2 PFDs issued for inpatients in 2021/22 and 3 in 2022/23.

NSFT's communications messages

These consistently set a wrong tone and have caused offense and further distress to bereaved families. The usual platitudes about this being about people not data were presented but they lacked sincerity. Some weak apologies were made for the poor processes - *"We are deeply sorry that we have not previously had systems and processes to record and report mortality data as we should"* (NSFT Chair). This implies that the systems and processes currently used will be correct. However, it is clear from recent board papers that the mortality data recording is still opaque and incomplete. And, from the action plan it is abundantly clear that work to address mortality data issues has not, or only just, started. Any apology for the distress caused or for any potential lack of learning was totally missing. The clever choice of words such as 'previously' are classic deflection techniques from owning responsibility. The CEO's interviews were disastrous and his deflection onto GPs and partners has really angered people.

The report spent 5 months being checked for accuracy yet the final report was full of inconsistencies and ambiguously worded statements. So, it was no surprise to us that the media, who had only a short time to read and understand the report night not grasp the nuances of the data within it. Instead of focussing their time and energy on putting their own house in order, or working on reparation and rebuilding public trust, or supporting bereaved relatives (some of whom are their staff), NSFT decided to issue a statement about the way the media had correctly quoted but not adequately explained the 278 people whose death and discharge are the same day. As if this was not bad enough, in quoting Grant Thornton's report in their statement they skipped two paragraphs that might have presented the trust in a poor light. This is not transparency it is gaslighting.

To top all the above, NSFT contacts and 'comms,' who are connected to Caroline on Twitter and usually keen to join in with any of her 'good news' tweets, ignored any critical tweets or those that showed she was distressed. Instead they decided to jump in on the Chair's tweets to correct Caroline about the PFD discrepancy. This has not gone unnoticed by others and it exemplifies how NSFT are maintaining an arrogant and insensitive position.

Different messages for different audiences

We understand that briefings need to be tailored to different audiences. However, we feel that the briefings were disingenuous and, in some cases, caused harm.

At the media briefing the CEO and Chair both said that people (implication being the campaigners, bereaved relatives and public) would need help to understand the data because the terms unexpected deaths is being confused with avoidable deaths. When questioned the CEO said they could not comment on campaigners 1000 deaths claim because NSFT did not know where we got our data from. For clarity – Caroline told NSFT, both ICBs, and Grant Thornton that NSFT had been conflating terms and she provided all the working out for 2,600 deaths complete with links to NSFT's own published data. She was clear that the data was unreliable because of the many changes in methodology and terminology used by NSFT over the previous decade. The following day, in our briefing it was all care and concern for our wellbeing and thanking us for our work on mortality data. This dissonance was triggering for Caroline.

At the staff 'Hear to Listen' briefing the CEO commented on the way the media were reporting 'inaccurately' and 'liked a headline', forgetting that some of the staff listening to, or hearing

about this, found the minimisation upsetting. There was no appreciation in the staff briefing that some staff are themselves bereaved relatives or that they might have lost patients they care about.

Wider system's communications messages

These are weak and minimal. The impression given is that by keeping their heads down, commissioners, monitoring and regulatory bodies, can keep the focus on NSFT and absolve themselves from owning their part in this mess. The message from the wider system seems to be 'say little and wait for it to blow over'. This is not good enough. And, we are not going to let this blow over.

The impact on bereaved relatives

There does not seem to have been any insight by NSFT or the ICBs about the likely impact on bereaved relatives when Grant Thornton's report was published. The report should have had a trigger warning on the front along with contact details of who to contact if you think you might be affected by anything in it. There are people asking: "Has my relative been included in NSFT's figures?" There is no helpline number for them to contact.

There should have been an action plan in place and clear signposting for sources of support. As far as we are aware, partner agencies who might have people turning to them for help did not have advance notice of the report so that they could prepare for any aftermath.

We have all, but particularly Caroline, had distressed people contacting us via any means they can because there is no support for them. This includes members of NSFT's staff who felt unable to work and totally unsupported. A general feeling of how can they continue 'working for truth twisters' (this is our polite paraphrasing). Likewise, bereaved people who are involved in working with NSFT to improve things have been left wondering if they are naïve and have been used in tokenistic ways. Did nobody think beyond learning their carefully worded 'comms' lines and consider taking some responsibility for the fallout?

The damage to confidence and trust is huge. Any clumsy attempts to be seen to do the right thing now could be counter-productive and further traumatise people. The ICBs and NSFT need to urgently look at co-producing a reparation plan.

The sound of silence

We have worked diligently, and we hope respectfully, with senior leaders at NSFT and the ICBs to raise concerns. We had felt optimistic that, after years of failed attempts, the system was listening to us and respecting our understanding of the deep-seated problems at NSFT. We felt we had built some trusting relationships with key people. On the run up to the publication of Grant Thornton's report, the authenticity of these relationships was tested. We know who contacted us and offered support and care and who was silent (or offered minimal, tokenistic comments). It has been profoundly disappointing and re-traumatising. .

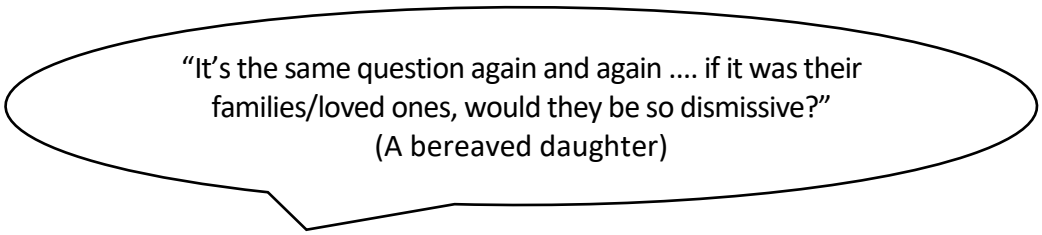
> *"Many organisations send out the message -verbally or non-verbally – that falling into line is the safest way to hold on to our jobs and further our careers"* (Rahman, 2019 p129).

We know that within the system there are those in senior positions who know that things are wrong but they remain silent. They might hold positions of responsibility but they lack the courage (or perhaps the moral fibre) to speak out. Vitullo (cited in Sicora,2017) says that leaders need to be reflexive, brave, authentic, able to listen, and open to others' opinions. We suggest that in Norfolk and Suffolk they need to find their 'everyday courage' that is *"required for health professionals who work in an environment of high complexity, responsibility and uncertainty…"* (Myers, 2019 p 29). What is needed now is for others to speak out and break the silence.

We are whistle-blowers who have stood up many times to try and get the system to notice that, among other things, mortality recording and reporting is in disarray. Caroline and Emma know only too well the impact that whistle-blowing about NSFT has had on their careers. Whistle-blowing takes courage and it is exhausting. We will not stop until things have improved.

Actions required

Bereaved families reading Grant Thornton's report do so with their hearts. They will be wondering if their loved one was included in the figures or whether their deaths have been discounted. They will inevitably look at the numbers presented and feel incredibly sad to know so many other families have experienced the agony of losing someone to a premature and maybe avoidable death. They might justifiably be very angry that this has happened.



We invite people reading our response to pause for a moment and imagine someone they care about has died under the care and treatment of NSFT and think about how they would feel.

A public apology

First and foremost, NSFT need to issue a public apology that clearly and frankly says that:

- they cannot say with any confidence how many people under their care and management have died or why
- they unreservedly apologise for the distress caused to bereaved families (including some who are staff members or governors) for the distress caused by the content of the report and how publication was handled
- they unreservedly apologise that bereaved families had to beg for mortality statistics and their warnings were not listened to
- they unreservedly apologise that the report was not co-produced with bereaved people
- they unreservedly apologise that the action plan has not been not co-produced with bereaved people

- they unreservedly apologise for the lack of sensitivity and compassion shown by not preparing bereaved people for the publication of the report
- they unreservedly apologise for the lack of provision to support following publication
- they apologise for the insensitive and disingenuous behaviours of the communication team and the CEO in their public interactions

Any apology should include plans for reparation.

We are not making recommendations because successive reports (such as Verita and the CQC) and investigations have made recommendations that have not been actioned. We feel the seriousness of losing patients, in both the sense of patient deaths and in losing people from the data, means that it is time to act swiftly and wisely.

Working with bereaved families

We asked some bereaved families what actions they wanted to see:

" CHANGE CHANGE CHANGE and listening. And working together"
(A bereaved sister)

"I want the CQC to go back in and re-evaluate their own findings with this new information. I want NSFT to be so ashamed of their behaviour and structure that they beg to have conversations with those that can aid the organisation to grow and do it promptly without losing another day!"
(A bereaved mother)

"We were not listened to before the deaths, and nothing changed afterwards. Working WITH families has to be the way forward"
(A bereaved relative)

From this point forwards we would like assurance that every death will be properly accounted for. Each bereaved family needs their loss fully acknowledging and to know how their loved one's death features in NSFT's mortality data and learning.

NSFT told Norfolk HOSC on 8th September 2022 that the terms of reference for Grant Thornton's review had not been co-produced but bereaved families would be included in discussions around mortality numbers. We believe this is essential.

Bereaved relatives are the service-user with regard to anything following patient deaths. By proxy they are the voice of the person who was under the trust's care. There is research evidence to show that useful patient safety information is missed if service-users and carers are not involved in co-producing interventions arising from concerns about mental health services, however, operationalising this and incorporating at service-level can be difficult (Berzins et al, 2018). One of Berzins et al's findings is: "*the need to co-design methods for the systematic and routine gathering of information about the safety of care and care services"* (p6). They cite a service-user thus: *"If patient safety is seen as the sole preserve of professionals they are partially sighted. They are missing a vital part of the picture" (*p5).

In a large study into patient safety, that looked at the correlation between concerns raised by patients and their families and mortality rates in hospitals, Reader and Gillespie (2021) concluded that: "… *nonemployee stakeholders may provide alternative and independent source of data on safety in contexts where they observe and/or experience unsafe employee behaviours"* (p448) and they propose that 'holistic analysis' of safety and mortality requires viewing service-users and their families as important 'stakeholders in safety'. We suggest that bereaved families and campaigners (as independent observers and experts by experience), including ourselves, have been raising concerns (often via complaint processes) and have raised red flags which have been repeatedly ignored. We could see that something was seriously amiss in the way NSFT was gathering and reporting on mortality. A paradigm shift within the entire system is long overdue and we believe it is essential to include bereaved relatives as stakeholders in safety within every aspect relating to mortality and patient safety.

Bereaved families should be involved in all the steps moving forwards from Grant Thornton's report. We think bereaved families should help the ICBs to create an easy read version of Grant Thornton's report. This would benefit not just those with a learning difficulty or others who might struggle to comprehend the complex issues and technical language but also those within the system who do not seem to understand what the key findings are. It would have been helpful if the executive summary had bullet-pointed the key points. Representatives should be included in the formulation of action plans, and in monitoring progress against that plan.

NSFT already has a 'learning from deaths' policy that is unequivocal about the importance of involving and working transparently with bereaved families. Indeed, this has been in place since 2017. It cannot be okay that these conversations are still necessary 6 years later. We do feel that inviting Caroline Aldridge in to lead on a project exploring how NSFT works with and supports bereaved families was a positive move. It gives us hope that within NSFT there are people who genuinely see the need to behave better when patients die.

We believe NSFT has squandered an opportunity to build bridges with bereaved relatives by following through on promises that the mortality review would be independent and establish a 'single truth' about how many loved ones are forever gone. Root and branch change is needed if the longstanding problems with mortality data are to be overcome. To achieve this

NSFT needs to involve a range of bereaved relatives in every aspect of their work on mortality data and learning from deaths. The policies need to be converted to reality.

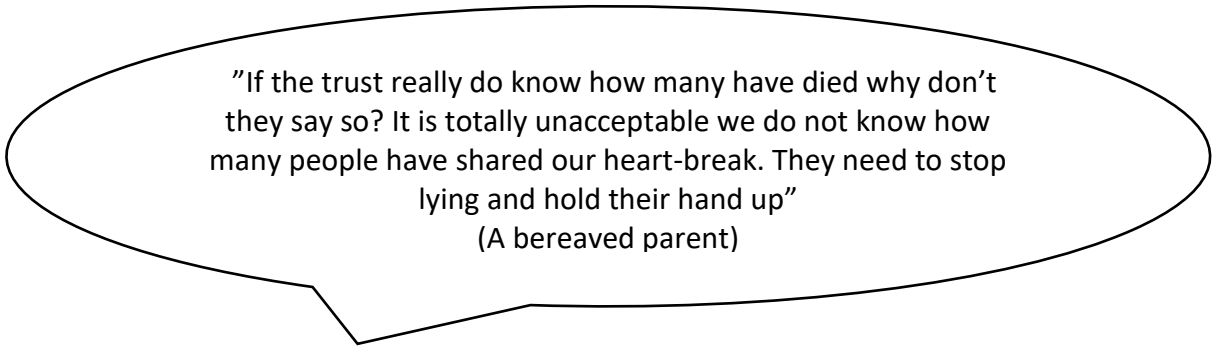
Establishing how many have died

It is almost a year since we went to London and met with MPs. We would not have said NSFT had lost count of their dead and that their mortality data was inconsistent unless we were 100% sure of this. We want to know how the decision was made for the requirement for Grant Thornton to verify the numbers was removed. We would draw your attention back to the first thing in the SoR which says: *"Verification of the number of deaths associated with care or treatment at NSFT per year…"* and to the statement made by the trust's deputy CEO to Norfolk HOSC.

In the period running up to publication, we have been told from more than one source that Grant Thornton were *not* asked to establish how many have died. We were not surprised because we knew this would be impossible given the way NSFT manage their mortality data (as evidenced by the contradictory numbers they have placed in the public domain). However, we feel there needs to be transparency about Grant Thornton not providing this data. It is really concerning that a firm of auditors say the data is not verifiable but the trust go on to publish death statistics.

Therefore, it seems reasonable to ask questions about how the Grant Thornton audit/review was conducted, particularly what occurred during the factual accuracy checking period. In a letter to campaigners (Appendix 2) the two ICBs state clearly how the review would be conducted under auditing processes and standards. This was confirmed by the Chair of Norfolk and Waveney ICB in our briefing.

It is disappointing that Grant Thornton were not able to do this because NHS data should enable trusts to establish how many of their patients have died. This seems a basic thing. That they could not, reflects the severity of NSFT's issues with mortality data. Instead of dropping the requirement to establish numbers it would have been more candid to own the impossibility of this.



We genuinely had hoped when this mortality review was commissioned, that NSFT and the two ICBs were committed to investigating how many patients had died and to explore the processes that had led to this. We are left feeling that they arrogantly believed we were wrong and that they were doing this with an aim of proving that so that bereaved relatives and campaigners could be disregarded and silenced. It shows a closed and defensive culture

that is rigidly continuing with behaviours that are unsafe. It is unsafe for an NHS trust to be unwilling or unable to identify their patient deaths and use this to inform safer practice.

Clearly, from the bereaved families' viewpoint, NSFT need to admit that they have lost count of how many of those under their care have died. Anything less is an insult to those who have lost loved ones and who realised this was the case long ago. Not establishing how many have died means the scale of loss goes unacknowledged. The raw data within the Grant Thornton report provides unequivocal evidence that the scale of deaths is worse than we imagined. There needs to be an acknowledgement of the seriousness of this and full ownership of this failing. However, we accept a line might need to be drawn under this because time and resources are better spent trying to remedy things than squabbling over numbers.

We want to see a credible and transparent plan, with resources from the wider system, to determine whether it is possible to identify a number. If not, there needs to be accountability for this shocking situation. We accept that it may not be possible to ever identify how many have died, and we want the focus to be on moving forwards with accurate data, but neither do we want this glossed over. All those involved in this sorry mess need to be seen to be accountable.

There needs to be a full stop to the current, poor quality, mortality data so that going forward all deaths are correctly identified, categorised, and reported. There has already been years of drift, with people doing what they have always done. Even since Grant Thornton have completed their report the drift has continued due to the inexplicable delay in publication and agreeing an action plan. This cannot continue because all the time more people become bereaved and are suffer iatrogenic harm by the NSFT's processes.

Critique of Grant Thornton's action plan

A criticism of Grant Thornton's report is that there is insufficient granular detail that shows exactly what has gone wrong and which would inform what needs to happen to resolve things. Interestingly, the recommendations and action plan provide clues about things that they found that are less clear in the report itself.

There are 16 recommendations that cover the following areas/operational groups (p9):

- 1 - 4 Data- which focusses on the technical management to be completed by business intelligence and related teams
- 5 – 8 Reporting - the process of producing internal/external reports, dashboards etc.
- 9 -11 Clinical engagement – engaging with clinical staff in use and production of mortality data
- 12 - 13 Partnership working- The Trust in the lead supported by the ICBs and partner organisations
- 14 – 16 Governance – oversight and controls over mortality data and reporting

There are key recommendations missing from the action plan, which can be drawn from the findings of the report. The action plan is inconsistent with information provided in the report itself in some areas and generally the recommendations do not reflect the severity of the report findings. For example, there is nothing to address the issue of not being able to establish how many people have died or recognising the high numbers cited within Grant

Thornton's report and seeking to reduce these (not via data manipulation but by prevention of deaths).

There are some notable omissions in the recommendations and subsequent action plan:

- There is nothing that acknowledges the impact of inadequate mortality data reporting and recording, and the inability to establish how many have died, on bereaved relatives reading Grant Thornton's reports. Indeed, bereaved relatives or any regret about patient deaths are missing from the report itself. This dehumanisation has rendered patients who have died and their families invisible within the data and the recommendations/action plan.
- There is nothing in the plan about reparation for the damage this report will have on bereaved families who will be upset by the report contents.
- Likewise, the impact on staff who have been attempting to protect life without good quality data to inform them is missing or the staff responsible for the creation of shoddy data who have done so in good faith under instruction, is missing.
- Any form of co-production is absent from the recommendations.
- There is nothing in the action plan that indicates any transparency such as making information about methodology, processes and the data publicly available so external stakeholders can scrutinise and flag up concerns.
- The plan contains minimal information about the difficulties with reporting to NHS England and again NRLS is omitted.
- There is nothing in the action plan to follow up on areas of unsafe practice that Grant Thornton's report brought into question – insufficient risk assessments and unsafe discharges.
- Although there are multiple mentions of things that might be presented to the board there is nothing that addresses the issues of inadequate overall governance including scrutiny of the data and curiosity about mortality in the action plan.
- There is also nothing in the action plan which properly covers the accountability of the ICBS or CQC or NHSE. With their roles absent how is there going to be any oversight or account both for them in relation to NSFT completing the action plan and of them in terms of their failures that led to this?

Of note in the action plan is a lack of urgency to address issues. In the action plan 9 of 16 recommendations are rated high (completion by August 2023), 6 are medium (completion November 2023), and 1 is low (completion 2024). This will be more than a year after Grant Thornton completed their audit. We know from previous reviews that recommendations might not ever be implemented.

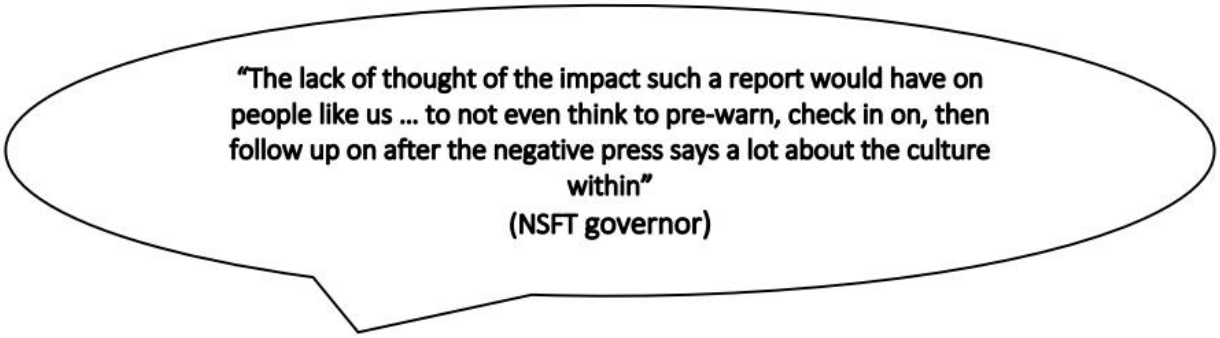
In setting the priority levels for meeting the recommendations in the action plan consideration has not been given to the priorities bereaved families, service-users and carers would want. Had the plan been co-produced it is more likely that it would hold patients at the centre and consider those forever gone or left behind.

The action plan needs reviewing to re-focus oversight and governance from the finance director to clinical staff. However, we acknowledge that the mortality statistics are complicated and maybe only the finance director has sufficient mathematical expertise to understand it. Nevertheless, we are concerned about how many of the actions will be overseen by the chief finance or digital officers. We would like assurance that in addressing

the errors Grant Thornton uncovered, the solution does not replicate the root of the problem. One of which was non-clinical staff categorising deaths.

The action plan cites the formation of Learning from Deaths Forums for both ICBs, which we welcome providing they have efficacy. We are aware that Norfolk and Waveney have stood one up but we are unsure whether Suffolk and North East Essex are planning their own or whether they will join Norfolk and Waveney. Whichever, the ICBs need to include people with lived experience on these. These need to be people who hold the corporate memory and have sufficient understanding of the issues to act as 'canaries in the mine' because they are attuned to signs of deaths or learning (or lack of) taking place. This report will provide essential background reading for the Learning from Deaths Forums.

We have been critical of NSFT's Council of Governors (CoG) for their lack of challenge regarding deaths at NSFT. However, we have become aware that this might be due to a culture that involves governors in a tokenistic way. The papers for their meetings seem to be glossy information and/or retrospectively giving information. A good example of this is the way the CoG were involved with the Mortality Review. Despite having governors who are bereaved relatives (both of whom are open about this and advocates for change), the governors were not forewarned about Grant Thornton's findings. Indeed, they were briefed and provided with the report to read *after* MPs, the media, and campaigners.



We are aware that governors with lived experience found the CoG briefing shocking and upsetting. It is symptomatic of the culture at NSFT towards bereaved people that support was not put in place for any governors before or after the publication. We are left wondering if NSFT have a tokenistic view of their CoG. And, whether the organisation is mature enough to work safely with people with lived experience of mental health related bereavement. Yet we know there are insightful and sensitive individuals with the right skills working for NSFT.

We welcome the creation of a Mortality Team at NSFT and the recognition they need to resource this if they are going to have capacity to meet demand. Going by their recently published figures, this team will need to screen around 50 deaths per week and follow up where appropriate. We are aware 2 leads have been appointed with a team being recruited over the next few months. We have a number of questions about these plans: How long will it be before the team has sufficient staff to be effective? What are the plans for co-production and/or the appointment of people with lived experience? How will this interface with the many other teams and committees at NSFT who undertake related tasks? Who will have the senior oversight? Who is creating their work plan and who will be quality assuring them?

We have observed the formation, amalgamation and disbanding of many posts and committees relating to mortality over the last decade. Our questions would be: How will it be different this time? How will the mortality team be sustained? How will the mortality team interface with bereaved relatives, the wider system and the public? Our experiences lead us to question whether the team will actually ever become fully formed let alone deliver on its goals.

Have both ICBs got an action plan to oversee and monitor mortality issues at NSFT? If so, is this a joint plan? If not, why not?

The new mental health collaboratives will have a vital part to play in any plans to move forward with accurate and reliable mortality data and any actions relating to deaths attributable to NSFT. They are invisible with the action plan. This needs addressing promptly.

As far as we are aware, the action plan has not been co-produced with system partners and key stakeholders, which is a missed opportunity, and furthermore, does not meet NSFT's own publicly expressed commitments to co-production. Recommendation 12 – "*Establish links with primary care networks to explore opportunities to improve the completeness of the Trust's mortality data (including cause of death) supported and enabled by the ICB"* (p14). How this will be achieved when point 12:1 states – *"This recommendation will be shared with the ICBs through dissemination of this report and to be added as an agenda item on ICB Learning from Deaths Forums where/when in place".* This indicates that the ICBs were not fully involved in creating partnership working sections of the action plan. We would hope that the ICB's Learning from Deaths Forums are going to be co-produced with bereaved relatives. Perhaps the absence of learning from deaths forums thus far might in and of itself partially explain how the problems with mortality data at NSFT might have become so entrenched.

It is worrying that several of the action plan points do not match things raised in the report. Or, if they are in the report, they are presented in a way that does not correlate to the level of priority in the action plan. For example: Standard Operating Procedures (SOPs) need creating; human error eliminated; a coherent mortality data pathway created; a tool to capture missing demographic information developed; processes for categorising deaths and establishing cause clarified; and policies updating. Their inclusion in actions tells us that these things were not already happening.

There is nothing in the action plan to address the issue of culture and consider what conditions at NSFT enabled these problems with mortality data to happen and continue for so long. This means there is nothing in this plan that inspires confidence that the underlying issues of the ways the organisation and individuals behave has changed.

A credible and concrete action plan

We would like to see an action plan that is co-produced between NSFT, the ICBs, NHSE, and, crucially, bereaved families. We would like to see some of the actions we suggest included in it.

We are concerned that this situation has been drifting for years and there seems to be no sense of urgency to sort this mess out. It is seven years since the Verita report, a whole year since campaigners raised the issue, and five months since Grant Thornton completed their

report. Five months in which 'checking for factual accuracy' has led to a report that has errors and curious inconsistencies in it. Five more months of drift and the status quo. It is reasonable to question whether the procrastination was about factual accuracy or an attempt to avoid publication.

Get the basics right
We need to see a transparent and accountable process that means there is an effective end-to-end mortality data journey. We note NSFT's aspirations for excellence but we want to see them get the basics right and a 'good enough' foundation first. Anything built on rotten foundations will collapse. We have seen this whenever there has been scrutiny of mortality figures – once the glossy top layer is turned over, what lies beneath is not palatable.

It is positive that NSFT are an early innovator of the new Patient Safety Incident Response Plan (PSIRP) and that the aims of this approach are co-produced. On their website it states that NSFT aims to be *"in the top quarter of mental health trusts for quality and safety by 2023"*. We are half way through 2023 and it feels we are further away from this than ever.

Swift and wise response to avoid drift
Given the length of time from the completion of the GT report to publication, both NSFT and the wider system should be able to demonstrate that they have reflected on the contents and their timescales for improvement works show pace and appropriate drive to improve.

Oversight of the action plan
The plan needs to be credible and concrete. There needs to be sufficient detail about what, how, who and when and with monitoring and checking built in. There is still a sense that NSFT are 'marking their own homework'. We believe that the action plan needs to be overseen by the Department of Health and Social Care. There monitoring and oversight needs to be publicly available and published on a monthly basis in order for bereaved families to be able to track tangible progress and that any improvements are sustained.

Robust oversight and management by local and national bodies
Whilst there has been previous system-wide oversight and assurance groups with local and national memberships in response to inadequate CQC ratings, these have failed to provide robust oversight and management of improvements within NSFT. As such, there needs to be innovative and challenging oversight and management of the action plan by local and national bodies. It will not be acceptable to keep mortality data processes and outputs internal and to simply issue statements saying progress is being made. Bereaved families and the public need to see evidence.

How will NSFT work with their partners
NSFT's action plan needs to more clearly show how they will work collaboratively with system partners to ensure that the data journey is accurate and to reflect the importance of ensuring that all available data is obtained for this to be affective.

Review of the Verita report

On 16th September 2016 NSFT's CEO answered questions about the Verita report to Norfolk HOSC. He said that *"all of the recommendations made are already, or will be acted upon"* and he presented an action plan that cited 8 of 16 recommendations were complete. He gave

assurance that NSFT undertook: *"regular analysis of our data and testing for trends and actions that would prevent further deaths".* It is clear from Grant Thornton's report that this is unlikely, given the quality of the raw data, to have happened. Witnesses to HOSC said that unexpected deaths were not discussed in any detail at board meetings because the quality and safety committee held regular meetings to review deaths and we know that the board showing minimal interest in deaths and relying on subcommittees is remains problem. In the same meeting, it was discussed that NHS England had asked NSFT to *"consider the appropriateness of closing an investigation when the cause of death is unknown.* This seems disturbingly similar to the issue raised by Grant Thornton of deaths with no known cause being categorised as 'natural'. It raises the question: "What did NHSE do to assure themselves? We wonder if they raised the concern but did not following up on NSFT's commitments to change.

Recommendation 2 of the 2016 Verita report states:
"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" (p 18) and that this should happen within 3 months. Therefore, Grant Thornton's findings that patient safety and mortality are still treated differently is concerning. We are curious about why this is and what the barriers to change are.

Having looked carefully at the Verita report we have noticed a number of their recommendations do not seem to have been implemented. We will never know what difference it might have made to patient deaths or NSFT's mortality data gathering and use. Nevertheless, we would like someone to review Verita's recommendations and where actions remain outstanding a plan is put in place to implement them. This would need following up to see if this actually happens. There cannot be a repeat of 2016 where promises are made but the changes do not happen.

Questions that need answering

As we have evidenced above, here remain some serious questions that need addressing:

How has mortality data been allowed to be so poor for so long at NSFT?
How will those responsible be held to account?
How can the public be assured that mortality data in future will be accurate?
What does this mean for patient safety?
What else might be happening?
Who will ensure that any improvements are made and sustained?
Who will be overseeing the implementation of the action plan?
What will happen next?

The protracted process of publishing Grant Thornton's report led to questioning from bereaved families and campaigners about why and whether the report has been 'watered down' in the interim. Campaigners challenged this and were assured in writing by the Chairs and CEOs of both ICBs that this had not happened.

"Self-interest and ineptitude at Executive level and a failure to listen and act. Result: systems not fit for purpose."
(A bereaved parent)

We anticipate that the trust will use the gap between Grant Thornton reporting and publication to support claims that they have already made the necessary changes. For example, the creation of Learning from Deaths Forums. The empty rhetoric of changes already being made and tokenistic actions have been repeated in responses to reports on deaths (such as the Verita report), at inquests, or in Prevention of Future Deaths, before. We suggest that the evidence we have presented shows that the problems with mortality are deep-rooted and longstanding. Therefore, even if changes have been made they probably will not be sustained. Additionally, we would question how we or anyone else in the system would know. The only way of knowing this would be if what Grant Thornton looked at was reviewed every 6 months to check for changes and quality control. This needs to be undertaken by people who have sufficient independence, skills, and willingness to challenge.

Wider system accountability

Full scrutiny and accountability for the mortality data

The ICBs, Norfolk and Suffolk Healthwatch, HOSCs and Mental Health collaboratives to monitor the effectiveness and accuracy of NSFT's mortality data and ensure appropriate chains of accountability are in place and will be sustained. The CQC need to ensure that they perform their duties within inspections to examine and challenge mortality data and take action if required.

NHSE need to act on the national issues:

> *"Among the most disheartening features of the post-Francis NHS are recurrent organisational catastrophes … the repeated failure to identify promptly and intervene effectively in the worst of these events, linked to a persistent lack of valid and reliable measures …the NHS's ongoing difficulty in tackling problems of culture and behaviour …the disproportionate representation of vulnerable groups in these disasters …Failure to listen to the voices of patients and carers is a recurrent theme of investigations and avoidable harm – and one that the system seems incapable of heeding"* (Martin, Stanford and Dixon-Wood, 2023).

The above quote resonates with bereaved relatives whose warnings have been ignored and for whom the worst has happened. Grant Thornton's report articulates what they already surmised – that there is a lack of reliable data, problems with the trust culture, and a failure to heed and respond to errors.

NHSE are the overseeing body for NHS digital, NRLS, Better Tomorrow and the NQB. They need to own their failings in determining consistent guidance and systems, monitoring trust mortality figures. They need to set some national definitions, and ways of gathering and

reporting data so that accountability and comparison between trusts is possible. They should be noticing and responding to red flags of mortality spikes and their current processes are demonstrably not fit for purpose.

Transparency about the Better Tomorrow initiative
There needs to be clarity about the scope of *Better Tomorrow's* work with NSFT and the wider system. It is not okay for this important work to be hidden within websites that the public cannot access or for board papers to omit information about this.

Use of this report by system partners
Extensive work that has gone into preparing our response and we hold a system memory. We suspect the 'system' will wish to drop Grant Thornton's report into the pit of inaction and expect the bereaved families to move on. However, we believe this will only lead to more deaths and it is time to do things differently. Invitations from system partners to discuss and review how they will use the findings to improve the commissioning and accountability of services are welcome.

Healthcare Safety Investigations Branch
A copy of this report is being sent to the Healthcare Safety Investigations Branch with a request for them to carry out an investigation into mortality data and processes. Wider system partners need to overtly support this.

Government intervention

MPs and local councillors in Norfolk and Suffolk have been made aware of the concerns around mortality being a system-wide problem over the last decade by campaigners. They have too easily taken the word of the system over the testimonies of bereaved families and campaigners. The exception being Clive Lewis, who has raised several questions in Parliament. More recently our other MPs, Duncan Baker and Tom Hunt, have listened and started to question and challenge platitudes about improvements. We are grateful for their persistence. There have been multiple ministers responsible for health and mental health during this time and they have shown minimal interest even when their own constituents have been affected. In our view, there needs be a strengthening of Parliamentary reporting processes to assist monitoring of NHS trusts mortalities. All the region's MPs and responsible ministers need to work together to ensure improvements are made and sustained.

A statutory independent public inquiry
Grant Thornton say: *"There may be matters, other than those noted on the Report, which might be relevant in the context of the Purpose and which wider scope assessment might uncover"* (p3). We suggest that the issues exposed by this report justify wider and deeper exploration because this relates to deaths and patient safety. We would like to see concrete evidence that the gaps in data and understanding surrounding mortality data is further assessed.

However, we feel that the issues are not just NSFT's failures but symptomatic of a longstanding national problem as evidenced by the CQC *Learning, candour and accountability* report (2017) and the NQB *National guidance on learning from deaths* (2017) and the serious issues with mortality data in Essex. For comparison, Essex has a population of c1.3m and 2000 deaths over a 20-year period. Norfolk and Suffolk have a combined population of neatly 1.7m

and a high but unquantifiable number of deaths. We support both the Essex families and Norfolk and Suffolk campaigners in their calls for statutory independent public inquiries. The Essex MPs who did not believe the bereaved families or advocate for them had to make public apologies. It is disappointing that only 2 MPs attended NSFT's briefing on Grant Thornton's review. This sends a message to their constituents that they are not interested.

The Essex families got their statutory public inquiry on the same day the mortality review was published. They know their inpatient death numbers, we do not. We respectfully suggest that the Secretary of State might want to consider holding a national public inquiry into how mental health trusts gather, report on and, crucially, use mortality data for learning and to prevent deaths.

Active involvement of those in government
Concerns about deaths associated with NSFT, and inadequate practice, have been raised consistently over the last decade. We are grateful to those MPs who have actively involved themselves in calling NSFT to account. However, we feel this serious situation has gone on for too long and it is time for the Department of Health and Social Care, our regions MPs and the Minister for Mental health to be proactive in further exploring what has gone wrong and in ensuring the problems are remedied in a sustainable way.

Meeting with the Minister for Mental Health
We would like the opportunity to meet with our region's MPs and the Minister to discuss Grant Thornton's report and our response. We would like to be part of co-producing any solutions.

Conclusion

We feel we hold the organisational and system memory relating to NSFT's mortality rates and processes. Our view and knowledge is not definitive or complete but we believe it is important and could be helpful to those trying to rectify the problems. One reason for writing such a detailed response is to share our wisdom in the hope of supporting positive change. We would suggest that careful reading of, and reflection on, this report should form an essential for anyone delivering, commissioning, and monitoring mortality recording and reporting. It will be of interest to anyone wishing to understand what Grant Thornton's report and NSFT's responses mean.

The Francis report (2013) identified *"…numerous warning signs which cumulatively, and in some cases singly could or should have alerted the system to problems developing at the Trust"*. We believe that we, along with campaigners, hold the memory of NSFT.

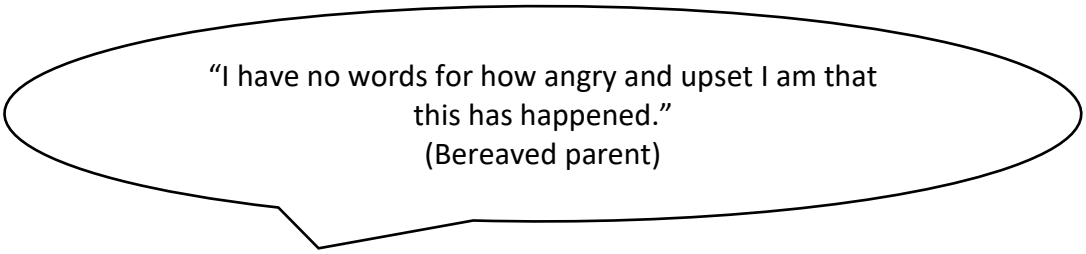
> *"Local scrutiny committees and public involvement groups detected no systemic failings. In the end, the truth was uncovered in part by attention to the true implications of [the Mid Staffordshire General Hospital NHS Trust] mortality rates, but mainly because of the persistent complaints made by a very determined group of patients and those close to them. This group wanted to know why their loved ones had been failed so badly.*" (Francis Report, 2013 Point 1)

If we three ordinary women could see what was going on and challenge it, why couldn't those who are actually responsible? It shouldn't be necessary for bereaved relatives to raise

concerns about things happening in plain sight, or for us to make the referral to the HSIB. There is a system who are responsible for holding to account and who should have intervened years ago.

We acknowledge the limitations of our information and the complexity of the issues. We might be naïve in some respects but our views hold the validity of being experts by experience who have perhaps looked more closely at mortality across a decade than some of those within the system. Our persistence and depth of scrutiny should not be under-estimated because we are motivated by exposure to the devastating consequences of patient deaths.

We recognise that in places this report is emotive. We feel that for the system to acknowledge what is wrong and to embrace change people need to connect to what this means to those who have lost their loved ones. We also feel that any anger bereaved families feel is understandable and justified. Indeed, everyone within the system should feel outraged that people are dying and their deaths are not even being accounted for properly. This is outrageous and it should prompt rapid and decisive change.



We cannot overstate how angry and distressed many bereaved relatives are about the way NSFT have handled the deaths. The findings of the Grant Thornton report offer no reassurance just confirmation that bereaved relatives and campaigners were correct about the chaotic and disrespectful way mortality data is gathered and presented. We are speaking for many bereaved relatives and service-users and carers who fear the death of a loved one may occur. We are determined and persistent and want to know why people's loved ones have been failed by the system. Not because we are vexatious or we enjoy complaining but because too many people have died and by incorporating our knowledge with the issues raised by Grant Thornton there is an opportunity for the system to change and improve.

To reiterate, the Trust's data governance over mortality data is poor and there are no effective controls to ensure the data is reported accurately and reflects the services understanding of patients. Mortality data recording and reporting does not meet the quality expected by NHS England (2018).

Many bereaved relatives perceive NSFT's approach to recording and reporting mortality data as casual and disinterested. They deserve better. Likewise, the public needs assurance that the poor practice surrounding mortality data will stop. Bereaved families should be able to understand mortality process so they can make sense of where their loved one sits within the data if they wish. Those who have died deserve their deaths to be treated with diligence, respect, curiosity, and candour.

NSFT ‘did not recognise’ that there had been over a 1,000 deaths over a nine-year period. They were right because there were indeed many more. We do not think NSFT ‘already knew’ or that Grant Thornton were able to establish a ‘single truth’. We do not think it is acceptable that a review that set out to establish how many deaths there had been at NSFT side-stepped this issue. We can fully understand why Grant Thornton were unable to answer this question but they should have explained clearly the impossibility of this in the context of NSFT’s poor mortality recording. The recording of deaths does not reliably and accurately capture all deaths and the data is incomplete, poorly categorised, lacking in validity and integrity. Therefore, NSFT do not know how many of their patients have died.

It is shocking that NSFT do not seem to know that they don’t know or if they do know they would not step forward with an answer to the question: How many of their patients have died since 2014? We have shown that from the data presented in the Grant Thornton report the numbers are meaningless. Even the best-case scenario is several thousand in the last decade. Each one is a life ended prematurely, someone forever gone, and a death that should not go unnoticed. We will never know how many of these deaths are attributable to the trust due to their data processes. **That is the scandal. No one knows how many have died. There is no way of finding out. This has happened in plain sight of those with a public duty to make mental health services safe.**

Information about report authors

Preparing this report has taken an emotional and physical toll on us. Many hundreds of hours of researching and writing in what should be our leisure time. Emotionally, it has been very difficult delving into the evidence and engaging with traumatically bereaved people. We do this because someone must speak out for those forever gone. We hope our efforts will lead to positive change.

We are three individuals who campaign for safer mental health services and advocate for bereaved families and those trying to access services. We have prepared this report in good faith from information that is available to us. We acknowledge that our analysis might have been different if we had access to the information Grant Thornton did. We have done this on a voluntary basis and we do not represent any organisation that we are, or have, been employed by. Although we have each of us supported the work of the Norfolk and Suffolk Campaign to Save Mental Health Services (the Campaign) in different ways, we have written this report in an independent capacity. Our affiliations with bereaved relatives and advocacy for improved mental health services is far wider than the campaign and indeed many bereaved relatives and families struggling to keep loved ones alive would not wish to be associated with campaigning. We will be sharing this report with the Campaign as an integral stakeholder and anticipate they will formulate their own response to the Grant Thornton report and our response. For clarity we summarise our interests and affiliations below.

Lead authors

Caroline Aldridge is a bereaved mother, mental health campaigner, and social worker from north Norfolk. She is author of *He Died Waiting: Learning the lessons – a bereaved mother's view of mental health services* (2020) and co-author of *They Died Waiting: The crisis in mental health – stories of loss and stories of hope* (Aldridge and Corlett, 2023). Caroline gave evidence to the 2016 Verita report. She is a former member of the Norfolk and Suffolk Mental Health Campaign and a patron of Mental Health Time for Action. Caroline advocates for bereaved people on a voluntary basis. Caroline is an independent trainer and public and patient advisor, her clients include NSFT, Norfolk and Waveney ICB and Suffolk and North Essex ICB. Currently, Caroline is an external project lead for NSFT assisting them to explore how they support their bereaved relatives. She is also chair of an informal group, *Remembering Together*, which aims to improve support for people bereaved due to mental illness.

Anne Humphrys

Anne was a teacher for the best part of 20 years and has two adult children, both of whom have mental health issues. During her children's teenage years, Anne wrote a popular blog about the experiences of mental health care. She has worked both locally and nationally to improve her area's education, social care and health services and co-authored some of the MindEd for families mental health resources. She is a former adviser to the Campaign to Save Mental Health Services in Norfolk and Suffolk. Anne is now an independent advocate for families in the fields of mental health and special educational needs and disabilities and supports young people and their families across the country as a continuation of her work to improve services for adults and young people. She is also carer for her sister who has early onset Alzheimer's and a complex history of trauma which has given her experience in the field of mental health services for older age adults. Anne also lost her brother-in-law through suicide and has represented her sister through the serious incident, complaint and inquest processes as part of this.

Co-author: Emma Corlett

Emma is a Labour Norfolk County Councillor in Norwich and has been a member or substitute member of Norfolk Health Overview and Scrutiny Panel since 2013. She was the Norfolk Member Champion for Mental Health (a non party-political role) from 2013 until the role was deleted in 2021. She was previously Vice Chair of Children's Services Committee and Chaired an in-depth cross-party scrutiny working group on the mental health of children and young people in Norfolk in 2016/2017. Emma worked as a mental health nurse at Norfolk and Suffolk NHS Foundation Trust for seventeen years until 2016. She was a UNISON trade union workplace representative for much of her time at NSFT and was a founder member of The Campaign To Save Mental Health Services In Norfolk And Suffolk.

Emma has advocated for, and supported numerous bereaved relatives over the last decade. She has set up a local charity that does grass-roots work, this includes a community café that aims to tackle the social determinants of poor mental health.

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Appendices

Appendix 1: Letter via email to Norfolk and Waveney and Suffolk and North Essex ICB chairs and CEOs on 9.5.2023.

Dear Zoe, Tracy, Patricia, Ed and Will,

We are writing regarding the Mortality Review to express our concern and disappointment that this has not yet been published.

We know that the initial report was completed and with yourselves in February and that you were waiting for any factual accuracy changes.

We were notified that Norfolk and Waveney ICB stated it would be published in April. NSFT then responded to questions during their public board meeting of the same month, that it would be published in May.

We now understand that there is no publication date and NSFT are saying the decision lies with the ICBs.

Given that the period for factual accuracy checking is long since over, we are deeply concerned about the continued delay and we are fast heading towards the system having had the report for longer than Grant Thornton took to do the work. We are also approaching a year since we travelled to Westminster to meet with MPs and the Minister to raise our concerns.

We would like to ask you to confirm the following:
1) the reasons for the delay
2) the date the report will be published and available to the public
3) the date on which the factual accuracy period ended

We are sure you can appreciate that this does not provide assurance to ourselves, service users, carers and members of the public that the process has been one of transparency or that the system is concerned about the findings of the report. We have long stated that NSFT have no idea about the number of people who have died and people continue to lose their lives and, therefore, the findings of the report are required urgently.

We have collated death numbers and raised concerns about them since the inception of the campaign. In April 2022 we knew the figure to be in excess of 1000 deaths. NSFT refuted this and further research from public documents found over 2600. We also found discrepancies in the figures reported in different official documents. We were under the impression that, as a system, you wanted to provide some clarity in a swift and transparent manner. The continued delays only serve to raise concerns that there is something much more sinister going on with potential collusion across the system to prevent the report being published.

Yours sincerely,
The Campaign to Save Mental Health Services

Appendix 2: Letter from Norfolk and Waveney and Suffolk and North Essex ICB chairs and CEOs replying to the Campaign on 30th May 2023.

Dear colleagues

Thank you for your letter. We understand that the factual accuracy check was completed on Friday, 26 May.

In terms of the number of drafts of the report, there was an original draft produced that was used to assess for factual accuracy. During the checking process, individual facts were checked for accuracy, but a whole new draft of the report was not created when each point was resolved. Once all the factual accuracy matters were agreed, another draft of the report was produced for approval.

It is of course standard practice for an audit like this to go through a factual accuracy check between the auditor and the organisation being audited. It is also standard practice for an action plan to be completed alongside an audit report, and we understand NSFT's action plan will be finalised shortly. When the report and the action plan are both ready, they will be combined to produce the final report, which will be shared with the ICBs and published.

On your final question, we would not and have not watered down the report. Only by understanding a challenge can it be solved, so it is vital we have a full and clear understanding of the situation. We are assured by Grant Thornton that as an experienced, certified and independent auditor, that the process for checking the factual accuracy of the report has complied with the standards expected.

Kind regards

Patricia, Will, Tracey and Ed

Rt Hon Patricia Hewitt Chair NHS Norfolk and Waveney ICB
Tracey Bleakley Chief Executive NHS Norfolk and Waveney ICB
William Pope NHS Suffolk and North East Essex ICB
Ed Garratt Chair Chief Executive NHS Suffolk and North East Essex ICB

Appendix 3: Overview of NSFT mortality data for the past five years

	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Total number of deaths overall from any cause including natural deaths[1] This represents all people who had been cared for as an inpatient and/or known to our community services and who had died whilst under our care or within six months of being discharged. It is important to note that these deaths include deaths from natural causes and don't equate to deaths relating to poor care.	585	2,343	2,951	2,636	2,864	11,379
Total patient safety incident related deaths[2] Number of patient safety incident related deaths investigated. However, it should be noted that following investigation not all these necessarily equate to poor care.	100 Breakdown: 100 - community	82 Breakdown: 76 - community 6 - inpatient	54 Breakdown: 40 - community 14 - inpatient	23 Breakdown: 21 - community 2 - inpatient	12 Breakdown: 9 - community 3 - inpatient	271
Total number of prevention of future death reports received by the Trust This is where the coroner has identified there has been learning for the Trust relating to an individual's care. This data relates to PFDs received within the five-year period, relating to deaths within the five-year period, but the figures are allocated to the year when the report was received and not when the individual died.	1	2	2	5	3	13

Total suicide and 'took own life' conclusions by the coroner of people known to our community services or within six months of their discharge Suicides are multifactorial and do not necessarily relate to poor care. This data relates to individuals who sadly died in this fiveyear period, but the figures are allocated to the dates the coroner inquest took place and not to the year the individual died.	53	53	72	66	15	259
Total suicide and 'took own life' conclusions by the coroner of people under the care of our inpatient services This data relates to individuals who sadly died in this five-year period, but the figures are allocated to the dates the coroner inquest took place and not to the year the individual died.	0	4	1	0	0	5

[1] After 2019/20, access to data from the NHS Spine (a shared data source amongst NHS organisations) allowed the Trust to collect much more data than previously, especially mortality data relating to people who died within six months of discharge from the Trust's care. This explains the rise in numbers between 2018/19 and 2019/20 and subsequent years.

[2] From 1 January 2021, NSFT became an 'early adopter' of the new national Patient Safety Incident Response Framework, which was introduced in a phased way. In the past deaths were considered under the old National Serious Incident Framework and reported through the national system. The new Patient Safety Incident Framework allows for the application of a range of system-based approaches to learning and all deaths are considered as part of a tiered range of reviews according to the Trust priorities, under the Trust Patient Safety Incident Response Plan. This means that a smaller number of deaths than previously are reported on the national system. All deaths are screened, and where appropriate, receive a form of review, such as a Screening Tool, After Action Review, or Safety Incident Review. This difference in approach and type of review limits direct comparisons across the five-year period. The national Patient Safety Incident Framework was rolled out across all NHS organisations from August 2022.

Appendix 4: Care Quality Commission Figures for Routine Inspection Reports

	April 2015 to September 2015	15th January 2015 and 12th March 2016	Since April 2016	During 2015/16	Between April 2012 and December 2015	Between 2012 & 2016	Between 1 April 2016 and 31 March 2017	Between 1 April 2017 and 31 May 2017	October 2018 to March 2019	Between May 2021 to July 2021	Between November 2019 to May 2021	PFDs	Since October 2020
2016 Inspection Report	8,803 incidents reported to NRLS 31 incidents categorised as death 8 resulted in severe harm	215 serious incidents which required further investigation. The majority of these were 'unexpected or avoidable death' at 152 incidents. The majority of	trust confirmed that there had been 55 deaths since April 2016 which were under investigation.	Overall, the trust had improved its reporting rates and had been a good reporter of incidents during 2015/16 when compared to trusts of a similar size.	there had been 686 deaths 405 of these incidents were investigated as serious incidents, as they were not due to natural causes.								

	in the highest 25% of reporters of incidents Trust reported 77% of no harm incidents compared to the national average of 62%	deaths had occurred in community adult services at 61. The majority of inpatient deaths had occurred in acute services at six incidents.		It was noted that the overall rates of severe and moderate incidents decreased during the reporting period.	620 in the community 51inpatient units. 14 had been detained at the time of their death. Overall, it was found that the trust's root cause analysis investigation process met								

					national requirements but improvements were needed to procedures following a death and the actions taken following the investigation.								
2017 inspection report						The trust had also undertaken an internal clinical review of	Reported 9,414 incidents to the NRLS. 48 incidents	27 deaths					

						deaths considered to be due to suicide or as a consequence of self-harm between 2012 and March 2016. The internal report found that the majority of people were under the care of a community or crisis services at the time of or just prior to their	categorised as death six had resulted in severe harm. When benchmarked, the trust was in the highest 25% of reported incidents when compared with similar trusts. reported 78% of no harm incidents which was above the national average.						

						death. Around a fifth of people were awaiting assessment or treatment. A fifth of people had been discharged from a ward for less than six months. The majority had a history of previous attempts, many within three months of their death.	Trust data showed there were 242 serious incidents which required further investigation. The majority of these were 'unexpected or avoidable death' at 184 incidents. 74 community deaths. 22 had occurred						

						However, in some cases there was no risk assessment or care coordinator in place. Approximately half did not have a crisis plan in place. During this inspection we looked in detail at these reviews and the actions the trust had taken. We found	in crisis services. The majority of inpatient deaths had occurred in older people's wards at 17 incidents. 191 incidents related to 'apparent /actual/suspected self-inflicted harm'						

						that work had begun on all required actions, but further work was needed to ensure that there were not missed opportunities.							
2018 inspection report													
2020 inspection report													
2022 inspection report									The trust was rated 'worse'	Between May 2021 to July 2021, mortality	Five coroners' reports were	The trust had received one	the trust had had five

									for consistency of reporting to the National Reporting and Learning System (October 2018 to– March 2019), which showed a downward trend when compared to the previou	rates had recovered to pre-pandemic figures. In the previous three months, August to October 2021, in total 133 people died within six months of contact with trust services. 71 (53%) of those people identified as male and 62 (47%) as female. The mean	submitted to the trust for deaths between November 2019 to May 2021. A further death was currently with the coroner.	prevention of future deaths notification in this reporting period, in July 2021.	deaths in detention, of which all the patients were on unescorted leave.

									s period. There were 115 unexpected or potentially avoidable deaths reported to Strategic Executive Information System (STEIS) from 1 September 2019 to 30 Septem	age of those who died was 67 years. This was slightly younger than had been the trend over the preceding 18 months, 70 years. The ethnicity of the person who died was recorded in 72% of these cases. In all but two cases the person			

									ber 2021.	who died was of a white backgrou nd, all but six of whom were British. 15 people who were in contact with trust services are thought likely to have taken their own lives in the previous three months. This was not a significan t change			

										from the number of people who had taken their own lives over the previous three years. Ten of these 15 people were men and five were women. These people were aged between 18 and 85 years of age, mean 48 years, median 46 years.			

										Where the person's ethnicity had been recorded, all identified as White and British. In all instances where a person takes their own life, the trust carried out an investigation following the principles of root cause analysis to			

										identify changes in local and trust wide practice which might lead to improve ments in care and treatmen t.			
2023 report	0 mentio n of mortali ty 0 mentio n of death												

Norfolk Health Overview and Scrutiny Committee

Proposed Forward Work Programme 2023/24

ACTION REQUIRED

Members are asked to consider the current forward work programme:

- whether there are topics to be added or deleted, postponed or brought forward
- to agree the agenda items, briefing items and dates below.

NOTE: These items are provisional only. The NHOSC reserves the right to reschedule this draft timetable.

Meeting dates	*Main agenda items*	*Notes*
7 September 2023	**Patient pathway item** Accident and Emergency (A&E) services • To include assessment of suicide risk of patients in A&E as discussed at January's FWP workshop. **Norfolk and Suffolk NHS Foundation Trust (NSFT) mortality review** An examination of the independent review by Grant Thornton into NSFT's mortality recording and reporting and associated action plan.	All patient pathway items to include request for workforce strategy data for each area then to be collated into single sub-report in end-of-year report.
9 November 2023	**Patient pathway item** Hospital discharge/palliative care **N&WICB transfer of responsibility for primary care services** – a six-month update about the transfer of dentistry, pharmacy and ophthalmology from NHS England to N&WICB with a particular focus on dentistry.	
18 January 2023	**Digital transformation strategy** An examination of N&WICB's digital transformation strategy as part of its vision to develop a fully integrated digital service across Norfolk and Waveney. To include information about the Electronic Paper Record.	

	Forward work plan workshop Planning workshop for agenda and briefing items for 2024.	

Information to be provided in the NHOSC Members' Briefing 2023/24

October 2023

- **Public Health** – an overview of people's health in Norfolk. TBC.
- **NHS 111** – an overview of NHS 111 local performance (N&WICB). TBC.
- **Care Homes At Scale (CHAS**) – an overview of the services/support offered by CHAS. TBC.

Future topics for re-consideration (meeting or briefing) following previous meetings/briefings:

- Major Trauma Unit (MTU) at the Norfolk and Norwich Hospital
- ambulance service
- proposed closure of Holt Medical Practice's branch in Blakeney – update
- proposed closure of Manor Farm Medical Centre in Narborough – update
- widening participation/staff retention workforce strategy

Further topics for future briefings as discussed at January's FWP workshop:

- speech and language therapy
- focus group re. LGBT+ health services
- Change Grow Live (CGL) addiction services
- blood donation
- Carers Identity Passport
- vaping (to be examined at People and Communities Select Committee)
- new hospitals programme
- cancer services for people with disabilities

NHOSC Committee Members have a formal link with the following local healthcare commissioners and providers:

Norfolk and Waveney ICB	-	Cllr Fran Whymark
Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust	-	Cllr Julian Kirk
Norfolk and Suffolk NHS Foundation Trust (mental health trust)	-	Cllr Brenda Jones

Norfolk and Norwich University Hospitals NHS Foundation Trust	-	Cllr Lucy Shires Substitute: Clllr Jeanette McMullen
James Paget University Hospitals NHS Foundation Trust	-	Cllr Jeanette McMullen
Norfolk Community Health and Care NHS Trust	-	Cllr Lucy Shires

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