Norfolk and Suffolk NHS
NHS Foundation Trust

Compliance Team – Health Records
Kestrel House
Hellesdon Hospital
Drayton High Road
Norwich
Norfolk
NR6 5BE

Tel: 01603 421687
Fax: 01603 421411

FOI REQUEST NUMBER 25 2015

Request:

I would like to submit the following request under the Freedom of Information Act.

Please could you tell me how many Norfolk and Suffolk Foundation Trust patients have died in each of the following years: (i) 2010 (ii) 2011 (iii) 2012 (iv) 2013 (v) 2014.

In each case could you please state the location of their deaths and the cause of death.

Could you also please state whether deaths which occurred outside of Norfolk and Suffolk were out of area for specialist care or out of area because of a lack of beds in Norfolk and Suffolk?

Response:

Thank you for your recent request under the Freedom of Information Act 2000. I do apologise for the delay in responding.

The Board receives an annual analysis of deaths each year at a public meeting and the October 2014 and October 2013 reports are attached. There is a time-lag in carrying out this analysis so as to be as clear as possible about causes of death. The next report covering 2013-2014 will be presented in October 2015.

The Trust provides a complaints procedure to deal with complaints about the Trust's handling of requests for information. If you feel you need to make a complaint, in the first instance, you should contact a Non-Executive Director via the Chair of the Trust. If you feel you have exhausted our internal complaints procedure, you also have the right and may feel you wish to write to the Information Commissioner who can be contacted on telephone number 01625 545740 or at www.ico.gov.uk.

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SUICIDE PREVENTION CLINICAL AUDIT
Norfolk & Suffolk NHS Foundation Trust
(1st April 2011 – 31st March 2012)

Hadrian Ball- Medical Director

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National Picture

- 1:10,000 people will take their own life
- Of these, 25 % will have had contact with Mental Health Services
- 0.03% are psychiatric inpatients
- The National Confidential Inquiry (Published July 2013) confirms that in 2011, the suicide rate in mental health patients increased

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Trust Picture

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- In April 2010- March 2011 the number of suicides and deaths with undetermined intent was 34
- In April 2011- March 2012 the number was also 34
- Of the 34, two occurred in an inpatient setting
- Per 100,000 service users seen- 49.7
- Compares to 87.8 nationally

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RESULTS:

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Figure 4 Primary Diagnosis ICD-10 Code (n=34)

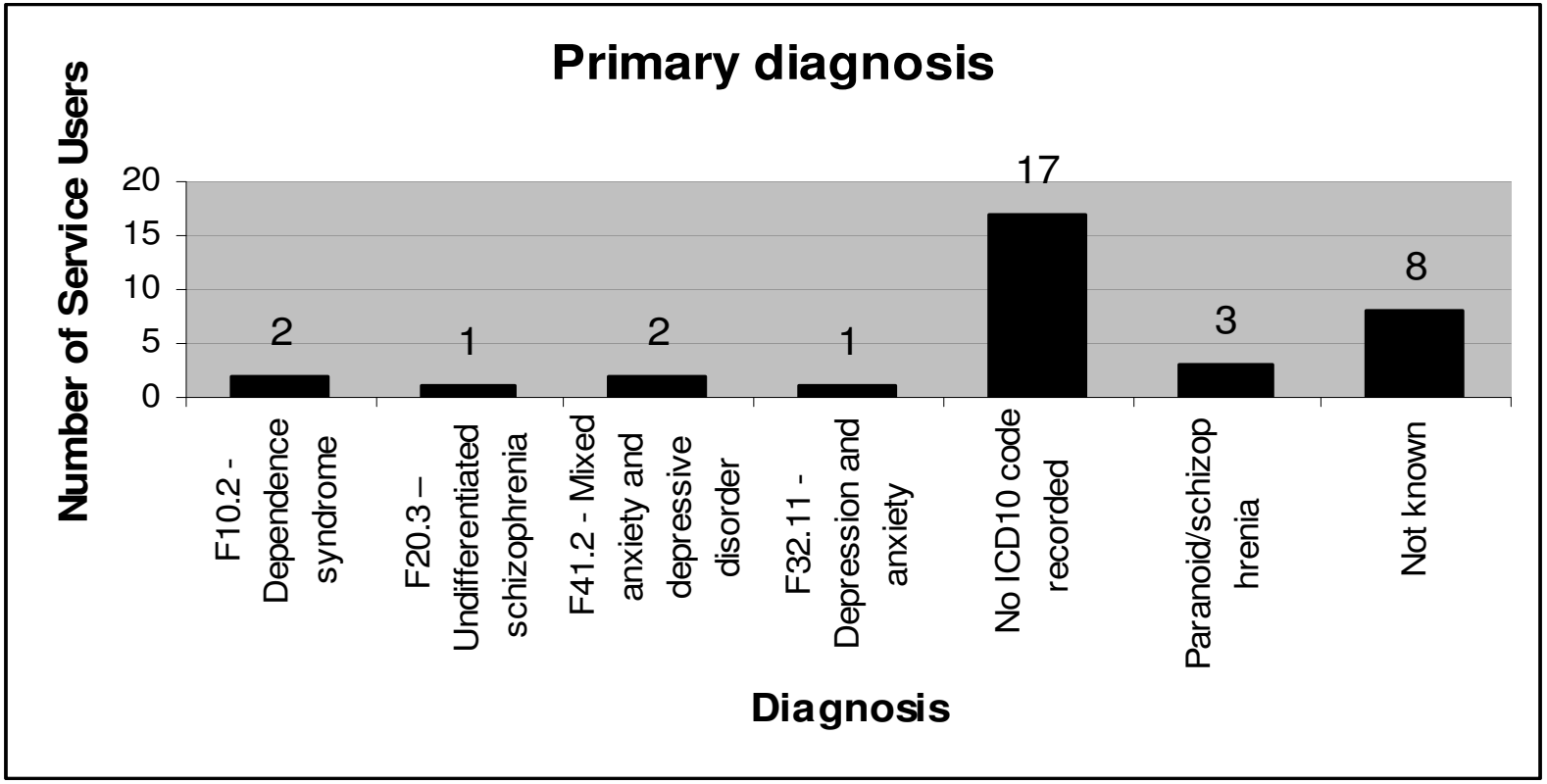

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Figure 3 Age Range

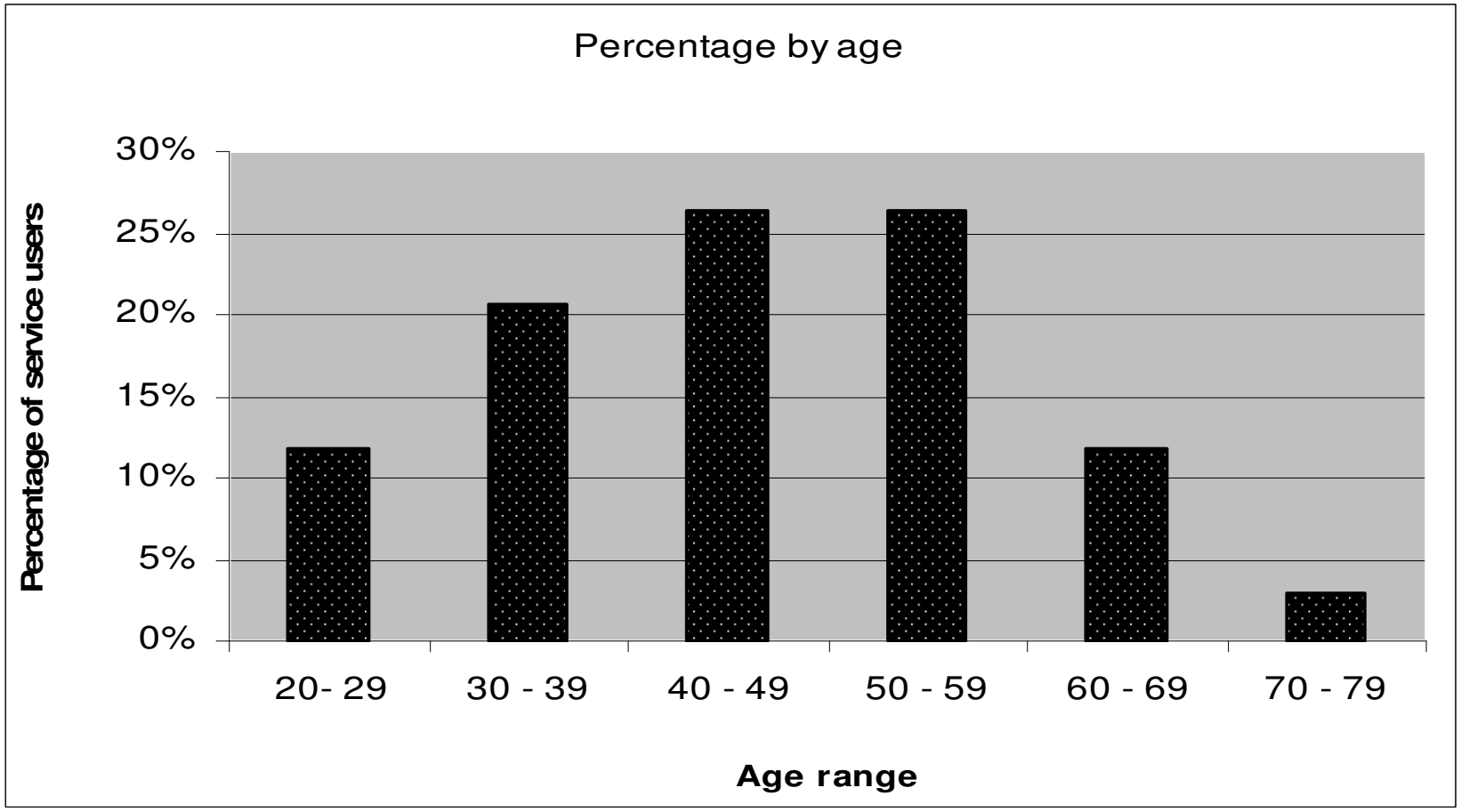

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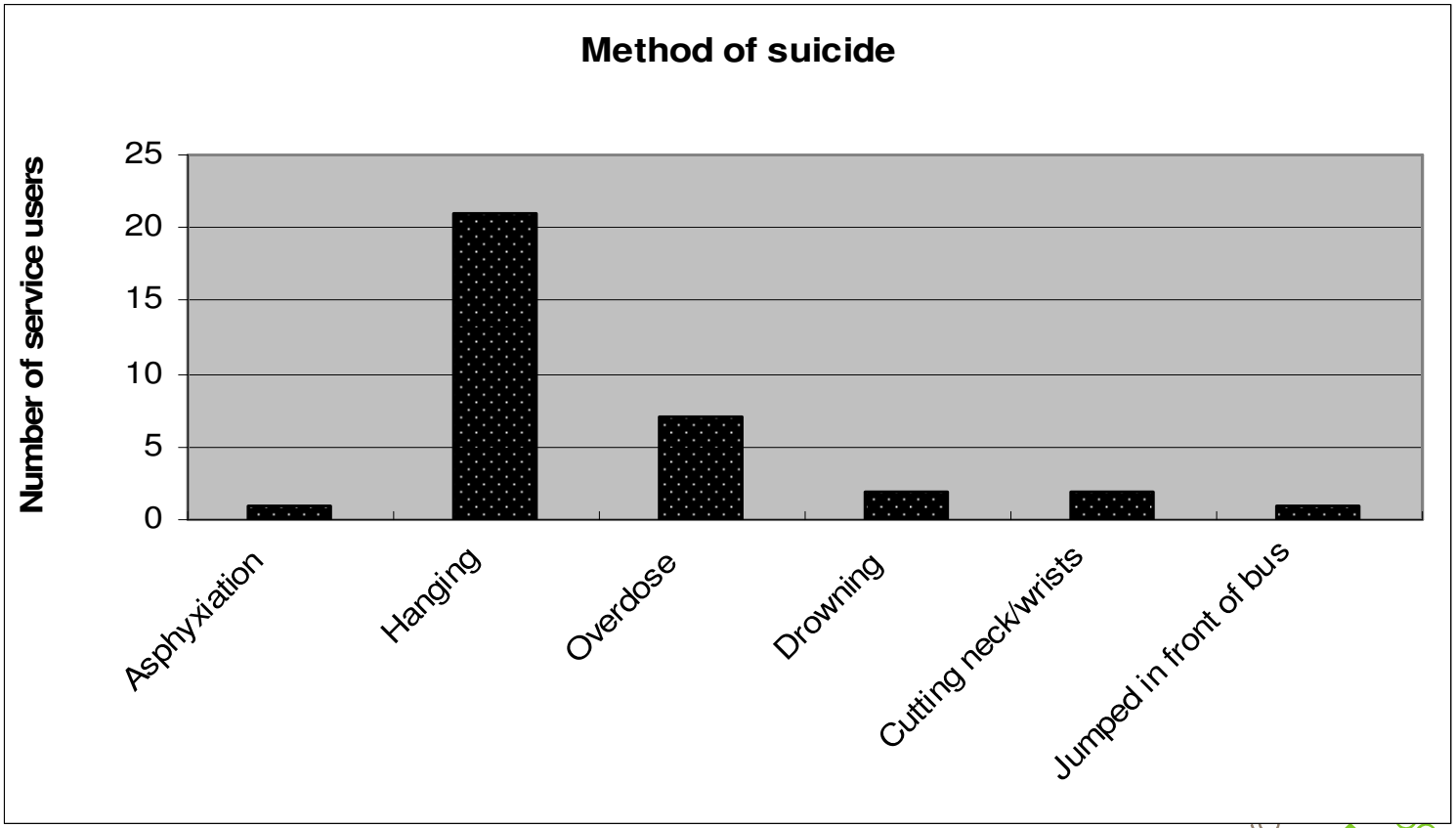
Figure 6 Method of Suicide as Recorded and Verdicts (n=34)



RESULTS:

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Figure 10 Area/Locality of last contact with mental health services (n-34)

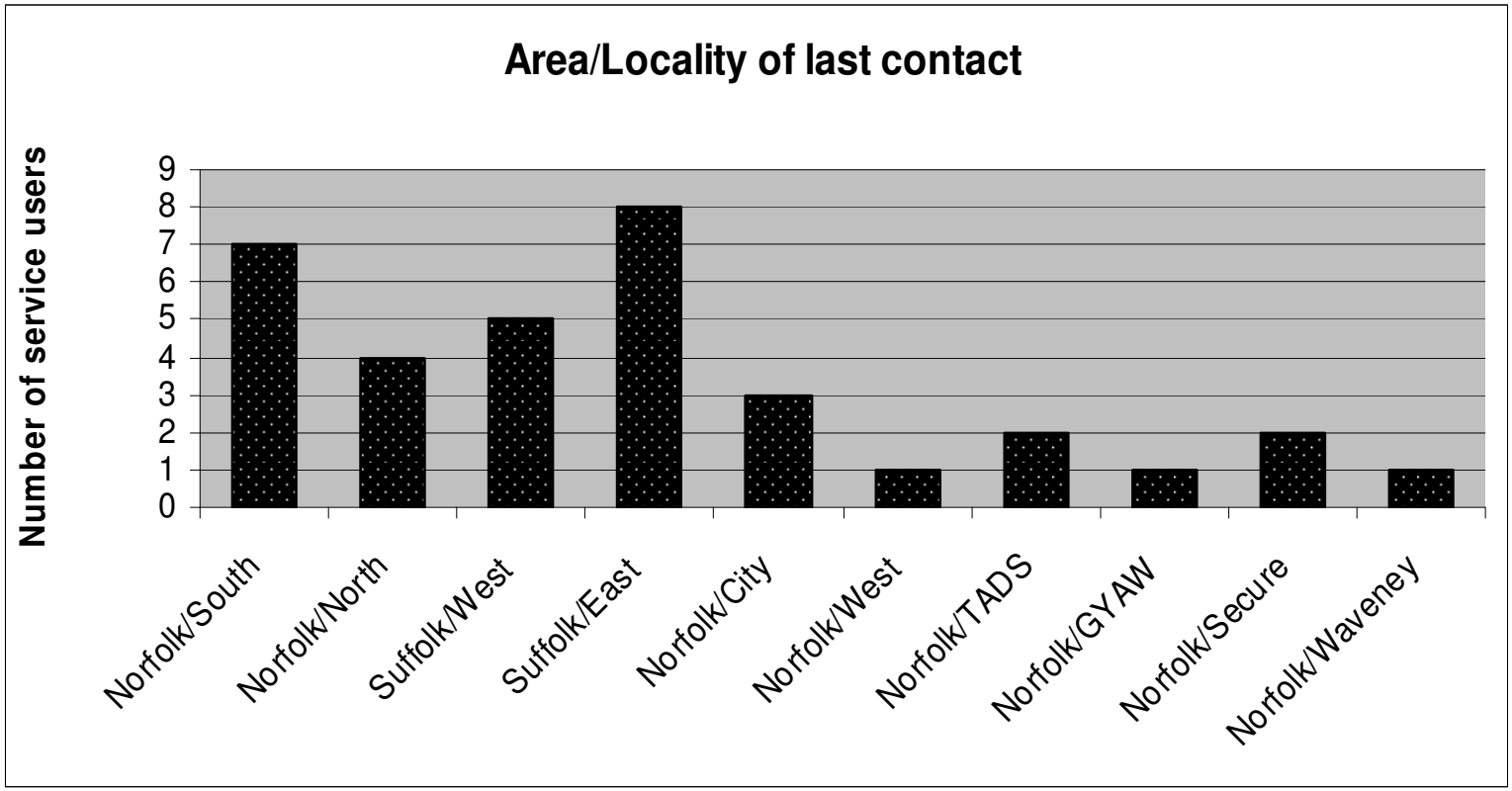

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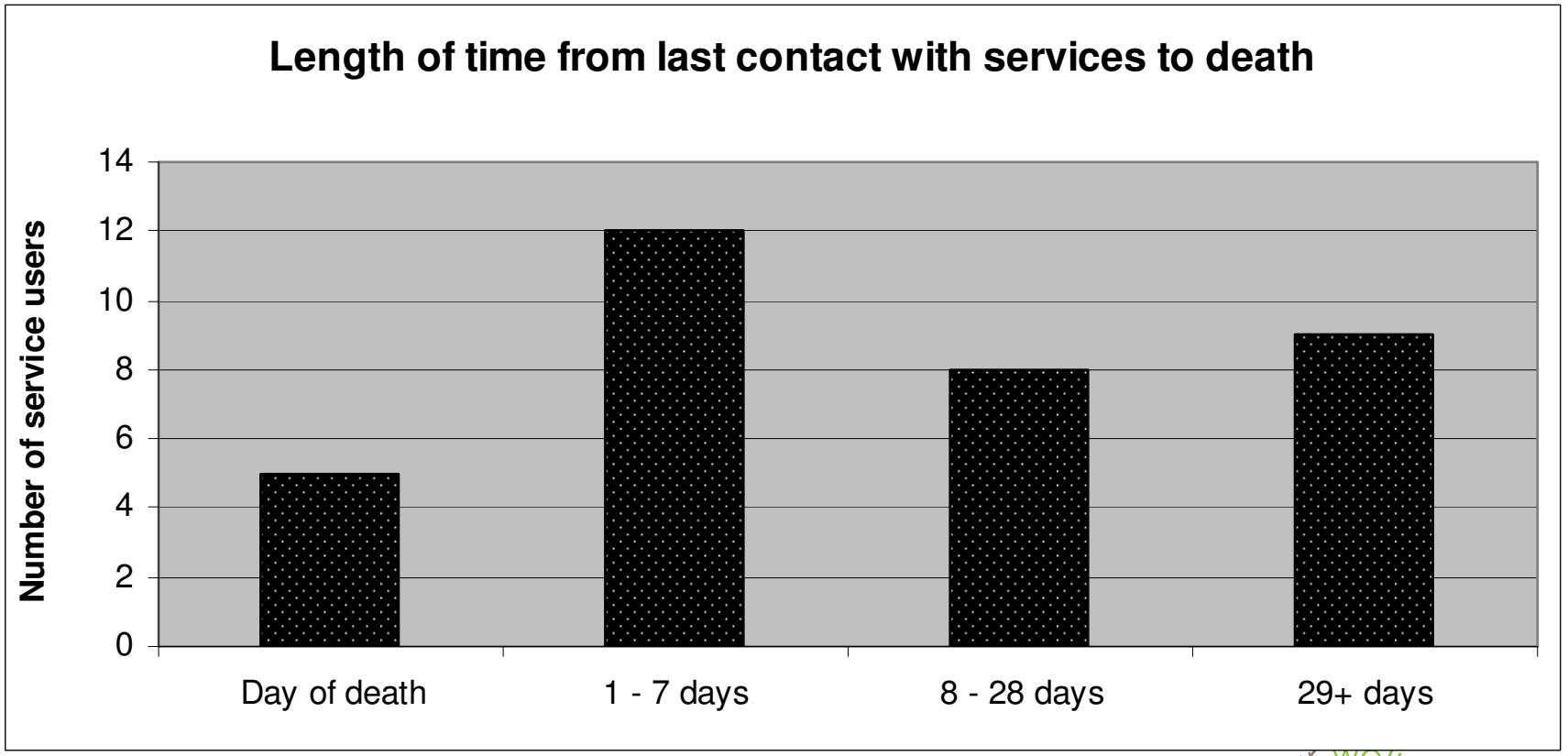
Figure 11 Length of time from last contact with services to death (34N)



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WARD MANAGER CHECKLIST AUDIT

- The practice was audited to measure it's adherence to:

- 'Preventing Suicide - A Toolkit for Mental Health Services':
- **Standard One** – Patient records
- **Standard Two** – CPA Patients
- **Standard Three** – Observation and Engagement
- **Standard Four** – Family or Carer Contact
- **Standard Five** – Discharge

- Updated version of the original toolkit published in 2009

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CONCLUSIONS

- Analysis of the **Monthly Ward manager audit** results showed that the following key points were consistently not achieving 100% compliance:-
- **Standard 3 – Observation and engagement**
- Compliance fell as records of observation were not fully completed, activities which were offered to clients were often not accepted and care plans did not record reasons for changes in observation levels or changes in client mood.
- **Standard 4 – Family/carer involvement**
- Families were not contacted within one week of client admission and were either not invited to contribute to the assessment process or this was not recorded adequately.
- Information regarding medication was either not given to clients/carers or the recording of this was incomplete.
- **Standard 5 – Discharge**
- Many of the clients did not have a contingency plan of discharge within 48 hours of admission and where these were produced the family/carer were often not involved in their creation.

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Annual Suicide & Death due to Undetermined Injury Audit 2012/13

Dr Hadrian Ball- Medical Director

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Historical View

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Year	Norfolk and Waveney	Suffolk
2006/2007	-	-
2007/2008	31	19
2008/2009	14	10
2009/2010	20	16
2010/2011	18	14*
2011/2012	21	13
2012/2013	29	10

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Annual Mortality Figures

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	2011/2012	2012/2013
Actual number of Deaths audited NSFT No. of deaths fitting the selection criteria	**34**	**39**
Suicides in a Standardised Rate NSFT per 100,000 mental health service users		**79.9**
Number of unique Patients seen by NSFT		**48,834**
Suicides in a Standardised Rate England per 100,000 mental health service users (NCI 2013 Annual report)	**87.8** Revised to 86.1 in 2014 report	**80.6**

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Age Profile

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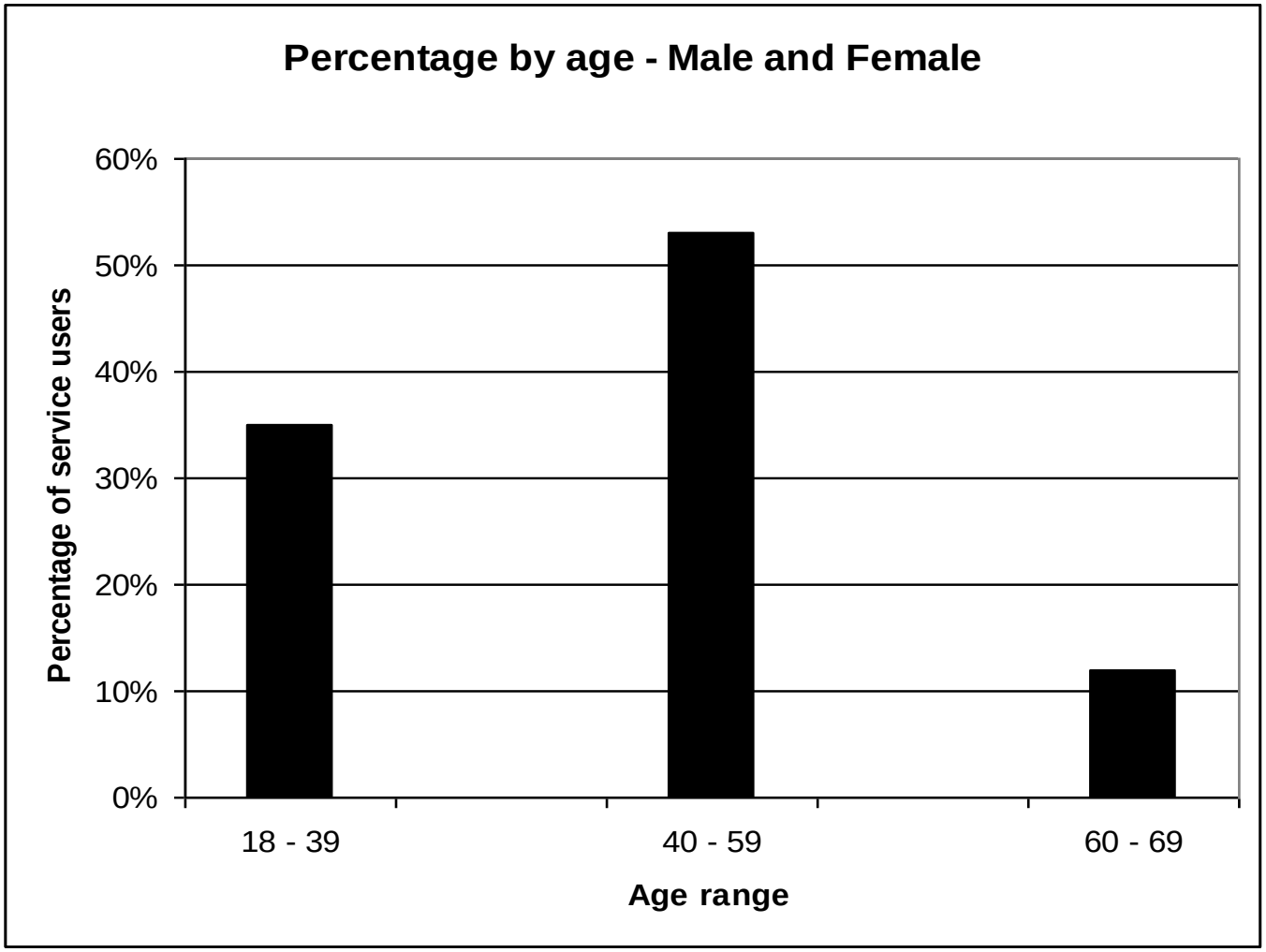

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Primary Diagnosis

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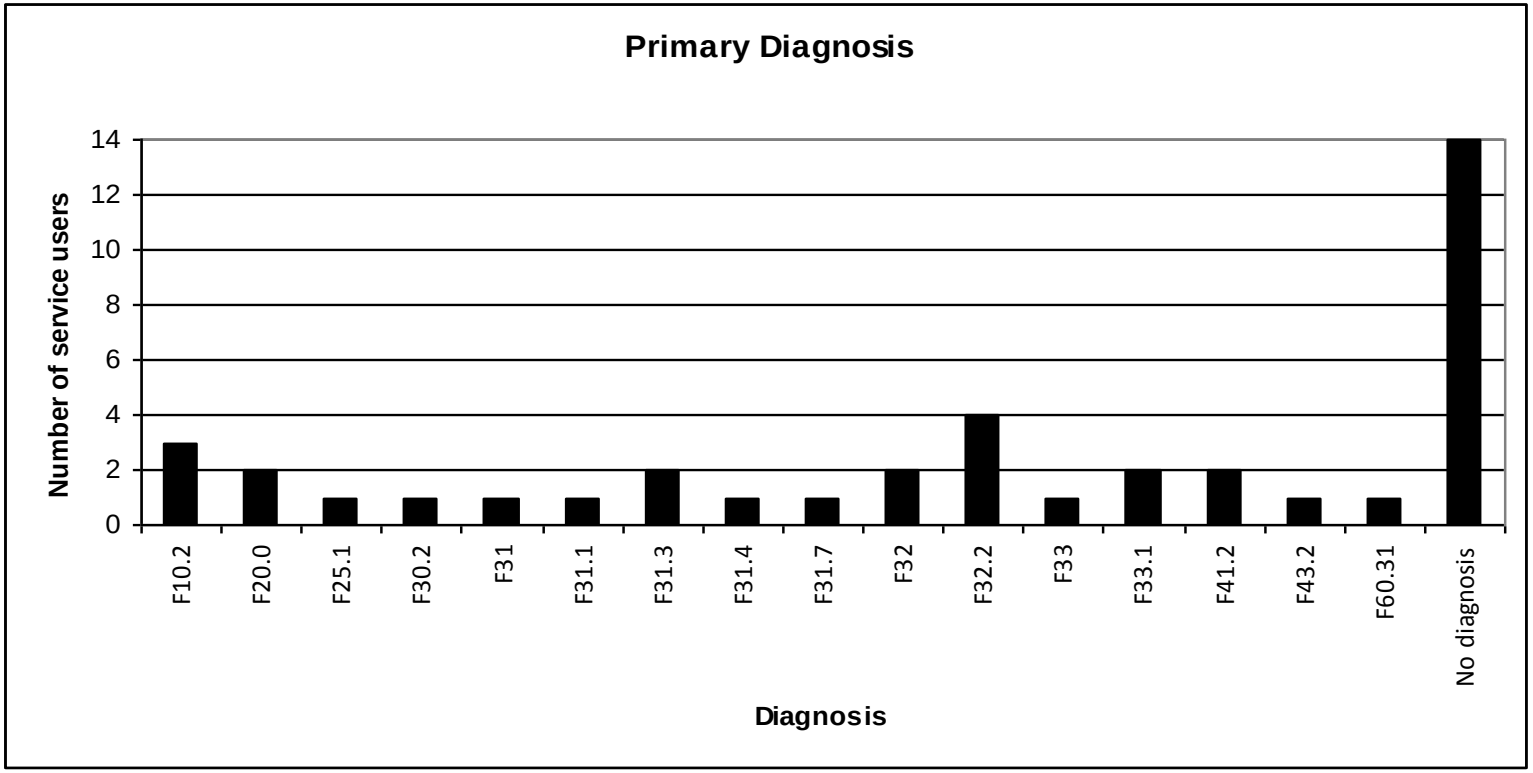

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Method

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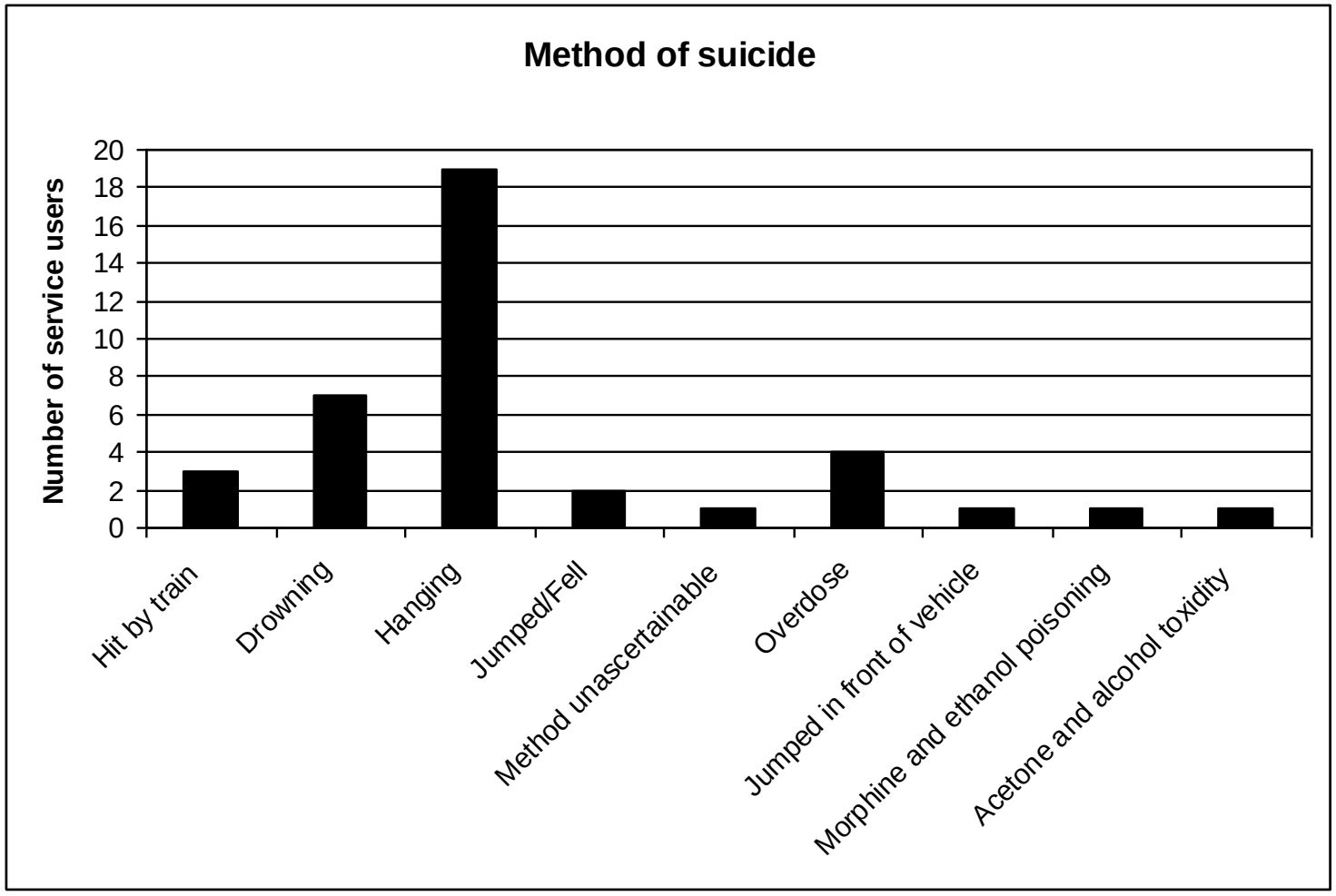

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Month

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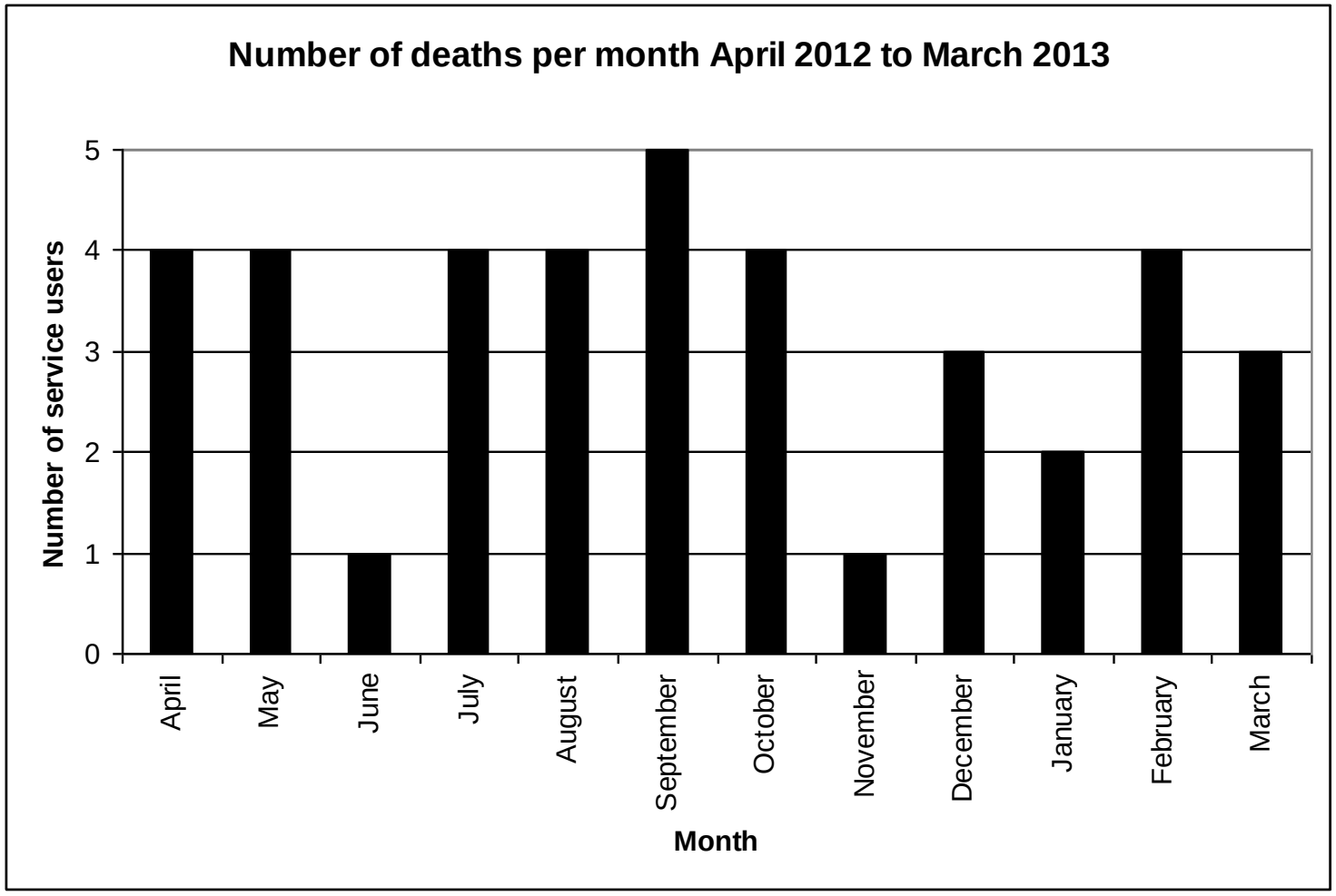

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Locality of last contact

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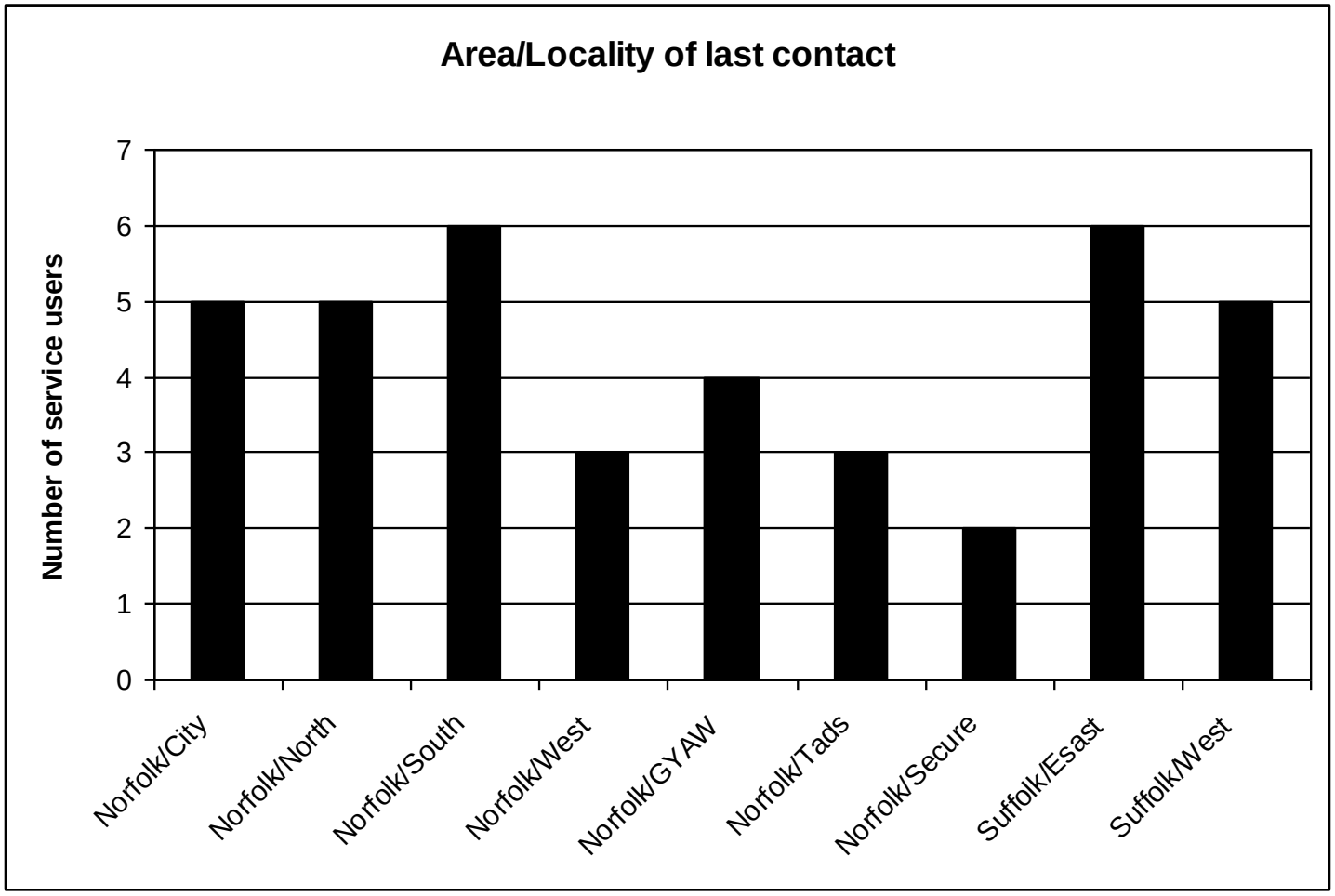

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Last Contact with Service

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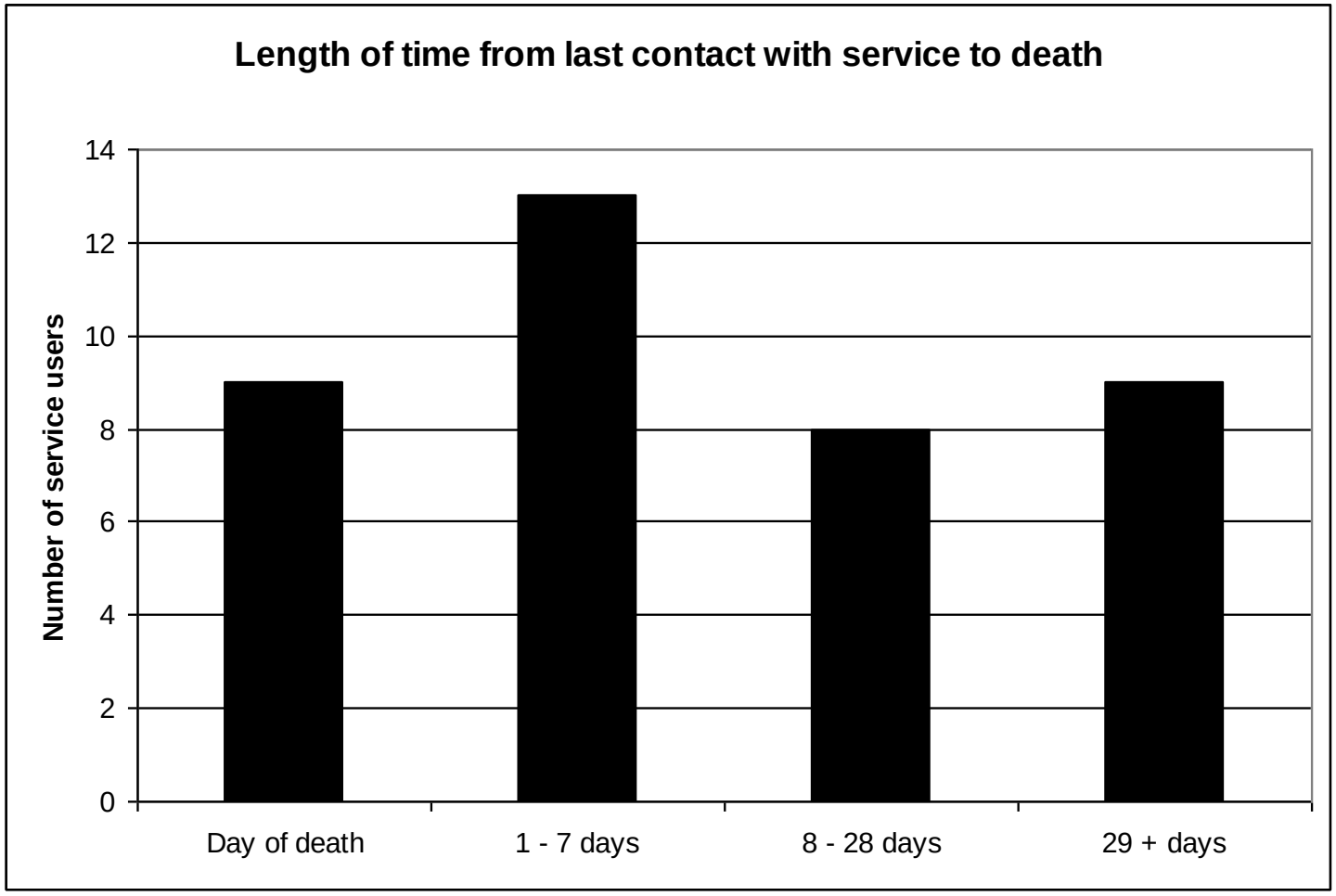

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Conclusions

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- Rate similar to England
- Profile consistent with National Confidential Inquiry
- High risk post-discharge emphasised
- Trust Policy:
- - greater focus on this group
- - Introduction of “Never Event”?

- Action: for further analysis and consideration through
- governance/operational mechanisms

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