## Board of Directors – Public Session

Meeting to be held on Thursday 24\(^{th}\) October 2013 from 09:30
in The Function Suite, Wherry Hotel, Bridge Street, Oulton Broad NR32 3LN
Lunch will be available after the meeting

### AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Item No</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:30</td>
<td>13.123</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>09:35</td>
<td>13.124</td>
</tr>
<tr>
<td>09:40</td>
<td>13.125</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>13.126</td>
<td></td>
</tr>
<tr>
<td>09:45</td>
<td>13.127</td>
</tr>
<tr>
<td>09:50</td>
<td>13.128</td>
</tr>
<tr>
<td>09:55</td>
<td>13.129</td>
</tr>
<tr>
<td></td>
<td>13.130</td>
</tr>
<tr>
<td>10:05</td>
<td>i.</td>
</tr>
<tr>
<td>10:20</td>
<td>ii.</td>
</tr>
<tr>
<td>10:40</td>
<td>iii.</td>
</tr>
<tr>
<td>10:55</td>
<td>iv.</td>
</tr>
</tbody>
</table>

Attachment A
Attachment B
Attachment C
Attachment D
Attachment E
Presentation (to follow)
Attachment F
Verbal
Time     Item No

11:05    BREAK

13.131    Items For Approval

11:15     i.  Patient Safety and Quality Report  (Roz Brooks)  Attachment G
11:30     ii. Service User and Carer Trust Partnership Terms of Reference (Gary Page)  Attachment H
11:35     iii. Joint working agreement between the Board of Governors and Board of Directors  (Robert Nesbitt)  Attachment I
11:40     iv. Separation of Chair and CEO roles (Robert Nesbitt)  Attachment J
11:45     vi. Service Governance Committee proposal (Gary Page)  Attachment K

13.132    Items for Information

11:50     i.  Quality Report (Sue Barrett)  Attachment L
12:00     ii. Feedback session from Youth Councils (follow up to February 2013 BoD meeting) (Emma Corlett in attendance)  Presentation

12:20  13.133    Any other urgent business, previously notified to the Chair

12:25  13.134    Date, time and location of next meeting

The next meeting of the Board of Directors will be held in public on Thursday 19th December 2013 from 10:00 – at the Public Library, Sergeants Walk St Andrews Street North Bury St Edmunds IP33 1TZ

12:30    CLOSE

LUNCH FROM 12:30 – 13:00

NOTE THE ‘FLU CREW WILL BE IN ATTENDANCE AT LUNCHTIME TO OFFER STAFF VACCINATIONS

Robert Nesbitt
Trust Secretary
15th October 2013
Minutes of the Board of Directors – Public Session
held on 29th August 2013 at 10.00
in the Pedlars Suite, George Hotel, Station Street, Swaffham, PE37 7LJ

Present:

Dr Hadrian Ball: Medical Director
Roz Brooks: Director of Nursing and Governance
Barry Capon: Non-Executive Director
Kathy Chapman: Director of Operations – Norfolk & Waveney
Graham Creelman: Non-Executive Director
Andrew Hopkins: Director of Finance & Performance
Jane Marshall-Robb: Director of Workforce and OD
Gary Page: Chair
Brian Parrott: Non-Executive Director
Stuart Smith: Non-Executive Director
Aidan Thomas: Chief Executive (joined at 10.12)
Debbie White: Director of Operations – Suffolk

In attendance:

Caroline Gregory: Deputy Trust Secretary (Minutes)
Robert Nesbitt: Trust Secretary
Ben Scarsbrick: KPMG (observing)

There were seven governors in attendance and four members of the public.

Meeting commenced at: 10:05

Certain items were taken out of order, but for clarity the minutes reflect the agenda.
13.90 Chair’s welcome, notification of any urgent business and apologies for absence

Apologies for absence were received from Leigh Fleming, John Brierley and Peter Jefferys.

Item 13.95iv Service User and Carer Group Terms of Reference will be taken to the September 2013 Board Meeting.

Item 13.105vi – Learning Disability Indicator will be taken in public with Item 13.97iv on the public agenda.

13.91 Standing Item: Declarations of Interest

Hadrian Ball advised that his wife has been appointed as Chief Executive of Norwich & Central Norfolk Mind.

13.92 To approve the minutes of the previous meeting in public held on 27th June 2013

The minutes were approved with no amendments.

The minutes were approved for release in accordance with the Freedom of Information Act.

13.93 To address any Matters Arising from the minutes of the previous meetings, not covered by the Agenda

   i. Min 13.63i: Report back to Board in three months on progress re physical health care for Service Users

   Roz Brooks advised that this will be reported to the October 2013 Board meeting.

   ii. Min 13.63ii: Note to Registrar of RCP to confirm content of telephone conversation

   Hadrian Ball advised that notes of the meeting with the Registrar have been taken and kept for reference.

   iii. Min 13.63ii: Communications pack for key stakeholders including NEDs, Governors

   Gary Page advised that he would follow this up with Leigh Fleming.

   Action 13.93
   Follow up communications pack with Leigh Fleming (Gary Page)

13.94 Chair’s report

Gary Page presented the report highlighting some main points.

Odgers Berndtson have been unanimously appointed to lead on the Chief Executive recruitment.

In response to Stuart Smith, Gary Page confirmed that the harmonisation of Terms & Conditions was specifically in relation to pay protection which was
locally agreed and was different in Norfolk and Suffolk. Jane Marshall-Robb advised that the Trust would work with the Unions during September 2013 to find a middle ground. The outcome of the discussions would be discussed at the OD & Workforce Committee in October 2013.

13.95 Items for Approval

i. Patient Safety and Quality Report

Roz Brooks presented the report and apologised that the up to date version of the complaints paper had not been included in the papers. An updated copy was tabled at the meeting and circulated to the Board.

The upward trend on Safeguarding referrals continues.

Electronic prescribing (eMMa) has now been implemented on Thorpe Ward and is due to be rolled out across the Norvic Clinic. In response to Barry Capon, Hadrian Ball advised that Suffolk would not be included until unified case records i.e. Lorenzo exist. The Board discussed the pace of the rollout of eMMa alongside the roll out of Lorenzo which they agreed would be appropriate to ensure it was safely deployed.

Prescribing errors continue to reduce. Hadrian Ball noted that there had been a dramatic decline in the number of prescribing errors since it received Board scrutiny which should continue. In response to Guenever Pachent, Roz Brooks advised the errors reported on Northgate Ward were due to poor recording but would confirm whether this relates to five separate incidents or one single incident.

The outstanding alert regarding window restrictors has now been completed.

During July and August 2013 there has been a dramatic increase in complaints. Barry Capon advised that a review of the procedure is about to take place and had been discussed at the Board of Governors, Planning & Performance sub-committee yesterday.

Serious incidents (SIs) have increased this quarter, particularly within Norfolk Recovery Partnership (NRP) and West Norfolk. Dr AJ Wagley, NRP has been asked to review the SIs and report back. An update will be reported to the Board. Hadrian Ball advised that the new NRP service started in April 2013. In response to the non-executive directors (NEDs), Roz Brooks advised that the partnership appears to be working well. A working party has been set up to consider all unexpected deaths. However, other service providers across East Anglia have also seen an increase.

There have been 23 Coroners inquests with seven verdicts drug and alcohol related. The lessons learnt from the Rule 43 letters will be considered at Service Governance and embedded into clinical practice.

Sara Fletcher is leading on the Harm Free Care initiative on behalf of the Trust.

CAMHS is reporting the highest number of physical assaults for both quarters. In response to the Board, Roz Brooks advised that the Trust is still waiting for the national guidance on restraint post Winterbourne which is being led by the Royal College of Nursing.
There have been two unannounced Mental Health Act Commission visits during the quarter. Internet access was highlighted as not all areas have access. Roz Brooks has been assured this will be in place by November 2013. Stuart Smith advised that this has been approved by the Investment Committee and that roll out starts in November 2013 and is likely to take six months to complete.

2 CCG visits have been undertaken Wedgewood House received a quality score of 55 out of a potential 56.

Esther Harris has been appointed as a volunteer and will be undertaking visits on in-patient areas using the 15 step challenge tool kit.

The service user and carers Norwich City Group commenced July 2013.

The appointment of Admiral Nurses is continuing.

### Action 13.95i

Circulate amended complaints report (Roz Brooks) **Completed**
Confirm whether prescribing errors on Northgate Ward relate to 5 separate incidents (Roz Brooks)

###  ii. Volunteer service accreditation

Roz Brooks presented the report and advised that the Trust has completed and submitted the self-assessment for Investing in Volunteers Award. The next step is the formal assessment.

The first copy of Trust Volunteer magazine will be distributed shortly.

In response to the NEDs, Roz Brooks advised that the service area has to identify the volunteer role and that there was no evidence that volunteers across the NHS were providing services that were not monitored.

The Board discussed the 22% decrease in the number of volunteers which is related to seasonal movement particularly relating to student. Roz Brooks will investigate whether leaving volunteers provide feedback. Caroline Gregory confirmed to the Board that the Youth Council will be invited to the October 2013 meeting.

### Action 13.95ii

Confirm with Pene Kendrick-Ward whether feedback/analysis is received from departing volunteers and report back to Board (Roz Brooks)

### iii. Safeguarding strategy

Michele Allott presented the strategy outlining that this had been developed in direct response to actions for the Trust following the NHS England audit.

The strategy outlines the approach for the next two years.

The Board discussed the strategy at some length and concluded that the document required some further development as although it was heading in the right direction it appeared to be more of an action statement rather than the final strategy document. Roz Brooks advised that it had been shared with all the scrutiny groups and circulated widely for comment. Michele Allott advised that all the policies supporting the strategy were in place. Guenever Pachent advised that service user group and strategy groups would like to see the policies.
Gary Page requested the policy be circulated and brought back to the Board for approval October 2013. Roz Brooks will email for further comment outlining the timeframe for comments.

**Action 13.95iii**
Email for consultation/comment with timeframe to respond by (Roz Brooks)
Strategy to Board meeting October 2013 (Roz Brooks)

---

iv. **Service User and Carer Group Terms of Reference**
To be taken at September 2013 meeting.

v. **Action taken under SO. 36**
Andrew Hopkins presented this report advising that this referred to the investigation into the fire at the Woodlands Unit and highlighted agreed actions and the formal position of the Trust.

The outstanding fire notices relating to the Wedgwood Unit have been worked on by NSFT and these have now been lifted. Leigh Fleming will meet with Suffolk Fire & Rescue Service in September 2013 to confirm there are no outstanding issues.

13.96 **Items for Debate**

i. **Staff wellbeing strategy update**
Debbie White updated the Board on the current position highlighting the four main areas of focus.

1) Reduce annual sickness absence to 3.56% by March 2015.
2) To develop a range of initiatives for Health & Wellbeing (H&W) access
3) To reduce stress, anxiety and depression to aid reduction of long term sickness absence
4) Embed a culture of H&W

The strategy was launched with the new Occupational Health provider in each locality and localities have developed action points.

In response to the Board, Debbie White advised there had been a mixed response from staff but that the main message for middle management to reinforce with staff was access to good supervision and good appraisals; to discuss the H&W element in team meetings which includes not working long hours and encourage team activities i.e. team away days.

13.97 **Items for Information**

ii. **The Francis Report – Update on actions to date**
Michele Allott presented the report which is based on the key recommendations. It provides information on actions put in place by the Trust since the report. Barry Capon advised that NEDs would have greater
engagement in the review of complaints. Graham Creelman advised that discussions had taken place with the Governors regarding issues within the community. Michele Allott and Robert Nesbitt outlined how the Trust was working to engage with local communities ie multicultural days.

Jane Marshall-Robb advised that there is a detailed workforce action plan at an advanced stage that underpins this and can be shared if requested.

In response to Gary Page, Sue Barrett advised that although the Trust was overall compliant with most aspects of NICE guidelines the new process through the Clinical Cabinet will be more effective in highlighting areas where we are not compliant with new guidelines. However, the Trust does not always consider NICE guidelines as things change and further consideration needs to be given on how to review this. Hadrian Ball advised that the implementation of NICE is about quality which has a cost aspect and that the Trust needs to make Commissioners aware of the cost involved of full compliance. Roz Brooks will report as part of the quarterly patient safety report going forward.

iii. Quality Account update

Sue Barrett presented the Quality Account highlighting the work that had been undertaken to date and the mandatory requirements in respect of the Quality Account. One of the mandatory requirements is for the Board to review the quality of services through quality indicators. The Board is being asked to agree to continue to report on the current indicators or to make suggestions for new indicators to be audited by internal and external audit. A new toolkit is expected for next year’s Quality Account as it has now moved to the NHS Commissioning Board.

The Board discussed at length the indicators that were currently being reported on, how these had been chosen and why the Board was being asked to consider indicators part way through the year. Sue Barrett advised that these had been carried over from previous years in order to maintain consistency and to identify comparisons to benchmark against. The guidance has changed on an annual basis which has not been helpful. The indicators were discussed at the time of the merger. Roz Brooks advised that from a quality perspective she would be happy to continue with the current indicators this year.

Andrew Hopkins suggested that a review of the Quality Indicators for audit purposes was scheduled annually into the Board work plan starting December 2013/January 2014. Sue Barrett agreed this would be helpful and provide clarity around the differences between the Quality Indicators and the Quality Account.

The Board approved the current indicators for this year.

iv. Update on access to services for people with a learning disability and Item 13.105vi – Monitor Compliance Framework – Learning Disability Indicator (Private Board Item)
Roz Brooks presented the reports highlighting that the second report is a review of the current service provision and reminded the Board that the Trust does not provide learning disability (LD) services in Norfolk.

The Board discussed the current service provision in Suffolk. Debbie White advised that a service specification has been produced and is waiting for financial information to complete the specification.

Brian Parrott highlighted to the Board some of the difficulties regarding access to mental health LD services and that the Trust needs to be mindful of the advocacy needs. The Board agreed that it is an area that lends itself to a joined up strategy.

The Board discussed the aim of the first paper and that the focus is to ensure that people with learning disabilities have access to mainstream services. Kathy Chapman supported this adding that being a provider of mental health LD services should help the Trust ensure that people with LD can access our mainstream services. Robert Nesbitt advised that Ravi Seenan would assist in updating the equality assessments for TSS.

Roz Brooks advised that the Trust is compliant with the Monitor Compliance Framework and also provides other support. Gary Page queried the level of service user involvement. Robert Nesbitt advised that the patient experience tracker would be available soon. The nonexecutive directors probed further for assurance that the Trust, by its actions, is making a difference to access. Roz Brooks advised that she was confident the Trust had not received complaints in relation to access. Gary Page suggested that the Trust canvas third sector organisations. Guenever Pachent advised that she was aware of a consultation infrastructure for LD in Suffolk that could be used to gain information and that the same would probably exist in Norfolk.

Roz Brooks advised that the new Director of Nursing has an LD background and could consider how the Trust can check access to services is enhanced due to the actions taken by the Trust.

Debbie White will hold further discussions on the LD strategy and bring back to the Board.

The Board approved the report.

**Action 13.97iv**

Consider how the Trust can check access to services is enhanced due to the actions taken by the Trust (Director of Nursing)

Updated LD strategy to be presented to Board at future date (Debbie White)

v.  *Infection control update*

Roz Brooks presented the report highlighting main points.

An audit of beds/mattresses has been undertaken and will be reported back to the Board.

It is currently proving difficult to recruit LIPACS due to all the changes.
There has been one case of Clostridium Difficile. The patient transferred from Ipswich Hospital into the Trust. There will be no financial sanctions applied as the infection was not developed in the Trust’s care.

The flu vaccination programme will be starting in September 2013.

Stuart Smith advised that an area of concern was that as the Trust moved towards more community based working, infection prevention control would be more difficult as these were not our premises. The premises would often be the responsibility of the host organisation the Trust was operating with.

vi. Charitable Funds Committee report – follow up of audit recommendations

Stuart Smith updated the Board on the items raised at the Committee.

Great Yarmouth and Waveney CCG (GY&W CCG) are conducting a strategic review and now consider the Minsmere proposal in relation to Beccles Hospital inappropriate and are looking to review this. GY&W CCG, the responsible organisation, shared the options appraisal with the Committee at the last meeting. This is a considerable change in direction and discussions need to be held with other Committee members. Graham Creelman noted that the change in thinking to a community based product by GY&W CCG may offer opportunity for mental health.

Charitable Funds have now merged and will be continuing under the SMHP registration as this is the larger fund. Norfolk & Waveney registration will be dissolved.

73% of the charitable funds is associated with Beccles Hospital with the remainder for consideration for NSFT. Requests for charitable funds are continuing on a similar basis to that of last year.

13.98 Standing Item: Items to be reported to the Board of Governors

- Volunteer service accreditation
- Safeguarding strategy
- Staff wellbeing strategy update
- Trust response to the Francis Reports
- Update on access to services for people with a learning disability
- Charitable Funds Committee
- Trust Service Strategy

13.99 Any other urgent business, previously notified to the Chair

i. Reporting of Trust Service Strategy (TSS)

Gary Page advised there were two main areas to highlight
1. Monitoring the implementation of TSS

2. Business as usual covering three areas;

- Quality of Care
- Safety of Service
- Operating within the financial envelope

Kathy Chapman advised that the executive team had reviewed the following five areas

- The high level position
- Quality Dashboard
- Performance monitoring
- Risk management
- Post implementation reviews

a) High level position – Ian O’Connor will provide an outline position at the end of quarter 2, month 7 and continue to report quarterly to the Board and monthly to the Finance & Performance Committee. This will include forward planning based on the current position and mitigations on that basis. In response to Stuart Smith, Ian O’Connor confirmed that change control requests and transitional funding would be included.

b) The quality dashboard is in development and will provide early warning of issues. This will be presented at the Service Governance Sub Committee and the Joint Quality Commissioning Group. It will also form part of Roz Brooks’ report to the Board. Roz Brooks advised that this will be fully populated by November 2013. The Board discussed whether this would cover sufficiently issues that the Board needs to be aware of. Kathy Chapman advised that the quality dashboard would highlight issues in near real time as possible and would include information relating to TSS implementation including any impact on the old service due to TSS implementation.

c) Performance management – new style reports will appear in January 2014. Informatics are restructuring the way items are reported on so that they are able to report back on the new structure. Drafts will be available at the Finance & Performance Committee (F&PC) before January 2014. The KPIs will be confirmed prior to the reporting. Brian Parrott requested that all NEDs receive the drafts taken to F & PC. Roz Brooks advised that TSS will also be a standing item on Service Governance.

d) Risk Register - the programme risk is reviewed monthly by the Directors of Operations. The programme risk becomes a trust risk once the service line is implemented. The Board discussed how the risks are captured and whether this was the correct method to ensure high level risks are captured
appropriately. The Trust risk register currently records the overarching risk of TSS not being delivered. Underneath that all high scoring risks are reported to the Audit & Risk Committee (A&RC) and passed to Board as appropriate. Gary Page outlined the issues associated with the current reporting. The risks should be reported with the Trust risks to ensure that it is not the project teams view of the risk and should be seen at A & RC who will review the mitigations to ensure that they are sufficient. In response to Gary Page, Kathy Chapman advised that she was meeting with Pat Southgate, Governor and Stuart Smith next week to discuss TSS risks.

e) Post implementation reviews will take place six months after implementation. These reviews will consider quality goals and outcomes, whether or not the expected benefits were achieved and were proposed savings achieved. Ian O’Connor advised that a review of the financial savings/costs would be earlier than six months after implementation but a six monthly report would go the Board. Kathy Chapman advised the first review would take place at the end of October 2013.

Guenever Pachent questioned whether there is sufficient communications reporting. Gary Page advised that the NEDs recognise this as an issue and he will set up a NED led committee to provide support. Graham Creelman confirmed he was currently drafting the Terms of Reference which he will share with Leigh Fleming.

**Action 13.99**
- F&PC to circulate TSS performance reports to all NEDs (Caroline Gregory)
- NED led committee to focus on communications be formed (Gary Page)
- Terms of Reference to be shared with Leigh Fleming (Graham Creelman)

**13.100 Date, time and location of the next meeting**

The next public meeting of the Board of Directors will be held on 24th October 2013 at 10:00 at The Function Suite, Wherry Hotel, Bridge Street, Oulton Broad, NR32 3LN.

Note – The Trust Board of Governors’ AGM will be held on 2nd October 2013 at the Park Hotel, Diss after the Board of Governors’ meeting (approx. 5.30pm)

**Meeting closed at: 13.05**

Chair: ........................................................

Date: ........................................................
# Actions from the previous Board of Directors’ meetings

## 29th August 2013 - Public

<table>
<thead>
<tr>
<th>Action 13.93</th>
<th>Follow up communications pack with Leigh Fleming (Gary Page)</th>
<th>Packs being printed - <strong>Completed</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Action 13.95i</td>
<td>Circulate amended complaints report (Roz Brooks) Confirm whether prescribing errors on Northgate Ward relate to 5 separate incidents (Roz Brooks)</td>
<td><strong>Completed</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>RB confirmed 5 individual unrelated errors – <strong>Completed</strong></td>
</tr>
<tr>
<td>Action 13.95ii</td>
<td>Confirm with Pene Kendrick-Ward whether feedback/analysis is received from departing volunteers and report back to Board (Roz Brooks)</td>
<td><strong>Completed</strong></td>
</tr>
<tr>
<td>Action 13.95iii</td>
<td>Email for consultation/comment with timeframe to respond by (Roz Brooks)</td>
<td>Circulated awaiting comments – November Board October Agenda</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strategy to Board meeting October 2013 (Roz Brooks)</td>
</tr>
<tr>
<td>Action 13.97iv</td>
<td>Consider how the Trust can check access to services is enhanced due to the actions taken by the Trust (Director of Nursing)</td>
<td><strong>Completed</strong></td>
</tr>
<tr>
<td></td>
<td>Updated LD strategy to be presented to Board at future date (Debbie White)</td>
<td>Board Discussion January 2014 Completed</td>
</tr>
<tr>
<td></td>
<td>Ravi Seenan is gathering the feedback from LD organisations about how accessible our MH services are for people who use LD services (Robert Nesbitt)</td>
<td></td>
</tr>
<tr>
<td>Action 13.99</td>
<td>F&amp;PC to circulate TSS performance reports to all NEDs (Caroline Gregory)</td>
<td>NEDs on F&amp;PC circulation list – <strong>Completed</strong></td>
</tr>
<tr>
<td></td>
<td>NED led committee to focus on communications be formed (Gary Page)</td>
<td><strong>Completed</strong></td>
</tr>
<tr>
<td></td>
<td>Terms of Reference to be shared with Leigh Fleming (Graham Creelman)</td>
<td><strong>Completed</strong></td>
</tr>
</tbody>
</table>
Unconfirmed

Minutes of the Annual General Meeting
held on Wednesday 2nd October 2013
in The Park Hotel, 29 Denmark Street, Diss, Norfolk, IP22 4LE

Present:
Dr Hadrian Ball: Medical Director
John Brierley: Non-Executive Director
Roz Brooks: Director of Nursing, Quality and Patient Safety
Barry Capon: Non-Executive Director
Graham Creelman: Non-Executive Director
Andrew Hopkins: Acting Chief Executive
Dr Peter Jefferys: Non-Executive Director
Jane Marshall-Robb: Director of Workforce and OD
Ian O’Connor: Interim Director of Finance
Gary Page: Chair
Brian Parrott: Non-Executive Director
Stuart Smith: Non-Executive Director
Adrian Stott: Non-Executive Director
Debbie White: Director of Operations – Suffolk

In attendance:
Kathleen Ben Rabha: Partner Governor – SAVO
Dr Duncan Double: Staff Governor
Paul Gaffney: Service User Governor – Suffolk
James Hogan: Service User Governor – Norfolk
Robert Nesbitt: Trust Secretary
Dr Karen O’Sullivan: Staff Governor
Guenever Pachent: Public Governor – Suffolk
Mary Rose Roe: Carer Governor – Norfolk
David Rollinson: Staff Governor
Lucy Want: Committee & Meeting Secretary (minutes)
Linda Weatherley: Staff Governor
Catherine Wells: Public Governor – Norfolk
Cllr Sue Whitaker: Partner Governor – Norfolk County Council
Christine Whitney-Cooper: Partner Governor, University Campus Suffolk

There were ten members of staff present.
There were six members of the public present.
Meeting commenced at: 17:09

Certain items were taken out of order, but for clarity the minutes reflect the agenda order

A13.01 Chair’s welcome, notification of any urgent business and apologies for absence
Gary Page welcomed those present and confirmed the meeting relates to 2012/13, noting there had been several changes in staff during the last few months. Thanks were extended to Aidan Thomas and Maggie Wheeler for their hard work while with the Trust.

Apologies for absence had been received and recorded in the Board of Directors’ file.

A13.02 To approve the minutes of the Norfolk & Suffolk NHS Foundation Trust Annual General Meeting held on 3rd October 2012
The minutes were approved subject to the following amendments:
Minute A12.01 – ‘event’ to be inserted after ‘stakeholder informal’
Minute A12.06 – ‘Andrew Hopkins started by..’ to be amended to ‘Andrew Hopkins stated..’

i. To approve the release of the minutes in accordance with the Freedom of Information Act
The minutes were approved for release in accordance with the Freedom of Information Act.

A13.03 To address any Matters Arising from the minutes of the previous meeting, not covered by the Agenda
There were no matters arising from the minutes of the previous meeting.

A13.04 To receive the 2012-13 Annual Report
Andrew Hopkins presented the 2012-13 Annual Report, highlighting the key points.

The Trust Service Strategy (TSS) dominated the year and was launched in October 2012 in consultation with staff. In the lead up to this several events were held with service users, carers and commissioners. Significant input was received from clinicians in developing new models of care. The changes are on-going and quality of service remains the highest priority, whilst balancing this against the funding available.

This was the first full year of the merger between Norfolk and Suffolk and changes in corporate staffing were seen with over 100 redundancies in the 2012/13 financial year. Further savings in corporate and support staff are planned for 2013/14.
The Trust is retaining emphasis on quality and a joint session with the Board of Governors was held to look at the Francis Report, which we will continue to build on.

Andrew Hopkins summarised by stating that it has been a turbulent year and whilst we are still in a time of change, the Trust is performing well with the opportunity to remain in a strong position.

A13.05 To receive the 2012-13 Annual Accounts

Ian O’Connor presented the 2012-13 Annual Accounts.

It was highlighted that demand is growing while income is reducing. This is expected to continue and by 2016 the funds available will have reduced by 20%. The Trust needs to bear this in mind as we will still need to deliver continued efficiency and productivity.

90% of the income received is from our Commissioners and therefore maintaining a good relationship with them is critical.

The outlook for 2013/14 is positive with a £1.9m surplus planned as per the original budget. Ian O’Connor advised that a surplus is planned for in line with Monitor requirements and in order to invest in buildings and IT equipment.

Cost improvements are not expected to impact on the services provided and quality assessments are regularly undertaken to ensure this is the case.

The Trust is conscious of how it can help the wider health economy as other organisations are facing financial challenges.

A13.06 Questions from the floor to the Directors

There were a number of questions from the floor:

- As the implementation of the youth service developed what engagement has taken place with young people and young service users? Andrew Hopkins advised this has been achieved through the Norfolk Youth Council which has been established for over 1 year. The Suffolk Youth Council is in development. Debbie White advised events have been held in Norfolk and Suffolk.

- What is included in the exceptional costs of the merger? Ian O’Connor advised that broadly this includes project management costs, redundancies, merging IT systems and legal costs. A specific question was asked about the redundancy costs. Gary Page advised a breakdown of costs will be produced for the next Board of Governors meeting.

Action 13.06

Breakdown of exceptional merger costs to be produced and taken to the next Board of Governors meeting in January 2014 (Ian O’Connor / Gary Page)

- How much does the Trust owe? Ian O’Connor advised the numbers are included in the Annual Report and the total owed as at 31st March 2013 was £15.3m.
A13.07 Motion to approve the Annual Report and Accounts 2012-13
David Rollinson proposed the motion.
Dr Karen O’Sullivan seconded the motion.
This was approved with no dissenters.

A13.08 Report on amendments to the Constitution
Robert Nesbitt updated the meeting on the amendments made to the Constitution. The changes have been discussed at length by both the Board of Directors and Board of Governors.

A13.09 Motion to approve the Constitution amendments by members
Roz Brooks proposed the motion.
Linda Weatherly seconded the motion.
The motion was approved with no dissenters.

A13.10 Questions from the floor to governors
There were no questions to the governors.

Meeting closed at: 18:07

Chair: ..................................................

Date: ..................................................
**Trust objectives:**

- To ensure the Trust retains and develops its focus on service quality; fully responding to the Francis report as agreed with the Board, responding to the views of service users and carers, engaging effectively with them, and implementing the safety and quality plan included agreed as part of the Service Strategy.

- To implement the 2013/4 programme of the agreed Trust Service Strategy, ensuring Trust Services are maintained to a high standard throughout the change and that Service users and carers are engaged throughout. Ensuring we adopt a strong “Recovery” culture across the organisation.

- To improve engagement with staff across the Trust so that staff report greater involvement and engagement, and the Trust improves its staff survey results (especially comparatively), sickness levels continue to reduce throughout the year, appraisal rates continue to improve and Net promoter score improves.

- To ensure the Trust delivers its agreed financial plan to assure the safety and stability of services.

- To develop stronger relationships with CCGs and commissioners, and partner organisations.

- To review and establish a long term commercial strategy to enable the Trust to continue to develop and grow in an increasingly commercial environment.

**Governance check list: ✓ any that apply and ensure these are addressed in main report**

<table>
<thead>
<tr>
<th>Finance / workforce effects</th>
<th>Equality impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality (patient safety, patient experience, clinical effectiveness)</td>
<td>Consultation</td>
</tr>
</tbody>
</table>

---

Board of Directors (Public) 24 Oct 2013
Chair’s Report
Page 1 of 4
1.0 Summary of Report

1.1 Please find attached summarising my most significant activities and observations over the last month.

2.1 Interaction with External Organisations

I spoke at an event in Suffolk to launch Age UK's Opening Doors Report, a project that was commissioned by Age UK Suffolk to find out the needs of Lesbian, Gay, Bisexual and Transgender (LGB&T) older people who use services that cater for their needs within Suffolk. This was also the opportunity to launch our own LGB guidelines for staff in Suffolk. The event was well attended including the presence of a number of NEDs and Governors. The Opening Doors report reinforced the need for us to continue to strive to make our services accessible to the older LGBT community.

I had held a number of discussions with potential candidates for the CEO role and the Interview Panel met with our recruitment advisers. Of the 20 people who submitted an application, 12 have been long listed. This represents a good spread of candidates across both NHS, Public and Private sectors. Odgers will now meet with these candidates individually and a further meeting is scheduled for 8th November 2013 to agree a shortlist of candidates who will attend the stakeholder day and the Interview panel on 18th / 19th November 2013.

I met with Dr John Hague who is the lead GP for Mental Health in Ipswich and East Suffolk. John was very enthusiastic about the new model and was complimentary about the Access and Assessment service based on his experience. He welcomed the fact that in recent meetings it was the Trust’s clinicians who were pushing the boundaries and giving the CCG’s something to think about. We are always very quick as a Trust to focus on the things that aren’t working so well, the discussion with John reinforced how many good things there are going on and how innovative we are being as a Trust. He had met Gerry Toplis, who is working with us on the design of our LD service and was very positive both of his reputation in this field and his ideas for Suffolk. I was advised that we need to improve both the level and quality of financial information that we provide. Also that our first attempt at costing for services is invariably way off the mark. We were encouraged to use the SWS tender as a template because it was seen as a great example of how to bid. On the service itself the familiar story about needing more people in the service, more marketing and encouraging ways of working other than face to face were heard.

I met with Carole Taylor Brown (Chair) and Anna Hughes (Chief Exec) of Suffolk MIND. They were complimentary of the working relationship which now exists between the two organisations and very keen to find new opportunities to work together. They were very keen to accelerate the Partnership Agreement with the Trust.

I attended the Trustees Meeting of the Suffolk User Forum. I updated the Trustees on the much improved position within the Access and Assessment Service in Suffolk, where they remained a perception that the backlog was in the order of 1,000 cases. SUF are evaluating new premises around Ipswich in preparation for moving off of St Clements before year end. They are also
consulting on a name change in response to an increasing number of people not liking the term Services Users.

I met with Christine Whitney-Cooper – the new Partner Governor from UCS Suffolk. Chris is new in post and keen to explore a closer working relationship with the Trust. UCS is aiming to achieve University status in the near future giving it independence from UEA / University of Essex and the ability to issue its own degrees. MH nursing courses continue to be more difficult to recruit to than adult or children’s courses, a theme echoed in my meeting with UEA.

I met with Rosie Doy, our Partner Governor from UEA and also Professor Ian Harvey. Exciting opportunities exist to build on the already good relationship around research and training. Progress is being made on the to be jointly funded professorial post and the recruitment process will being in the new year. I think there is work to be done to ensure our Dementia Academy is properly connected within the Trust and within the Academic Health Sciences Network.

2.2 Services and Staff Visits / Events

I have now completed the Interim Appraisals for all of the NEDs and the Interim Chief Executive. Short notes of issues discussed have been sent to each NED and a summary will go to the Nominations Committee meeting. Following the appointment of Adrian Stott as a NED I have discussed the rearrangement of NED responsibilities and details will be circulated in due course.

I visited the Access and Assessment Team in Ipswich. The professionalism and hard work of the staff was obvious and the day I visited the backlog was well below 300. There seems to be real issues around the availability of clinical space, with clinics having to be rearranged or even cancelled with obvious consequences for Service Users. I have raised this and it's clearly something management are aware of and plans are being developed to address this. I was also disturbed at the number of locum doctors, especially in the East. I raised this at the OD and Workforce meeting and am looking for further assurance at the Board that there is the necessary urgency around making substantive appointments.

I met with Pete Devlin who manages the Section 75 teams in Suffolk. The system in Suffolk appears to be working well. Pete is employed by SCC but has a dual reporting line into both the Council and the Trust.

I met with Karen Rix, Contracts Manager, to discuss the Annual Plan Reference Forum which gives Service Users, Carers and Governors a chance to influence our Annual Plan. Because Monitor have brought forward the submission date of the Plan to the end of March 2014 there will only be two meetings of the Forum in January and March 2014. We are approaching the appropriate groups for nominations as to who should join.

I presented at the Finance department away day. There was a strong message that they wanted decisive leadership from the Board, clearer and consistent communication and for Finance to be involved from the start in the development of new plans and tenders.
I met with Ross Brown and Norman Greenwald from HR. Service User interview training continues to be made available although take up is not as good as we would like. Good to see some really progressive thinking around the appraisal and talent management process.

2.3 Service User and Carer Interaction

I chaired the bi-monthly meeting of the Service User and Carer Trust Partnership. There continues to be confusion over the SU and Carers expenses policy and we agreed to reconvene the task and finish group to make any recommendations for changes in January 2014, and to clarify areas of uncertainty in the meantime. There was also concern over the roll out of the digital pens which are designed to obtain SU feedback and I have raised this with Leigh Fleming.

I facilitated the latest in the series of TSS Consultation Events in Suffolk on Complexity in Later Life. The event was sparsely attended but the quality of discussion was good. We do need a review of how we can increase the span of consultation in the future given our genuine willingness to engage and the time and money put into such events.

I visited the Compass School in Lowestoft with Andy Goff. It was an amazing experience seeing the great work our staff are doing in an educational setting with some really vulnerable children. Integration with Social Care in Action.

3.0 Recommendations

The Board is asked to note the Report.

Gary Page
Chair
16th October 2013
Report To: Board of Directors – Public

Meeting Date: 24th October 2013

Title of Report: Care Quality Commission Survey of people who use community mental health services 2013

Action Sought: For Information.

Estimated time: 20 minutes

### Purpose of the Report
For Debate

### Implications:

<table>
<thead>
<tr>
<th>NHS Constitution principles</th>
<th>1: The NHS provides a comprehensive service, available to all</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2: Access to NHS services is based on clinical need, not on an individual’s ability to pay</td>
</tr>
<tr>
<td></td>
<td>3: The NHS aspires to the highest standards of excellence and professionalism</td>
</tr>
<tr>
<td></td>
<td>4: NHS services must reflect the needs and preferences of patients, their families and their carers</td>
</tr>
<tr>
<td></td>
<td>7: The NHS is accountable to the public, communities and patients that it serves</td>
</tr>
</tbody>
</table>

Author: Sue Barrett – Head of Governance

Director: Roz Brooks – Director of Governance and Nursing

### 1.0 Summary of Report

This paper provides a high-level assessment of the Care Quality Commission’s (CQC) Survey of people who use community mental health services 2013.


The detailed report helps to identify areas of good practice and areas for development to inform an action plan which will be agreed with Service Users. The agreed actions will be monitored at the Service User and Carer Trust Partnership meeting and reported on a quarterly basis to the Service Governance sub-Committee.
2.0 Background

2.1 This survey is part of a wider programme of NHS patient surveys. The 2013 Survey of people who use community mental health services, involved 58 NHS mental health trusts in England.

“The results are primarily intended for use by NHS trusts to help them improve their performance. NHS England will use the results to understand service users’ experiences of NHS services and to drive improvements to them” Care Quality Commission 2013.

Data from the survey is included in the Quality and Risk Profiles for providers which contribute to the CQC assessment of compliance with essential standards of quality and safety.

2.2 The survey is a retrospective view of service user experience. Of note, previous survey data generated within 2011/2012 related to the periods before the merger and because of this, two surveys were carried out, one for Suffolk and the other for Norfolk & Waveney. The 2013 survey was carried out across the merged Trust which inhibits data comparisons.

An “approved provider”, Quality Health, was commissioned by Norfolk and Suffolk NHS Foundation Trust (NSFT) to carry out the data collection for the annual CQC Service User survey. A list of 850 Service Users was drawn from each Trust’s data base, these were anonymised and questionnaires sent to a random selection.

Inclusion criteria;

Service Users aged 18 years and over

People who received care or treatment for a mental health condition, including services provided under the Care Programme Approach (CPA)

Service users between 1st July - 30th September 2012

Exclusions:

People who were only seen once for an assessment, current inpatients, and anyone primarily receiving treatment in specific areas such as drug and alcohol abuse, learning disability services and specialist forensic services.

Questionnaires were sent out in February 2013 – data collection closed at the end of June 2013.

A good response rate was achieved of 30% (231) for NSFT. The national response rate ranged from 20% to 30% with the average being 29%.

The questionnaire contained 55 questions under 12 headings.
3.0 Findings

3.1 National survey summary

“People generally responded positively to questions asking about staff: this includes the health or social care worker that they had seen most recently and their care coordinator (or lead professional). However, scope for improvement remains in most other areas including information and involvement in: decisions about medication, care planning, care reviews, crisis care and support with day to day living”. CQC 2013

3.2 NSFT Data summary

Population data

<table>
<thead>
<tr>
<th></th>
<th>NSFT</th>
<th>All trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>43%</td>
<td>43%</td>
</tr>
<tr>
<td>Female</td>
<td>57%</td>
<td>57%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>96%</td>
<td>87%</td>
</tr>
<tr>
<td>Multiple ethnic group</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>Arab or other ethnic group</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Not known</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-35</td>
<td>15%</td>
<td>14%</td>
</tr>
<tr>
<td>36-50</td>
<td>21%</td>
<td>26%</td>
</tr>
<tr>
<td>51-65</td>
<td>25%</td>
<td>26%</td>
</tr>
<tr>
<td>66+</td>
<td>39%</td>
<td>35%</td>
</tr>
</tbody>
</table>

3.3 What we did well

Where NSFT score result is ‘better’ compared with most other trusts in the survey:

Q10. Were you given information about the medication in a way that was easy to understand?

Q14. Do you think your views were taken into account in deciding which medication to take?

Where NSFT score results are within the higher percentiles of ‘about the same’-‘better’ range compared with most other trusts in the survey:

Q13. Were you told about possible side effects of the medication?

Q25. Have NHS mental health services helped you start achieving these goals? (related to care planning)
3.4 What we need to work on

Noting NSFT score results are within ‘about the same’ range compared with most other trusts in the survey with exceptions as stated above, but the following questions generated the lowest scores (<5.0) for NSFT:

Q34. Do you have the number of someone from your local NHS mental health service that you can phone out of office hours?

Q41. In the last 12 months, have you received support in getting help with your care responsibilities?

Q42. In the last 12 months, have you received support in getting help with finding or keeping work?

Q43. In the last 12 months, have you received support in getting help with finding and/or keeping your accommodation?

Q44. In the last 12 months, have you received support from anyone in NHS mental health services in getting help with financial advice or benefits?

4.0 Action plan

The availability of an out of hours contact number is currently a quality priority for the Trust Quality Account and quarterly updates are provided on progress to the Board of Directors.

The remaining four areas will be addressed in an action plan linked to the IMROC project and the Trust service user and carer locality forums.

The final action plan will be monitored by the Service User and Carer Trust Partnership meeting and quarterly progress reports presented to the service governance sub committee by the service user and carer experience lead.

Sue Barrett
Head of Governance
1.0 Summary of Report

This report contains background information, recommendations and an action plan in response to an audit conducted into the RCA process by NED Dr Peter Jefferys.
The Trust Board is asked to approve the action plan, attached as appendix 1.

2.0 Background

2.1 Trust Board held on Thursday 26th September 2013 received a report on an audit conducted by Non-Executive Director Dr Peter Jefferys into the Trust's Root Cause Analysis process.

2.2 It was agreed that, in response to the audit, an action plan would be developed to respond to the recommendations made within the audit, based on the 6 audit standards and recommendations within the report.

2.3 This Report is therefore not a response to the clinical practice or organisational issues of concern that were identified within the audit, but contains an action plan in response to the audit based on the recommendations and findings within the audit for information and agreement by Trust Board (Appendix 1).

2.4 The audit overview report and this action plan will be made available to staff, published internally on the intranet; made available to the public externally on the Trust's website; shared with commissioners and HM Coroner.

3.0 Recommendations and further action

3.1 That, following brief discussion, the Trust Board approves and agrees with the action plan contained within this report (Appendix 1).

3.2 That progress against the action plan is reported back to the Board in April 2014.

3.3 It is worth reflecting on the limitations of the RCA process. A nationally prescribed process, first promoted by the then National Patient Safety Agency (NPSA), the RCA process borrowed from the airline industry, providing a structure to review the events that led to an untoward/serious incident. By looking back at the timeline it becomes possible to identify root causes, care and service delivery problems and contributory factors. Having identified these, it is the function of the RCA to create a recommendation/solution to reduce its likelihood of recurrence.

3.4 The key limitation of looking back upon an event is that the recommendations/learning is seen to solve/reduce that particular set of circumstances that had led to that particular incident, rather than a wider set of scenarios. As part of a regional managed clinical network the Trust, via the Patient Safety Team, is engaged in a project that seeks to identify potential risks before they occur. Applying engineering theory (Proactive Hazard Analysis), the basic premise is to plot a timeline/process and then to ask the simple question “what can go wrong?” Through the creation of a list of all the potential “what can go wrong?”, it becomes possible to systematically assess the risk, identify current controls and then analyse
what actions are required to eliminate or reduce the risk to an acceptable level.

3.5 Applying this process allows for a far wider range of scenarios to be considered compared to the RCA structure of looking back at a single set of circumstances.

3.6 The current project involves the Waveney Locality Crisis Resolution and Home Treatment (CRHT) Team. Looking at the process of a service user's experience from referral to discharge, the project is tasked to identify the elements of higher potential risk (for example, the manning of the CRHT phone 24 hours; process of information gathering at point of referral) and then identify solutions. This project is running currently and due to conclude in spring 2014.

3.7 Whilst not advocating the replacement of Root Cause Analysis investigations (it provides a robust structure to a critical process of learning and the Trust is obliged to complete them), it is suggested that the Trust Board supports the development of this project and further supports feedback upon its conclusion, with the view to applying it more widely across the Trust.

4.0 Conclusion

The challenge, if any organisation is to learn from adverse incidents and make future care safer, is to identify weaknesses in systems used and to devise appropriate management responses. The attached action plan focuses on improving the way in which Serious Incidents involving the death of a service user are analysed and, in particular, the way in which lessons are learned following individual incidents and shared across the Trust. Setting a higher standard for the RCA process and addressing the limitations identified in the audit should help achieve it.

Michele Allott
Deputy Director of Nursing and Patient Safety
24th October 2013

Background Papers / Information

Appendix 1 attached.
<table>
<thead>
<tr>
<th>Audit Standard</th>
<th>Recommendation</th>
<th>Action Required</th>
<th>Responsible lead &amp; completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCA Process</td>
<td>Audit results made available to those whose work has been audited.</td>
<td>The overview and case specific audit will been shared with the facilitators and investigators.</td>
<td>Michael Lozano Patient Safety and Complaints Lead November 2013</td>
</tr>
<tr>
<td></td>
<td>Training programmes for RCA investigations should be reviewed.</td>
<td>RCA training is provided by University Campus Suffolk (UCS), with a member of the Patient Safety Team attending for a period of the day. Feedback has indicated the helpfulness of learning the local actions applicable to the Trust in tandem with the theoretical elements. It is proposed to further support this learning by the Patient Safety Team practitioner co-facilitating for the whole day. Those identified as responsible for reviewing training will also meet with provider of training to review course content materials used within the course. A process will also be developed to ensure a buddy system and shadowing opportunities are put in place to support</td>
<td>Michele Allott Deputy Director of Nursing and Michael Lozano Patient Safety and Complaints Lead March 2014</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Audit Standard</th>
<th>Recommendation</th>
<th>Action Required</th>
<th>Responsible lead &amp; completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection criteria for RCA investigators for Serious Incidents related to unexpected deaths to be reviewed.</td>
<td>theoretical learning. &lt;br&gt;A RCA facilitator newsletter or briefing paper to be developed to provide regular updates and information to facilitators including best practice and any change to RCA process requirements. &lt;br&gt;Consideration to be given to the development of update sessions and workshop days for facilitators as part of their development and supervision in relation to RCA facilitation. &lt;br&gt;In line with national guidance unexpected deaths in the community are graded as level 1. The operational manager for the affected locality has a number of RCA trained staff from which to select a facilitator for the review. All facilitators are currently band 7 and above. To further strengthen the robustness of the review the Patient Safety Team will identify to the locality manager key individuals to attend the RCA review including the lead clinician or a senior operational manager. If the initial review of the case indicates the need for an alternative facilitator e.g. member of the safety team, Lead Clinician then they will appoint appropriate facilitator in collaboration with the Locality Manager.</td>
<td>Michele Allott Deputy Director of Nursing and Michael Lozano Patient Safety and Complaints Lead &lt;br&gt;December 2013</td>
<td></td>
</tr>
<tr>
<td>Audit Standard</td>
<td>Recommendation</td>
<td>Action Required</td>
<td>Responsible lead &amp; completion Date</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Care Service and Delivery Problems</td>
<td>Specific individual issues were picked up within the report related to specific RCA reviews including robustness of care plans, risk assessment, compliance with Trust Policy, response time and communication.</td>
<td>It is recommended that these key factors are picked up via the Trust’s current review of community deaths reported since April 2013, as part of a more detailed analysis and reported back to Board in December 2013 as part of that specific piece of work.</td>
<td>Dr Peter Jefferys and Michele Allott, Deputy Director of Nursing December Trust Board 2013</td>
</tr>
</tbody>
</table>
| Contributory Factors – Service User History       | Clearer emphasis should be placed on contributory factors arising from a service user’s history including:  
  - Nature of mental disorder and past self harm,  
  - The risk assessment document,  
  - Team’s acknowledgement and management of the risk, | RCA template to be amended to prompt facilitator to ask key questions around these specific themes focusing on:  
  - The risk assessment document,  
  - Team’s acknowledgement and management of the risk, | Michele Allott Deputy Director of Nursing and Michael Lozano Patient Safety and Complaints Lead |

For inpatient unexpected deaths (graded as level 2) a member of the Patient Safety Team will facilitate the RCA review.
| Factors increasing self harm risk,  
| Patient compliance and social support.  
| Social and support networks available.  
<p>| January 2014 |</p>
<table>
<thead>
<tr>
<th>Audit Standard</th>
<th>Recommendation</th>
<th>Action Required</th>
<th>Responsible lead &amp; completion Date</th>
</tr>
</thead>
</table>
| Lessons Learnt Recommendations and Action Plan | For lessons learnt and recommendations identified within the RCA process to be embedded into practice leading to service and safety improvements across the Trust. | The Patient Safety Team has recently created a Clinical Safety Practitioner post within the team to ensure lessons learnt are embedded. The post will continue to deliver lessons learnt to a number of Trust-wide forums including:  
  - Acute Services Forum  
  - Nursing Leadership Forum  
  - Service Governance Sub Committee (SGSC)  
  - Directly into clinical teams as required  
  Based on the findings of the RCA audit and safety themes identified by the Patient Safety Team, patient safety projects will be identified and approved at SGSC. RCA recommendations and lessons learnt will be themed by Patient Safety Team to facilitate this.  
  A Patient Safety newsletter to be developed to share Trust-wide with key learning and lessons identified which will be available on the Trust intranet for all staff to access. | Michele Allott Deputy Director of Nursing and Michael Lozano Patient Safety and Complaints Lead March 2014 |
<table>
<thead>
<tr>
<th>Audit Standard</th>
<th>Recommendation</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>As a result of retirement within the Patient Safety Team, a new post will be developed to ensure a more robust process in the implementation of recommendations, and lessons learnt are embedded into practice and have led to consistent improvements in services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The post will involve active follow up following closure of actions/recommendations in clinical teams to ensure they are maintained and established.</td>
</tr>
</tbody>
</table>
Provider Action Statement

Please use this template to tell CQC about the improvements you will make in response to your visit feedback report, including how and when the improvements will be made.

You should involve service users to determine the actions to be taken and to monitor their completion, wherever appropriate.

If you wish, you can use the 'comments' box to make any comments in response to our findings. If you need to add more actions, please copy and paste as many tables as you need for each action and make sure that you number each one.

Your Action Statement should be signed by the registered person and returned to CQC by the date that we stated on page 1 of our visit report.

Please list your actions on the following pages for each of the areas where we have specified that improvement is needed.
**Action 1**

<table>
<thead>
<tr>
<th>Page in report:</th>
<th>Domain and issue:</th>
<th>MHA Section &amp; CoP Ref:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 4</td>
<td>Domain 2 - Consent to Treatment: How the trust will ensure that all clinicians are supported to develop and adhere to best practice in relation to consent and treatment of medication for mental disorder, as set out in Chapters 23 and 24 of the Code of Practice.</td>
<td>MHA Section: 58, CoP Ref: 23 and 24.</td>
</tr>
</tbody>
</table>

**Action you will take:**

Sandringham ward is moving to 2 Consultants, there will be MDT meetings every Monday, Wednesday and Friday where patient’s will be discussed and documentation checked. Medication cards and consent to treatment documentation will also be audited on a monthly basis to ensure compliance.

**How you will know it is achieved:**

Audit reports.

<table>
<thead>
<tr>
<th>Date when action will be completed: (dd/mm/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>14/10/13</td>
</tr>
</tbody>
</table>

**Comments:**

Name of responsible manager: Jackie Johnson

**Action 2**

<table>
<thead>
<tr>
<th>Page in report:</th>
<th>Domain and issue:</th>
<th>MHA Section &amp; CoP Ref:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 5</td>
<td>Domain 2-Leave of Absence. How staff will be supported to develop and maintain best practice in relation to Section 17 leave.</td>
<td>MHA Section 17, CoP Ref: 21</td>
</tr>
</tbody>
</table>

**Action you will take:**

The nursing teams are going to be realigned to allow for better skill mix, they will go from 3 nursing teams to 2. There will also be a standing agenda item in the weekly staff meeting and also at line management supervision. A clear email will also be sent to all registered nurses outlining the processes expected. Risk assessment training will also be organised for all registered staff who are not up to date.
<table>
<thead>
<tr>
<th>How you will know it is achieved:</th>
<th>Date when action will be completed: (dd/mm/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff meeting and line management records, follow up audit of Section 17 patients, training records.</td>
<td>18/11/13</td>
</tr>
<tr>
<td>Comments:</td>
<td>Name of responsible manager:</td>
</tr>
<tr>
<td></td>
<td>Jackie Johnson</td>
</tr>
</tbody>
</table>

**Action 3**

<table>
<thead>
<tr>
<th>Page in report:</th>
<th>Domain and issue:</th>
<th>MHA Section &amp; CoP Ref:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 5</td>
<td>Domain 2 – Admission to the ward. How the Trust will plan to support ward staff in understanding the requirements and processes relating to CTO’s</td>
<td>MHA Section 17 A-G, CoP Ref: 25</td>
</tr>
</tbody>
</table>

**Action you will take:**

An experienced AMHP has been booked to do teaching sessions on CTO’s for all registered staff. All registered staff will also be booked on to the Trust’s MHA awareness training.

<table>
<thead>
<tr>
<th>How you will know it is achieved:</th>
<th>Date when action will be completed: (dd/mm/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance list for all staff attending the teaching sessions and the training. Understanding will also be checked via line management supervision.</td>
<td>18/11/13</td>
</tr>
<tr>
<td>Comments:</td>
<td>Name of responsible manager:</td>
</tr>
<tr>
<td></td>
<td>Jackie Johnson</td>
</tr>
</tbody>
</table>

**Action 4**

<table>
<thead>
<tr>
<th>Page in report:</th>
<th>Domain and issue:</th>
<th>MHA Section &amp; CoP Ref:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 6</td>
<td>Domain 2 - Purpose, Respect, Participation, Least Restriction. The Trust is asked how it</td>
<td>CoP Ref: 1.6</td>
</tr>
</tbody>
</table>
will ensure that staff have access to all the relevant information about any proposed changes in a way which minimises potential disruption to all staff

<table>
<thead>
<tr>
<th>Action you will take:</th>
<th>Date when action will be completed: (dd/mm/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deputy Service Manager to attend staff meeting on a monthly basis to ensure information is shared with staff. Clinical Team Leader to attend the team meeting weekly to ensure prompt information sharing. Staff to be encouraged to access their emails as relevant information can be distributed to the whole team in a timely manner.</td>
<td>14/10/13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How you will know it is achieved:</th>
<th>Name of responsible manager:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minutes of staff meeting, line management supervision records</td>
<td>Terri Cooper-Barnes &amp; Jackie Johnson</td>
</tr>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
</tr>
<tr>
<td>Role:</td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td>(dd/mm/yyyy)</td>
</tr>
</tbody>
</table>
1.0 Summary of Report

1.1 This is an exception report to the Board of Directors October meeting.
2.0 Serious incidents

2.1 The Serious Incident policy has been implemented for the following three cases.

2.2 Police are investigating the circumstances surrounding the death of a 49 year old man who had been receiving treatment at the PICU (Rollesby ward) at Hellesdon Hospital.

On Tuesday 1 October, the man had a medical emergency and there has been an allegation around the care he received before being taken to the Norfolk and Norwich University Hospital where he sadly died on the evening of Friday 4 October.

The death is being treated as unexplained and an investigation, led by the joint Norfolk and Suffolk Major Investigation Team, is currently underway. The Trust are working closely with the Police to facilitate this.

The case has attracted significant media attention following a member of staff alerting the EDP. The family do not want any media attention but remain in close contact with Trust staff.

2.3 On 22/09/2013 at the CAMHS inpatient unit, a 14 year old female under Section 3 of MHA started to self-harm in her bedroom. Staff attempted de-escalation techniques without success. Because the patient had been hiding medication on her person the staff undertook a search of the patient which was undertaken outside of Trust policy. This has been reported as a safeguarding incident and reported to the appropriate authorities.

2.4 On 25/09/2013 an informal patient on Glaven ward was found in a bathroom at approximately 14.55 having ligatured from the window (patient had slid a belt around the bracket that joins the fixed frame to the moving part of the window (that opens out)). The CPR process was commenced by staff and emergency services called. The patient was transferred to Intensive Care Unit at the NNUH but sadly died on 7/10/2013.

3.0 CQC inspections and Mental Health Act visits

3.1 The CQC MHA team visited Sandringham ward at the Julian Hospital on 05.09/2013. The report and action plan are enclosed for information as Appendix A.

4.0 Recommendations

4.1 The Board is asked to note the contents of this report.

Roz Brooks
Director of Nursing
16th October 2013
Background Papers / Information

Appendix A

20130905 Sandringham 29239
20130905 MHA provider actions...
**Mental Health Act 1983 monitoring visit**

<table>
<thead>
<tr>
<th><strong>Provider</strong></th>
<th>Norfolk and Suffolk NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nominated Individual</strong></td>
<td>Roz Brooks</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td>Central</td>
</tr>
<tr>
<td><strong>Location name</strong></td>
<td>Julian Hospital</td>
</tr>
<tr>
<td><strong>Location address</strong></td>
<td>Bowthorpe Road, Norwich, NR2 3TD</td>
</tr>
<tr>
<td><strong>Ward(s) visited</strong></td>
<td>Sandringham</td>
</tr>
<tr>
<td><strong>Ward type(s)</strong></td>
<td>Old age psychiatry</td>
</tr>
<tr>
<td><strong>Type of visit</strong></td>
<td>Unannounced</td>
</tr>
<tr>
<td><strong>Visit date</strong></td>
<td>5 September 2013</td>
</tr>
<tr>
<td><strong>Visit reference</strong></td>
<td>29239</td>
</tr>
<tr>
<td><strong>Date of issue</strong></td>
<td>12 September 2013</td>
</tr>
<tr>
<td><strong>Date by which you must return your Provider Action Statement to CQC:</strong></td>
<td>2 October 2013</td>
</tr>
</tbody>
</table>

**What is a Mental Health Act monitoring visit?**

By law, the Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. We do this by looking across the whole patient pathway experience from admission to discharge – whether patients have their treatment in the community under a supervised treatment order or are detained in hospital.

Mental Health Act Commissioners do this on behalf of CQC, by interviewing detained patients or those who have their rights restricted under the Act and discussing their experience. They also talk to relatives, carers, staff, advocates and managers, and they review records and documents.
This report sets out the findings from a visit to monitor the use of the Mental Health Act at the location named above. It is not a public report, but you may use it as the basis for an action statement, to set out how you will make any improvements needed to ensure compliance with the Act and its Code of Practice. You should involve patients as appropriate in developing and monitoring the actions that you will take and, in particular, you should tell patients what you are doing to address any findings that we have raised in light of their experience of being detained.

This report – and how you act on any areas we have identified for improvement – will feed directly into our public reporting on the use of the Act and our monitoring of your compliance with the Health and Social Care Act 2008. However, even though we do not publish this report, it would not be exempt under the Freedom of Information Act 2000 and may be made available on request.

Our monitoring framework

We looked at the following parts of our monitoring framework for the MHA.

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Domain 2</th>
<th>Domain 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment and application for detention</td>
<td>Detention in hospital</td>
<td>Supervised community treatment and discharge from detention</td>
</tr>
<tr>
<td>Purpose, respect, participation and least restriction</td>
<td>Purpose, respect, participation and least restriction</td>
<td>Purpose, respect, participation and least restriction</td>
</tr>
<tr>
<td>Patients admitted from the community (civil powers)</td>
<td>Admission to the ward</td>
<td>Discharge from hospital, CTO conditions and info about rights</td>
</tr>
<tr>
<td>Patients subject to criminal proceedings</td>
<td>Tribunals and hearings</td>
<td>Consent to treatment</td>
</tr>
<tr>
<td>Patients detained when already in hospital</td>
<td>Leave of absence</td>
<td>Review, recall to hospital and discharge</td>
</tr>
<tr>
<td>People detained using police powers</td>
<td>Transfers</td>
<td>Control and security</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consent to treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>General Healthcare</td>
</tr>
</tbody>
</table>
Findings and areas for your action statement

<table>
<thead>
<tr>
<th>Overall findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandringham is a ward for older people with a functional mental illness, and is located on the Julian Hospital site. On the day of this visit we were initially told that although the ward has 22 beds, two beds were closed pending a change to the ward's role and function. However, during the course of the day, two beds which had been closed were opened again, and 22 beds were in operation.</td>
</tr>
</tbody>
</table>

At the time of this visit there were five detained patients on the ward. We spoke with four detained patients and looked at three sets of legal and casefile papers. The detention papers we looked at appeared to be lawful. Clear and repeated efforts had been made to provide patients with information about their legal rights, and we saw leaflets promoting the local independent mental health advocacy (IMHA) service. Care plans were in place, and on two out of three files we looked at, these had been signed by patients.

Those patients who were able to express an opinion said that they felt safe on the ward. Patients said that they were spoken to respectfully, and felt that their views were listened to.

We were told that the ward tries to provide care that suits the individual and heard about examples of this, including self-medication care plans, and the one patient who asked for night time observations to be changed. This was risk assessed and implemented.

The ward environment looked clean and well decorated. There is a large pleasant garden with separate sitting areas for smokers and non smokers. The ward has three shared, two person bedrooms. We noted that a record from the patient community meeting on 24 July 2013 said that patients were asking for a greater choice of rooms because “sharing is difficult”, and on 7 May 2013 there was a request for “single rooms”.

All patients have a small safe in their rooms for keeping personal items. There is a telephone for patients’ use which is situated in a booth, providing privacy, and we were told that patients can use internet facilities at the nearby Hammerton Court.

On the day of this visit we saw a Tai-Chi exercise group taking place in the morning and a pianist playing in the lounge in the afternoon.
Section 120B of the Act allows CQC to require providers to produce a statement of the actions that they will take as a result of a monitoring visit. Your action statement should include the areas set out below, and reach us by the date specified on page 1 of this report.

<table>
<thead>
<tr>
<th>Domain 2</th>
<th>MHA section: 58</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent to treatment</td>
<td>CoP Ref: 23 and 24</td>
</tr>
</tbody>
</table>

**We found:**

We looked at patient 4 (D)’s medication card and noted that although she was being administered medication for mental disorder, and had been detained for more than three months, there was no T2 or T3 present.

When we asked ward staff about this we were told that the responsible clinician believed that because the patient had initially been placed on section with a view to providing ECT treatment, certification of consent was not required.

The Code of Practice paragraph 24.13 states:

“Section 58 applies only to detained patients. They cannot be given medication to which section 58 applies unless:

- the approved clinician in charge of the treatment, or a SOAD, certifies that the patient has the capacity to consent and has done so; or
- a SOAD certifies that the treatment is appropriate and either that:
  - the patient does not have the capacity to consent; or
  - the patient has the capacity to consent but has refused to do so.”

We saw that patient 2 (B)’s treatment was certificated with a number of successive T2s. T2s which had been superseded had not been removed or crossed through. We looked at the patient’s notes to find a record of the conversations relating to the completion of these certificates. We were only able to find records which stated “T2 signed” and “T2 posted to MHA office” and “T2 completed”.

The Code of Practice paragraph 23.34 states:

“The information which must be given should be related to the particular patient, the particular treatment and relevant clinical knowledge and practice. In every case, sufficient information must be given to the patient to ensure that they understand in broad terms the nature, likely effects and all significant possible adverse outcomes of that treatment, including the likelihood of its success and any alternatives to it. A record should be kept of information provided to patients.”

**Your action statement should address:**

How the trust will ensure that clinicians are supported to develop and adhere to best practice in relation to consent to treatment of medication for mental disorder, as set out in chapters 23 and 24 of the Code of Practice.
## Domain 2

<table>
<thead>
<tr>
<th>Leave of absence</th>
<th>MHA section: 17</th>
<th>CoP Ref: 21</th>
</tr>
</thead>
</table>

### We found:

We looked at section 17 leave authorisation and found that there was no record of patients, carers or others being provided with copies of leave authorisations, or reasons why this should not happen.

The Code of Practice paragraph 21.21 states:

“...Copies of the authorisation should be given to the patient and to any carers, professionals and other people in the community who need to know...”

We were unable to find any record of the assessment of risk relating to periods of leave.

### Your action statement should address:

How staff will be supported to develop and maintain best practice in relation to section 17 Leave.

## Domain 2

<table>
<thead>
<tr>
<th>Admission to the ward</th>
<th>MHA section: 17 A-G</th>
<th>CoP Ref: 25</th>
</tr>
</thead>
</table>

### We found:

We looked at the papers relating to the recall and revocation of a Community Treatment Order (CTO). On this file there were two copies of the form CTO4, each giving different times of completion.

We understand from ward staff that they have experienced some complex situations around the CTO recall and revocation process, and not all staff members feel that there is confidence and clarity about what is required.

### Your action statement should address:

How the trust will plan to support ward staff in understanding the requirements and processes relating to CTOs.
We found:

There seemed to be real confusion about the trust’s progress and timescale in moving to a change in function for the ward. We were told that Sandringham would be taking only “complexity in later life” patients, and that there would be a reduction in bed numbers to 10 beds.

On the day of this visit this was evident in the discussions which had to take place regarding room allocation for patients. At the beginning of the day when two beds were closed, two of the ward’s double rooms could have single occupancy. When beds were re-opened this meant that staff had to move patients whose presentation and behaviour might not be suitable for sharing a bedroom.

Your action statement should address:

The trust is asked how it will ensure that staff have access to all the relevant information about any proposed changes in a way which minimises potential disruption to patients and staff.
During our visit, patients raised specific issues regarding their care, treatment and human rights. These issues are noted below for your action, and you should address them in your action statement.

### Individual issues raised by patients that are not reported above:

<table>
<thead>
<tr>
<th>Patient reference</th>
<th>Issues: Purpose, Respect Participation, Least Restriction And Section 130A</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 (D)</td>
<td>We spoke to patient 4 (D) and her husband during our visit. Patient 4’s husband told us that he lived outside Kings Lynn, some 43 miles from Norwich. The hospital in Kings Lynn has closed and he now has to travel to visit his wife by taxi, bus then taxi, or alternatively by taxi all the way. He visits his wife daily and this costs either £25 or £90 per trip. Patient 4’s husband said that he was initially informed that he could recoup his travel expenses from the trust. He has been keeping receipts and has thus far been paid £50. His costs have reached approximately £3,000. At a meeting on the morning of the visit he was told that the trust does not have a policy which covers his travel costs, and he asked us for help in clarifying this for him. I spoke to the trust carers’ specialist, who confirmed that the trust does not yet have a policy which covers this situation. I asked the trust carers specialist to ensure that patient 4’s husband has something in writing within seven days to confirm what the situation is regarding the travel expenses he has already incurred, and additionally what the trust’s position will be regarding future expenses. The carers’ specialist worker agreed that this matter needs clarification. The trust is asked to confirm that this matter has been clarified and the patient’s husband informed in writing. Also, that information on any independent support or advocacy is provided, if this is required.</td>
</tr>
<tr>
<td>1(A)</td>
<td>When we spoke with patient 1 we asked him whether he had ever used an IMHA, but he did not appear to know what this meant. We later looked at his file and found that there was a record of a discussion about his rights which resulted in him asking for IMHA support. We were unable to locate further records about this IMHA referral going ahead, and the nurse on duty could not advise us. Please confirm that this referral was completed, or that there was a good reason for it not going ahead.</td>
</tr>
</tbody>
</table>
Information for the reader

<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Mental Health Act monitoring visit report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Audience</td>
<td>Providers</td>
</tr>
<tr>
<td>Copyright</td>
<td>Copyright © (2012) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.</td>
</tr>
</tbody>
</table>

Contact details for the Care Quality Commission

Website:  www.cqc.org.uk
Telephone:  03000 616161
Email:  enquiries@cqc.org.uk
Postal address:  CQC Mental Health Act
                Citygate
                Gallowgate
                Newcastle upon Tyne
                NE1 4PA
Report To: Board of Directors  
Date: 24th October 2013  
Title of Report: Service User and Carer Trust Partnership Terms of Reference  
Author: Gary Page: Chair

**Trust objectives:**

- ✓ all objectives that this report relates to:
  - To ensure the Trust retains and develops its focus on service quality; fully responding to the Francis report as agreed with the Board, responding to the views of service users and carers, engaging effectively with them, and implementing the safety and quality plan included agreed as part of the Service Strategy.
  - To implement the 2013/4 programme of the agreed Trust Service Strategy, ensuring Trust Services are maintained to a high standard throughout the change and that Service users and carers are engaged throughout. Ensuring we adopt a strong “Recovery” culture across the organisation.
  - To develop stronger relationships with CCGs and commissioners, and partner organisations.

**Governance check list:** ✓ any that apply and ensure these are addressed in main report

<table>
<thead>
<tr>
<th>Finance / workforce effects</th>
<th>Equality impact</th>
<th>Quality (patient safety, patient experience, clinical effectiveness)</th>
<th>Consultation</th>
</tr>
</thead>
</table>

1.0 The Service User and Carer Trust Partnership (formally Service User and Carer Overarching Group) comprises representatives of the SU and Carer Groups in the Trust as well as representatives from the Board of Governors, Trust Management and our Partner Organisations.

2.0 We have now established Locality Groups throughout Norfolk. Members of these Locality Groups now sit on the Service Users and Carers Council respectively. These Councils send representatives to the Trust Partnership. In Suffolk the East and West Scrutiny Groups, which are joint SU and Carer Groups, also send representatives. The Youth Council also has a member.

3.0 The expectation is that many issues can be resolved in the various locality forums but that any issues which are Trust wide or where resolution cannot be achieved locally can be raised in the Partnership meetings.

4.0 As the Chair of the Trust also Chairs this Group, this ensures that any significant issues can get Board level attention. This improves the quality of our consultation and ensures that any issues of concern around the patient experience can be raised at Board level.
5.0 The attached Terms of reference have been widely discussed and were approved at the last Trust Partnership meeting on 27th September. The Board is likewise asked to approve these ToR.

Gary Page
Chair
13th October 2013

Background Papers / Information

Copy of Terms of Reference
Norfolk and Suffolk Foundation Trust

Service User and Carer Trust Partnership

Terms of Reference

1.1 Terms of Reference

1. The Service User and Carer Trust Partnership will ensure the implementation, monitoring and evaluation of the Service User Involvement and Carers Strategies across the Norfolk and Suffolk NHS Foundation Trust.

2. The Service User and Carer Trust Partnership will create a forum for effective dissemination and implementation of national guidance and best practice in relation to service user and carer experience.

3. The Service User and Carer Trust Partnership will ensure that issues related to service change are compatible with Board objectives.

4. The Service User and Carer Trust Partnership will support and monitor the implementation of the Triangle of Care model across the Norfolk and Suffolk NHS Foundation Trust.

5. The Service User and Carer Trust Partnership will support and monitor the implementation of the IMROC (improving recovery through organisational change) model across the Norfolk and Suffolk NHS Foundation Trust.

6. The Service User and Carer Trust Partnership will act as a reporting base for all service user and carer involvement and engagement activities across the Norfolk and Suffolk NHS Foundation Trust.

7. The Service User and Carer Trust Partnership will adopt a facilitative, 2-way approach to information sharing; from the Board – to the Service User and Carer groups and from the Service User and Carer groups, up to the Board. The reporting structure would see local issues, being dealt with at a local level through Service User and Carer locality groups, will report in to the Service User Council and Carers Council in Norfolk and the Service User and Care Scrutiny Groups in Suffolk. The Service User and Carer Trust Partnership will deal with any items and issues that cannot be resolved locally.

8. The Service User and Carer Trust Partnership will not be the forum to discuss any personal issues. The group will focus on business issues only.

9. The Service User and Carer Trust Partnership will report directly in to the Board of Directors.

1.2 Membership

- Chair of NSFT
- Non-Executive Director NSFT
• Operational Director for Suffolk NSFT
• Director of Nursing and Patient Safety (Deputy Director of Nursing and Patient Safety) NSFT
• Lead Governor
• Service User Governor
• Carer Governor
• IMROC Project Manager NSFT
• Voluntary Services Manager/Patient Advice and Liaison Manager
• CPA and Risk Lead
• Chair – Service User Council (Norfolk)
• Chair – Carers Council (Norfolk)
• Chair – West Suffolk Service User and Carer Scrutiny Group
• Chair – East Suffolk Service User and Carer Scrutiny Group
• Co-ordinator – Suffolk User Forum
• Service User and Carer Experience Lead NSFT
• Chair – Service User Service Strategy Communication Group
• Representative – Suffolk Family Carers
• Overarching Chair of VASP
• Carers Lead NSFT
• Service User and Carer Involvement Co-ordinator (Norfolk) (as and when)
• Representative of Youth Council for Norfolk and Suffolk

An open invitation will be given to Service User and Carer Governors to attend the meetings.

Standard reporting items must be forwarded to the Chair 10 days prior to the meeting.

Members are expected to read papers prior to meetings.
1. Purpose and status

The FT code of governance recommends that the roles and responsibilities of the Board of Governors should be set out in a written document (A. 1.1 and B.1.4) and should establish an engagement policy with the Board of Directors (B.1.7). The purpose of this document is therefore to fulfil these functions by clarifying expectations for governors, non-executive directors, and for the wider Trust in order to promote effective and efficient accountability to the people we serve.

Although the governors’ duty to ‘hold to account’ is set out in law, it is not defined anywhere. Monitor acknowledges that there is no ‘right way’ to hold non-executive directors to account and it recommends that a jointly agreed process be developed.

The document sets out the structures, flows of information, relationships and behaviours that underpin good governance for governors and non-executive directors working together.
Once agreed by both boards it is intended to complement and put into practice the legal and governance framework.

2. Legal and governance framework

Foundation Trust governance is based on accountability of boards of directors to the local population through the board of governors. This is reflected in the powers of governors for the appointment and removal of NEDs and the Chair, the appointment of the external auditors, the approval of the appointment of the CEO and the approval of the forward plan.

The Health and Social Care Act (2012) strengthened the role of governors by placing a two-fold duty upon them;

S.151 (4)

“The general duties of the council of governors are—

(a) to hold the non-executive directors individually and collectively to account for the performance of the board of directors, and

(b) to represent the interests of the members of the corporation as a whole and the interests of the public.”

For its part the FT, under S.151 (5);

“…must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.”

In addition to the legal powers and duties, Monitor’s Code of Governance and the publication, “Your statutory duties: a reference guide for NHS foundation trust governors (Aug 2013)” provide further guidance on joint working arrangements.

The Foundation Trust Network offer this definition of accountability:

“To be accountable is:

• To be responsible for the delivery of a specific task or outcome,
• To be liable to explain and justify to another party,
• To be subject to judgement and possible sanction or reward.
• To hold to account is to receive the explanation or justification, to test it through questioning, to form a judgement and to feed back.”
3. Structures, functions and the flow of information

I. The relationship between the board of governors and its subgroups

The formal exercise of governors’ duties is carried out at the board of governors’ (BoG) general meetings as set out in the Constitution. The BoG meets four times a year and whilst this is sufficient to make appointments and receive reports, it is not frequent enough to fulfil an effective scrutiny role nor to capture the interests of the wider public.

The BoG therefore delegates some functions to subgroups which are empowered by their approved terms of reference to act on behalf of the full BoG. Final decisions in relation to the BoGs’ legal powers and duties can only be made at a general meeting.

Although the subgroups are an important way in which detailed work can take place, governors remain collectively responsible for the delegated functions. For example, every governor must individually engage with members and the wider public. This role cannot be left to the Membership Subgroup. Similarly, every governor must take individual responsibility for monitoring the performance of the board – this role cannot be left solely to the Planning and Performance Subgroup.

II. Performance monitoring functions

Consideration of performance information takes place at the Planning and Performance Subgroup and is in the context of assessing the performance of the board of directors (BoD).

The purpose of this scrutiny is not to duplicate the work of the BoD in challenging information, but to gain assurance on the performance of the board in doing so. The focus of questions from governors should therefore be “What have NEDs done to examine this issue and to ensure that the board addresses it?”, and not “How can this performance be improved by governors?”

In order for governors to be able to fulfil their role the Trust must supply subgroup members with information that is up-to-date, accurate, relevant and timely (i.e. received in sufficient time for governors to read and consider). At least two non-executive directors will normally attend each Planning and Performance Subgroup meeting with NED attendance varying over the course of the year; their purpose is to answer questions put by the subgroup, either at the meeting or in writing within a given timescale. As this subgroup primarily looks into the organisation it provides a good opportunity for governors to hold NEDs to account.

This does not mean that governors need to see all reports or to question every line of information that they receive. To do so would risk getting lost in the detail of Key Performance Indicator definitions and measurement problems instead of taking a wider view of board performance.
Governors will normally therefore question a small selection of measures or reports which reflect issues of concern. These concerns could include incongruence between the data and other sources of information or a theme emerging from complaints made by patients or the wider public.

III. Planning functions

In order for governors to contribute effectively to forward planning they need to have an understanding of members' and the public’s views, and have a clear mechanism through which to feed these views into the process.

Engaging with members and the wider public overlaps with the work of the Membership Subgroup (see 3.4).

The Board of Governors express a view on the Board of Directors’ forward plans. Governors should be involved throughout the planning cycle and should not be presented with plans as a ‘fait accompli’. Governors are invited to nominate representatives to be part of the Annual Plan Reference Forum run by the Trust that meets 3 or 4 times per year over the business cycle. These governors (normally drawn from the Planning and Performance Subgroup) inform and track the development of the plan before it is considered by the Planning and Performance Subgroup and the full BoG at its April meeting.

The BoG can influence the direction of the organisation through the selection of the Chair and NEDs, but responsibility for setting the Trust’s strategy sits solely with BoD.

In setting the strategy and the forward plan that flows from it, the BoD should be able to demonstrate how they have taken account of governor views, particularly in so far as they flow from S.151 (4)b whereby governors represent “the interests of the members of the corporation as a whole and the interests of the public.” This does not mean that the BoG and BoD will necessarily agree. The BoD have to take into account their formal obligations (such as to operate the Trust as a going concern) and a divergence of views may simply reflect the different responsibilities of governors and directors. It is for this reason that the BoG cannot veto the forward plan.

IV. Member and public engagement / Membership Subgroup

Elected governors are accountable to their members and should report to them on work undertaken. To some extent this function is fulfilled by the publication of the minutes of BoG meetings on the public website, but this is a narrow format and few members are likely to read these documents.
The main method of communicating with members is through the Trust's Insight Magazine which is sent out four times a year. Governors can communicate directly with their constituents by submitting material for articles in Insight. The communications team can assist by drafting text based on these materials.

Constituency feedback that is given to each BoG meeting will be reported in Insight; as well as summaries from the Planning & Performance and Membership sub groups.

The membership database also includes c. 3500 member email addresses although with only about 1 in 10 emails being read this is less effective as a means of communication.

The Trust employs a full-time membership and engagement officer to support this function and pays for stands at community events across both counties. This provides an opportunity for governors to listen to the views of local people, talk about the work of the Trust, and explain the governor role.

Coordination of membership recruitment, and member and public engagement takes place through the Membership Subgroup. This group also oversees preparation of election materials.

As this group primarily looks out from the organisation to the communities served, NED attendance is less relevant and not normally expected.

Members can contact their governors through a general email address governors@nsft.nhs.uk which is monitored by the Trust Secretariat. Member queries will be forwarded to the relevant governor, with advice and support on options for responding.

V. Governor attendance at BoD meetings in public

There are six BoD meetings in public a year. These are held in public at venues across the two counties.

For governors, these meetings provide an important opportunity to assess the performance of the BoD, and to consider how the NEDs fulfil their functions within it. The role of the governor at a BoD is therefore as an observer. Whilst the Chair may invite questions and comments from governors, the function of these is to assist governors in their role rather than for governors to act as an additional member of the BoD.

In order to fulfil their general duties to hold the NEDs to account for the performance of the BoD, governors should therefore aim to attend at least two BoD meetings a year.
The BoD conducts some confidential or commercially sensitive business in private. There is a requirement for FTs to share the agenda and minutes from these meetings with governors, but NSFT goes further and shares all private board papers with those governors who have signed a special confidentiality form. This form deals with the handling and disposal of the private papers as well as the protection of the information they contain. Governors can return papers to the Trust Secretariat for secure disposal.

VI. Governor attendance at other BoD committee meetings

Governors will normally give priority to attendance at BoD meetings (for the reasons set out in 3.5), but governors are also welcome to attend other committee meetings, in the role of observer, by prior arrangement with the Chair of the committee. BoD committee meetings are chaired by NEDs.

It is important to be clear as to the rationale for attending BoD committee meetings since the governors’ role can usually be assured by the committee reports that come to the BoD. Most committee agendas are very full and it would impede the work of the committee if time was spent explaining the background to papers or answering governor questions. There may be value, however, in governors attending as ad hoc observers to understand the role of the committee and the work of the NED in more detail. A briefing before or after the meeting with the NED may also be useful.

VII. Governor attendance at Trust operational / management meetings

There are a small number of operational meetings that NEDs attend (but do not chair). For the most part governors would not attend operational meetings since this is not part of their role (and, if the limited time available to governors was spent in this way it would be time lost to fulfilling their core duties).

VIII. Director attendance at BoG meetings

There are four BoG meetings a year, held at locations across the two counties.

For directors, the BoG provides a good opportunity to meet governors and to listen to their priorities and concerns; this is particularly important for NEDs who are directly accountable to governors. The expectation therefore is that NEDs will usually attend BoG meetings and that EDs will make reasonable efforts to do so, notwithstanding that operational priorities may prevent this.

IX. Governor requests for information
Governors cannot fulfil their role unless they can ask questions and request information and the Trust must try to provide up-to-date, accurate replies to fulfil its accountability to local people.

There are three main ways to request information.

The first is informally through a discussion with a board member or the Trust Secretary about why the information is needed. This is helpful because it may be that the information sought would not meet the need, but that there is another way of addressing the same question. A meeting or telephone discussion with a manager may be more useful than a table of figures.

The second is via the Planning and Performance Subgroup meeting. This has the advantage of putting the information into a wider context and including other governors in the analysis. Requests should be discussed with the Subgroup Chair(s).

The third is that any governor can ask that an item be put on the BoG agenda, giving two weeks' notice. This right is set out in the Constitution and would generally be used when the other methods have proved ineffective.

If the information is already collected it will be shared as soon as practical.

If the information is not already collected then a discussion will take place about the benefits and costs of retrieving it. Normally this will resolve the matter to everyone’s satisfaction but if agreement cannot be reached the Chair will be asked to adjudicate.

X Governor feedback on operations

Governors frequently hear feedback about services not working quite as they should, or indeed about them working exceptionally well. Governors should normally report such feedback to the Directors of Operations (Norfolk & Waveney or Suffolk) so that they can take appropriate action.

4. Working relationships and behaviours

i. Support for governors to carry out their role

NSFT has a legal duty to ensure that governors are equipped with the skills and knowledge that they need to discharge their duties. The training and development needs of governors are overseen by the Education Subgroup. The Trust will ring-fence a training budget based on 2013/14 expenditure for 2014/15.

The Trust organises induction sessions for all new governors and arranges development sessions throughout the year on specific topics. So far as possible these are held on BoG days. Additional sessions between BoG days can also be arranged at the request of the Education Subgroup.
The Trust subscribes to the FT Governors’ Association so that all governors can access online advice and information on the role. The Trust is also a member of the Foundation Trust Network which provides training events.

Elected governors are paired with a director who can act as an initial contact for queries and exchange of ideas. Partner governors can also request to be paired. This informal relationship can be used in whatever way is most useful to the governor.

Governors also elect a Lead Governor from among their number, normally for a three year period. The Lead Governor is available for conversation and advice or chat over a cup of coffee.

The Chair of the Board of Governors, who is also Chair of the Board of Directors, is also available for one to one conversations.

**ii. Objective setting and appraisals**

The role of the BoG is first to define the process for objective setting and evaluating the performance of the Chair and, in consultation with the Chair, the NEDs and second, to be assured that it has been followed.

The Nominations Committee oversees this on behalf of the BoG and reports the outcomes of the appraisals to the full BoG for approval. The Senior Independent Director carries out the Chair’s appraisal and the Chair carries out the NEDs’ appraisals. The process followed is overseen by the Nominations Committee in both cases.

As part of the appraisal process, governors are invited to provide confidential feedback on the performance of the Chair and NEDs. This is the formal point at which governors reflect on the performance of the Chair and NEDs as they have seen them operate during the year, for example at the meetings of the BoG, the BoD or the P&P Subgroup, and provide their feedback on their performance.

**iii. Promoting good relationships**

Effective relationships between governors and directors are promoted by all parties:

- Acknowledging that governors and directors have the same goals but different responsibilities.
- Accepting that constructive tension is required in any accountability structure and that an effective relationship is neither cosy nor adversarial.
- Fulfilling but not exceeding their remits.
iv. Resolving disagreements between the Board of Directors and the Board of Governors

The Chair, in liaison with the Lead Governor and the Senior Independent Director, will facilitate discussions between the two Boards to resolve disagreements.

An informal approach to resolving disagreements will usually be sufficient and the requirements will depend on the matter under consideration. It may consist of ensuring that further information is made available (for example, where there is a disagreement over the basis for a decision) or taking legal advice where there is a question over interpretation of responsibilities.

Where an informal approach does not resolve the matter to the satisfaction of the governors and a motion is passed by two thirds of the Board of Governors to call a Resolution Meeting then this will be arranged as soon as practical, but no later than 20 working days after the motion.

A Resolution Meeting is a joint meeting of the two boards, held in private. The agenda and papers will be issued in line with the Trust Constitution and quoracy requirements for both Boards apply. The Chair may choose to invite a facilitator to the meeting.

All participants will make every effort to resolve the matter, but if the issues cannot be resolved to the satisfaction of both boards (by a simple majority vote of those present from each board separately) then the final decision rests with the Board of Directors. The Board of Governors may then decide to escalate the matter to the Panel for Advising Governors (established by the Health and Social Care Act (2012)) or through the lead governor to Monitor in relation to a potential breach of the terms of its licence.

v. The role of the lead governor

The lead governor is the main contact point for Monitor (although any governor may contact Monitor if they feel this is appropriate). The lead is elected by governors through a secret ballot. The role is set out in full in the role profile (available separately).

Robert Nesbitt
Trust Secretary
25th September 2013
(for review annually once approved by the two Boards)
Norfolk and Suffolk NHS Foundation Trust

Report To: Board of Directors – Public

Meeting Date: 24th October 2013

Title of Report: Board of Governors / Board of Directors Joint Working Agreement

Action Sought: For Approval

Estimated time: 5 mins

Author: Robert Nesbitt: Trust Secretary

Executive lead: Robert Nesbitt: Trust Secretary

Trust objectives:

✔ all objectives that this report relates to:

✔ To ensure the Trust retains and develops its focus on service quality; fully responding to the Francis report as agreed with the Board, responding to the views of service users and carers, engaging effectively with them, and implementing the safety and quality plan included agreed as part of the Service Strategy.

☐ To implement the 2013/4 programme of the agreed Trust Service Strategy, ensuring Trust Services are maintained to a high standard throughout the change and that Service users and carers are engaged throughout. Ensuring we adopt a strong “Recovery” culture across the organisation.

☐ To improve engagement with staff across the Trust so that staff report greater involvement and engagement, and the Trust improves its staff survey results (especially comparatively), sickness levels continue to reduce throughout the year, appraisal rates continue to improve and Net promoter score improves.

☐ To ensure the Trust delivers its agreed financial plan to assure the safety and stability of services.

☐ To develop stronger relationships with CCGs and commissioners, and partner organisations.

☐ To review and establish a long term commercial strategy to enable the Trust to continue to develop and grow in an increasingly commercial environment.

Governance check list: ✓ any that apply and ensure these are addressed in main report

☐ Finance / workforce effects

☐ Equality impact

✓ Quality (patient safety, patient experience, clinical effectiveness)

✓ Consultation
1.0 Summary of Report

1.1 The FT code of governance recommends that the roles and responsibilities of the Board of Governors should be set out in a written document (A. 1.1 and B.1.4) and should establish an engagement policy with the Board of Directors (B.1.7).

1.2 This document has been approved by the Board of Governors at its meeting on 2\textsuperscript{nd} October 2013 and is now presented to the Board of Directors for consideration.

2.0 Financial implications (including workforce effects)

2.1 None.

3.0 Quality implications

3.1 This document supports the corporate governance of the organisation.

4.0 Equality implications / summary of consultation

4.1 There are no equality implications. Directors and governors were asked to comment on draft versions of the document and this feedback has been incorporated.

5.0 Mitigation in relation to the Trust objectives (implications for Board Assurance Framework)

5.1 There are no direct implications for the Trust’s objectives 2013/14

6.0 Recommendations

6.1 That the Board of Directors approves the joint working agreement.

6.2 The agreement should be reviewed annually.

Robert Nesbitt
Trust Secretary
16.10.13

Background Papers / Information

Joint working agreement attached.
**Norfolk and Suffolk NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Report To:</th>
<th>Board of Directors – Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting Date:</td>
<td>24th October 2013</td>
</tr>
<tr>
<td>Title of Report:</td>
<td>Separation of responsibilities between the Chair and CEO</td>
</tr>
<tr>
<td>Action Sought:</td>
<td>For Approval</td>
</tr>
<tr>
<td>Estimated time:</td>
<td>5 mins</td>
</tr>
<tr>
<td>Author:</td>
<td>Robert Nesbitt: Trust Secretary</td>
</tr>
<tr>
<td>Executive lead:</td>
<td>Robert Nesbitt: Trust Secretary</td>
</tr>
</tbody>
</table>

**Trust objectives:**

- To ensure the Trust retains and develops its focus on service quality; fully responding to the Francis report as agreed with the Board, responding to the views of service users and carers, engaging effectively with them, and implementing the safety and quality plan included agreed as part of the Service Strategy.

- To implement the 2013/4 programme of the agreed Trust Service Strategy, ensuring Trust Services are maintained to a high standard throughout the change and that Service users and carers are engaged throughout. Ensuring we adopt a strong “Recovery” culture across the organisation.

- To improve engagement with staff across the Trust so that staff report greater involvement and engagement, and the Trust improves its staff survey results (especially comparatively), sickness levels continue to reduce throughout the year, appraisal rates continue to improve and Net promoter score improves.

- To ensure the Trust delivers its agreed financial plan to assure the safety and stability of services.

- To develop stronger relationships with CCGs and commissioners, and partner organisations.

- To review and establish a long term commercial strategy to enable the Trust to continue to develop and grow in an increasingly commercial environment.

**Governance check list:** ✓ any that apply and ensure these are addressed in main report

- Finance / workforce effects
- Quality (patient safety, patient experience, clinical effectiveness)
- Equality impact
- Consultation

---

Board of Directors (Public): 24Oct2013
Separation of Chair and CEO responsibilities
Page 1 of 3
1.0 Summary of Report

1.1 Monitor’s best practice guidance, the NHS Foundation Trust Code of Governance (2010), recommends that the Board of Directors approves a written statement setting out the division of responsibilities between the Chair and the Chief Executive (A.2.1). This is drawn directly from the UK Corporate Governance Code (Updated 2012), which states “There should be a clear division of responsibilities at the head of the company between the running of the board and the executive responsibility for the company’s business. No one individual should have unfettered powers of decision.”(A.2)

1.2 The statement is attached and is drawn from the Trust’s Standing Orders and the role profile / job description for the Chair and CEO

2.0 Financial implications (including workforce effects)

2.1 None.

3.0 Quality implications

3.1 This document supports the corporate governance of the organisation.

4.0 Equality implications / summary of consultation

4.1 There are no equality implications. The role profile for the Chair and job description for the CEO have both been reviewed and updated in 2013 following extensive consultation. It is not proposed therefore that the Board of Directors proposed any amendments to these at this meeting. Any recommendations should be considered by the Nominations and Remuneration and Terms of Service Committees respectively.

5.0 Mitigation in relation to the Trust objectives (implications for Board Assurance Framework)

5.1 There are no direct implications for the Trust’s objectives 2013/14

6.0 Recommendations

6.1 That the Board of Directors approves the written statement, with future changes to the role profiles of the Chair or JD triggering a review by the Joint Remuneration / Nominations Committee meeting.

Robert Nesbitt
Trust Secretary
16.10.13
Background Papers / Information

Written statement attached
Statement of division of responsibilities between the Chair and the Chief Executive

Introduction

Monitor’s best practice guidance, the NHS Foundation Trust Code of Governance (2010), recommends that the Board of Directors approves a written statement setting out the division of responsibilities between the Chair and the Chief Executive (A.2.1). This is drawn directly from the UK Corporate Governance Code (Updated 2012), which states “There should be a clear division of responsibilities at the head of the company between the running of the board and the executive responsibility for the company’s business. No one individual should have unfettered powers of decision.”(A.2)

1. The responsibilities of the Chair

The Standing Orders for the Trust state:

7.5 Chair

7.5.1 The Chair shall be responsible for the operation of the Board of Directors and chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with the terms of appointment and with these Standing Orders.

7.5.2 The Chair shall take responsibility either directly or indirectly for the induction, portfolios of interests and assignments, and the performance of Non-Executive Directors.

7.5.3 The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board of Directors in a timely manner with all the necessary information and advice being made available to the Board of Directors to inform the debate and ultimate resolutions.

1.1 Overarching principles as set out in Monitor’s Code of Governance:

a. Leadership of the board of directors, and the board of governors.
b. Ensure the effectiveness of both boards separately and working together.
c. Set the agendas for both boards.
d. Ensure that directors and governors receive accurate, timely and clear information appropriate to their duties.
e. Ensure effective open communication with service users, carers, foundation trust members, staff and other stakeholders.
f. Facilitate constructive and productive relationships between the executive and non-executive directors and between the two boards.

These are supplemented by the responsibilities specified in the Chair’s job profile:

1.2 Role Purpose
Lead the Board of Directors to ensure it both develops its strategy and achieves its targets in delivering services efficiently and effectively as contracted by the commissioning bodies, as required by statute and in accordance with the standards set by Monitor;

Lead the Board of Governors to ensure the Board of Governors and Board of Directors work effectively together;

Role model the values and principles of the organisation internally and externally; and

Raise the profile of the Trust locally, regionally and nationally

1.3 Meetings of the Boards

Chair Board meetings and other formal meetings of the Trust, in a manner which results in consensus and a commitment to clear and unambiguous Board decisions giving due consideration to all options;

Set the board agendas in consultation with the Chief Executive and Lead Governor as appropriate, taking into account the issues and concerns of all Directors and Governors and where necessary the wider stakeholder community. Ensure that Board discussions effectively address the critical issues facing the Trust;

Foster a climate of openness, common purpose and debate where contributions from all are encouraged and valued; ensure an atmosphere of trust and mutual respect wherein the non-executive directors can effectively challenge the executives

Oversee the establishment and operation of Board Committees, including their composition, terms of reference, effectiveness and remuneration;

Ensure that Board minutes properly record Board decisions and the business conducted at the meetings; and

Chair Board of Governor meetings, facilitating the effective contribution of Governors and encouraging active engagement. Maintain a clear structure for Board of Governor meetings and sub-groups, including appropriate regularity of meetings. Ensure that the concerns of the Governors are effectively considered at the Board of Directors.

1.4 Strategy and direction

Provide leadership to the Board of Governors and the Board of Directors, ensuring their effectiveness in all aspects of their roles;

Work with the Trust Board and Board of Governors to establish the strategy and objectives of the Trust and to promote its vision and values;

Lead and direct the work of the Board and ensure the timely dissemination of adequate information relevant to each Board’s deliberations and responsibilities including obtaining further information and advice as required;

Share and use relevant expertise with senior managers and clinicians in a changing healthcare environment;

Ensure that the Board establishes clear objectives to deliver the agreed plans and meet the terms of its authorisation making best use of resources. Ensuring that the Board continually reviews the Trust’s performance against these objectives.
1.5 Leadership and responsibilities

- Act as a link between, and support for, the Non-Executive Directors, the Directors and Council of Governors between meetings; ensure constructive and effective relationships and contributions from all parties;
- Ensure that the performance of Directors and Governors are reviewed annually to ensure that the Boards both perform effectively;
- Provide coherent and visible leadership to the Trust in regular communications including, in conjunction with the Chief Executive, representing the Trust to service users, carers, staff, members, government, fellow NHS bodies, regulators and stakeholders including the voluntary sector and the media;
- Act as an ambassador for the Trust, safeguarding the reputation of the organisation and representing the Trust amongst the wider public domain across Norfolk and Suffolk;
- Uphold the values of the Trust by example, and ensure that the organisation promotes equality and diversity for all its service users, staff and other stakeholders;
- Develop a productive, ongoing relationship of support and challenge with the Chief Executive;
- Respect and value the role of Governors, and provide leadership to the Board of Governors in holding the Board of Directors to account in its development of the strategic direction of the Trust and its delivery of effective services to the communities of Norfolk and Suffolk.
- Take responsibility for own continual personal development in conjunction with the Board and undertake annual appraisal with the Senior Independent Director
- Be aware of and understand the impact of regulator and Central Government Policy as well as local issues impacting on the Trust.

2. Responsibilities of the Chief Executive

The Standing Orders for the Trust state:

“7.2 Chief Executive

The Chief Executive shall be responsible for the overall performance of the executive functions of the Trust. The Chief Executive is the Accounting Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum”.

2.1 Role summary

- The Chief Executive is responsible for the direction and leadership of the Trust, and for implementing the organisation’s strategic goals and objectives as established by the Board of Directors. Together with the Board, the Chief Executive will be
responsible for growing the assets of the organisation and will have overall responsibility for the sustainability and continued success of the Trust.

- With the Chair and through the Executive Team, the Chief Executive will enable the Board to fulfil its governance function and establish mechanisms for the delivery of the key priorities of the Trust's Integrated Business Plan; and work towards achieving the Trust's philosophy and annual objectives.

- The key role of the Chief Executive is to ensure the delivery of efficient and effective mental health and social care services for the population served by the Trust.

### 2.2 Duties and responsibilities

- To increase the market share of mental health and social care services for the Trust through organic and strategic growth, including identification of acquisition opportunities.
- To be accountable for meeting all the Board's expectations for organisational performance.
- To support the operations and administration of the Board by advising and informing Board members and providing the interface between Board and Staff.
- To take responsibility for positioning the Trust to competitive advantage, establishing systems that enable the identification of emergent niches within health and social care.
- To maximise the involvement of members and governors in the work of the Trust.
- To meet, and strive to exceed, the requirements of the Regulators: Monitor and the Care Quality Commission.
- To create and sustain organisational cultures which are responsive to the needs and aspirations of individual consumers.
- To establish cultures focussed on continual improvement in quality and cost effectiveness.
- To use the power of the organisation as employer, purchaser and owner of resources, including intellectual property, to contribute to the economy and well being of the local communities.
- To ensure the Trust is compliant with its authorisation and statutory obligations at all times.
- To provide leadership in the development of the Trust's statement of vision, mission, and values, and the corresponding strategies, goals, and funding to achieve them.
- To implement a dynamic, rigorous and flourishing business planning process.
- To establish standards for business processes of the organisation.
- To develop effective and mature external working relationships with stakeholders and suppliers through formal alliances. To ensure that the Trust and its goals and services are consistently presenting a strong, positive image to relevant stakeholders.
- To contribute to and maintain awareness of National Policy development related to health and social care and local Government.

### 2.3 Leadership and people management

- To develop devolved leadership through the organisation within an explicit framework of authority, responsibility and accountability.
- To provide clear leadership and promote and foster a team culture consistent with the Trust's values.
• To provide support to the Chair in developing the Governors’ role and ensuring local community accountability.
• To implement processes for education, development and succession planning throughout the organisation.
• Demonstrate high visibility within the organisation.
• Support effective staff engagement.
• Ability to work as part of a team in a mutually supportive environment.
• Demonstrate appropriate role modelling as the senior leader of the organisation.
• Enable devolved leadership through the organisation within an explicit framework of authority, responsibility and accountability.
• To ensure high standards of people management including the delivery of appraisals and personal and professional development supporting the values of the Trust.

2.4 Governance

• To achieve the requirements of the annual plan: Annual assessment, in–year monitoring and remedy of any compliance failures.
• To develop the systems for integrated governance throughout the organisation ensuring that the Governors and the Board of Directors receive timely and accurate information.
• To ensure systems for compliance with our Terms of Authorisation as a Foundation Trust.
• To deliver on core and developmental Care Quality Commission standards.
• To ensure the delivery of the recommendations of the Francis report.
• To operate in accordance with health and safety requirements.
• Effectively manage and report risk using the local and corporate risk reporting processes.
• Ensure robust corporate and clinical systems and processes are in place within areas of responsibility and across the Trust.
• To ensure the management and security of confidential information in accordance with Trust policy, the Data protection Act and Freedom of Information.

2.5 Finance and resources

• To prudently manage the Trust’s resources within budget guidelines, current laws and regulations.
• To establish robust systems for securing legally binding contracts.
• The post holder will be expected to operate within Standing Financial Instructions and Standing Orders.
• To be accountable for financial planning and budgetary control of all contracts and services in area of responsibility.
• To ensure that all areas of responsibility are working within financial limits including the delivery of cost reduction programmes

2.6 Performance

• To build and maintain a high performance culture in areas of responsibility through effective performance management.
• Establish productivity measures for services in area of responsibility and monitor performance.

2.7 Equality and diversity
- Demonstrate dignity and respect at all times.
- Undertake all duties in accordance with the Equality Act, the Trust’s Equality policy and the Single Equality Scheme.

2.8 Communication

- To ensure that staff and the Boards of Directors and Governors have sufficient and up–to–date information and that reporting is transparent.
- To provide the interface between Trust and community.
- To act as a key spokesperson and ambassador for the Trust.

Robert Nesbitt
Trust Secretary
16.10.13
For review when either Chair or CEO role description is updated

statement of division of responsibilities between the chair and the chief executive 26jul2013v2
Report To: Board of Directors – Public

Meeting Date: 24th October 2013

Title of Report: Proposal for Service Governance Committee

Action Sought: For Approval

Estimated time: 5 minutes

Author: Robert Nesbitt: Trust Secretary

Director: Gary Page: Chair

Trust objectives:
✓ all objectives that this report relates to:
✓ To ensure the Trust retains and develops its focus on service quality; fully responding to the Francis report as agreed with the Board, responding to the views of service users and carers, engaging effectively with them, and implementing the safety and quality plan included agreed as part of the Service Strategy.

☐ To implement the 2013/4 programme of the agreed Trust Service Strategy, ensuring Trust Services are maintained to a high standard throughout the change and that Service users and carers are engaged throughout. Ensuring we adopt a strong “Recovery” culture across the organisation.

☐ To improve engagement with staff across the Trust so that staff report greater involvement and engagement, and the Trust improves its staff survey results (especially comparatively), sickness levels continue to reduce throughout the year, appraisal rates continue to improve and Net promoter score improves.

☐ To ensure the Trust delivers its agreed financial plan to assure the safety and stability of services.

☐ To develop stronger relationships with CCGs and commissioners, and partner organisations.

☐ To review and establish a long term commercial strategy to enable the Trust to continue to develop and grow in an increasingly commercial environment.

Governance check list: ✓ any that apply and ensure these are addressed in main report

☐ Finance / workforce effects

✓ Quality (patient safety, patient experience, clinical effectiveness)

☐ Equality impact

☐ Consultation
1.0 Summary of Report

1.1 As part of the Trust’s response to the Francis Report, we have considered how we can further strengthen our focus on quality. This paper sets out the rationale for a change to the Trust’s governance structure so that the Service Governance Sub-Committee becomes a formal board committee in its own right. It would therefore no longer report to the board of directors via the Audit and Risk Committee, but report directly. This paper seeks agreement to create the committee. The terms of reference for committee (including any proposal for a different name, such as Quality Committee) would then be developed to return to the board for approval. Changes will also be required to the terms of reference for the Audit and Risk Committee.

2.0 Financial implications (including workforce effects)

2.1 None.

3.0 Quality implications

3.1 The purpose of this change is to ensure that service governance has the same priority within the board agenda as finance and business performance. It will also relieve pressure on the Audit and Risk Committee agenda.

3.2 Close liaison between the Chairs of the two committees will be needed both to align the terms of reference (so as to avoid duplication and potential gaps) and to ensure effective flows of information between the committees on areas that may overlap (such as internal audit reports).

4.0 Risks / mitigation in relation to the Trust objectives (implications for Board Assurance Framework)

4.1 The proposal provides mitigation for Trust Objective 1 (fully respond to the Francis Report in relation to patient safety).

5.0 Recommendations

5.1 That the Board approve the setting up of a Service Governance Committee with Dr Peter Jefferys as the Chair and Adrian Stott as vice-chair.

5.2 That Peter Jefferys and John Brierley with the support of Robert Nesbitt, devise the terms of reference for the committee, and update the Audit & Risk Committee’s ToR.

5.3 The Service Governance Committee ToR to come to the November 2013 board for approval, with the Audit and Risk returning to the February 2014 board.
Background Papers / Information

Draft updated governance structure diagram.
Trust objectives:

✓ all objectives that this report relates to:

✓ To ensure the Trust retains and develops its focus on service quality; fully responding to the Francis report as agreed with the Board, responding to the views of service users and carers, engaging effectively with them, and implementing the safety and quality plan included agreed as part of the Service Strategy.

☐ To implement the 2013/4 programme of the agreed Trust Service Strategy, ensuring Trust Services are maintained to a high standard throughout the change and that Service users and carers are engaged throughout. Ensuring we adopt a strong “Recovery” culture across the organisation.

☐ To improve engagement with staff across the Trust so that staff report greater involvement and engagement, and the Trust improves its staff survey results (especially comparatively), sickness levels continue to reduce throughout the year, appraisal rates continue to improve and Net promoter score improves.

☐ To ensure the Trust delivers its agreed financial plan to assure the safety and stability of services.

☐ To develop stronger relationships with CCGs and commissioners, and partner organisations.

☐ To review and establish a long term commercial strategy to enable the Trust to continue to develop and grow in an increasingly commercial environment.

Governance check list: ✓ any that apply and ensure these are addressed in main report

☐ Finance / workforce effects

☐ Equality impact

✓Quality (patient safety, patient experience, clinical effectiveness)

☐ Consultation

Board of Directors 24th October 2013
Quality update
Page 1 of 11
1.0 Summary of Report

1.1 This report sets out the initial progress for the quality priorities identified in the Quality Account for 2013-14 and further progress for the quality priorities identified in 2012-13.

1.2 The paper also provides an update on progress for the CQuIn targets for 2013-14.

2.0 Quality priorities

2.1 The quality priorities identified for 2013-14 are identified in appendix 1 with the progress to the end of Q2.

2.2 The patient experience priority, that all inpatient areas should have a programme of activities is currently complete and evidenced by the schedules available. Following feedback received however from some service users a paper will go to service governance subcommittee in November to facilitate discussion and agreement regarding the Trust expectation of activities. CQC standard 4 states that services should provide daytime activity and the AIMS standards identify further detail around what should be provided. In order to manage expectation however the Trust needs to set clear parameters around what activities are organised and led by staff, usually therapeutic and planned activity, and what activities are social and available for in-patients to choose. These activities may be facilitated by staff but not exclusively organised and managed.

2.3 The Quality Account is required to continue reporting on the indicators identified in previous years until the Trust is confident that the improvement is embedded in practice.

The target for completing physical health checks for inpatients continues to be achieved (100%). There have been a number of instances where it has been identified in the data that a breach has occurred but these have been investigated and found to be data errors which have subsequently been corrected.

The table below shows that length of stay continues to fluctuate. The audit and risk committee has requested that the median position should be reported and this has been discussed with the informatics department. This discussion has raised the issue of reporting a numerical target when the quality pathway goal is that service users should remain in hospital for the minimum length of time necessary, no numerical target is identified. With the current initiatives regarding alternatives to admission and intensive community support, this may indicate that people being admitted are more unwell and require longer stays. Delayed transfers of care are also increased and the recent in patient survey results particularly identify delays for people waiting for accommodation or community services to be available.

The board is asked to consider whether this measure should continue to be reported in the Quality Account.
Length of stay

<table>
<thead>
<tr>
<th></th>
<th>March 2013</th>
<th>April 2013</th>
<th>May 2013</th>
<th>June 2013</th>
<th>July 2013</th>
<th>August 2013</th>
<th>Sept 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>32.87</td>
<td>28.44</td>
<td>31.34</td>
<td>24.81</td>
<td>28.97</td>
<td>30.36</td>
<td>39.59</td>
</tr>
</tbody>
</table>

The latest audit of crisis plans took place in West Norfolk and West Suffolk. The results show that for West Norfolk compliance was at 35% and 100% for West Suffolk. An action plan is in place for West Norfolk and as part of the work for 2013-14, Suffolk localities are reviewing the crisis planning process as service users continue to report that they don’t have a crisis plan although the audit results are very good.

The 2013 community survey results show no change in the percentage of people reporting they had a crisis plan. The 2013 in patient survey however identifies an increase of 5%.

The availability of psychological therapy was part of the Trust service strategy and reflected in the community service user survey. The survey reports whether service users received talking therapy and in 2013, although the score remains “about the same” as other Trusts, the actual score has reduced from 7.3 in 2012 to 6.2 in 2013. It should be noted however that the sample of people surveyed were within the service in 2012 and therefore were receiving services before the service strategy was in place. A small group of clinicians is currently working with governor Adrian Stott to look at the availability of electronic CBT on in patient areas.

3.0 Commissioning for Quality and Innovation (CQuIn)

3.1 The Trust has a CQuIn scheme for each of the 5 contracts it holds with commissioners, Norfolk main contract, Suffolk main contract, Norfolk IAPT and specialist commissioning contract for secure services and CAMHS tier 4.

3.2 An overview of each scheme is presented in appendix 3. With the inception of CCG’s, there has been further discussion about the cquin targets that apply to GtY&W and the separate schemes are indicated in the chart.

Due to delays in agreeing the CQuIn schemes, it has been agreed that NSFT will receive full payment for the Norfolk component of Q1, including IAPT with the agreement that the Trust will have caught up by the end of Q2. It has been further agreed that NSFT will receive full payment for the GtY&W component of Q1 and Q2 with the expectation that the Trust will have caught up by the end of Q3.

4.0 Recommendations

5.1 To note the progress made in achieving quality account priorities and CQuIn targets

5.2 To decide whether the average length of stay should continue to be reported in the Quality Account.
Background Papers / Information
## Patient safety

<table>
<thead>
<tr>
<th>Action plan and Q1</th>
<th>Q2 Update</th>
<th>Q3 Update</th>
<th>Final achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>To develop a joint pilot project with Health East</td>
<td><strong>Suffolk</strong> Working draft protocol produced and meeting established. <strong>Norfolk</strong> The pilot project with health east has been identified and a consent form developed for service users to give permission for primary care to share appointment dates with care coordinators. A paper will be presented to the November service governance committee with full details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To be included as part of a task and finish group in West Suffolk</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Leads
- Marcus Hayward
- Helen White/Chris Warner
- Sue Howlett

### Patient experience

<table>
<thead>
<tr>
<th>Action plan and Q1</th>
<th>Q2 Update</th>
<th>Q3 Update</th>
<th>Final achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Suffolk East a meeting is planned for the 15th August to review this target following implementation of TSS. In the West a new operational policy has been</td>
<td><strong>Suffolk</strong> A working group has been set up. Aide memoir being progressed. Service user led training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All crisis / care plans will identify how to contact a mental health worker out of hours and what the Crisis Resolution &amp;</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Leads
- Terri Cooper-Barnes
- Viqui Savage
- Jane Coates
- Mike Seaman

---

Appendix 1
<table>
<thead>
<tr>
<th>Home Treatment Team (CRHT) may be able to provide. Develop a leaflet that gives contact numbers and describes the role of the CRHT</th>
<th>developed and all service users given the number to contact as part of contingency planning. In Norfolk the leaflets are already in use and teams will ensure that service users receive the information</th>
<th>programme. Leaflets developed and awaiting authorisation. Crisis plans monitored via clinical supervision <strong>Norfolk</strong> Due to the current TSS workload no further progress has been made</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All inpatient areas will have a programme of activities which will be available over seven days and include evenings</strong></td>
<td>Mary Jane Boden Jane Coates Mike Seaman</td>
<td>Most areas of the Trust already have activity programmes in place. A review is being carried out in East Suffolk involving service users and elsewhere the use of volunteers is being considered and monitoring and audit of current practice <strong>Suffolk</strong> Activity programmes have been implemented in all areas Participation in activity is recorded in service users records. Feedback forms in use 3 monthly reviews take place informed by service users <strong>Norfolk</strong> All areas currently have a programme</td>
</tr>
<tr>
<td><strong>Clinical effectiveness</strong></td>
<td><strong>When a new medication is prescribed, the prescriber should always discuss this with the service user</strong></td>
<td><strong>Review of the medicines reconciliation document. Discuss at drug and therapeutics committee Discuss with regard to junior doctors training.</strong> Need medical lead to be identified to be involved in leading implementation of action plan.</td>
</tr>
<tr>
<td>Information leaflets should be given and this should be recorded in the service user's record</td>
<td>Information leaflets are widely available. This will be audited</td>
<td>K Barker (Principle Clinical Pharmacist) will raise at next local Suffolk non medical prescriber forum (18/10/13) and agree non medical prescribers will implement QA and always record in patient record when new medication discussed with service user and prescribed. Information leaflet will also be given and recorded. Information leaflets are accessible on all wards. Internet access for service users on all areas and service users can access Choice and medication website. Pharmacy drop in sessions held weekly on each ward to provide opportunity for service users to discuss their medications and obtain information etc.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Need to identify medical lead to be involved in developing audit tool and completing audit.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
## 2013/2014 NSFT CQUIN SCHEMES

<table>
<thead>
<tr>
<th>Norfolk CQUIN</th>
<th>Suffolk CQUIN</th>
<th>IAPT Norfolk CQUIN</th>
<th>Tier 4 &amp; Secure Services CQUIN</th>
</tr>
</thead>
</table>
| **1.1: NHS Safety Thermometer**<br>
To collect data on the elements of the NHS Safety Thermometer: pressure ulcers, falls, urinary tract infection in patients with a catheter and VTE | NHS Safety Thermometer – Harm Free care/Safety Cross<br>Achieved in Q1 | Measuring Quality Outcomes | Quality Dashboards for Specialised Services<br>• Secure Services (S)<br>• CAMHS (C)<br>Achieved in Q1 |
<p>| <strong>1.2: NHS Safety Thermometer</strong>&lt;br&gt;Individual VTE Risk Assessment | CAHMS awareness and education&lt;br&gt;Improve awareness of and access to CAHMS services amongst the public and professionals&lt;br&gt;Achieved at 90% Q1 | Improve Understanding of IAPT Services | Optimising pathways&lt;br&gt;• Secure Services (S)&lt;br&gt;Achieved in Q1 |
| <strong>Dementia Awareness</strong>&lt;br&gt;Enhanced efficiency and effectiveness of Dementia Assessments. | CAMHS/Perinatal Mental Health&lt;br&gt;To carry out a review of existing services against the Guidance for commissioners of Perinatal Mental Health Services.&lt;br&gt;Achieved in Q1 | Increasing Access for Older People | Improving Physical healthcare and well-being of patients&lt;br&gt;• Secure Services (S)&lt;br&gt;• CAMHS (C)&lt;br&gt;Achieved in Q1 |
| <strong>System Wide Assurance Process – Reduced emergency admissions to acute hospitals</strong> | Psychiatric Liaison (E&amp;W) incl alcohol improvements&lt;br&gt;This CQUIN is for the development and delivery of a comprehensive psychiatric liaison service for west Suffolk.&lt;br&gt;Further discussion is ongoing with | Improved Access from Young People | Reducing social exclusion by improving literacy, numeracy, IT and vocational skills&lt;br&gt;Secure Services (S)&lt;br&gt;Achieved in Q1 |</p>
<table>
<thead>
<tr>
<th><strong>Access and Assessment Team</strong>&lt;br&gt;<strong>Patient Experience/Satisfaction Survey</strong></th>
<th><strong>Eating Disorders</strong>&lt;br&gt;<strong>To improve awareness of eating disorders amongst the public and professionals</strong>&lt;br&gt;<strong>Not achieved</strong></th>
<th><strong>Reduction in the IAPT DNA rate</strong>&lt;br&gt;<strong>Improving Patient Experience Through ensuring effective Care Programme Approach (CPA)</strong>&lt;br&gt;<strong>Secure Services (S)</strong>&lt;br&gt;<strong>CAMHS (C)</strong>&lt;br&gt;<strong>Achieved in Q1</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capacity Planning Group</strong>&lt;br&gt;<strong>Operational management group to a group responsible for the co-ordinated planning of future capacity and demand arrangements for the Central Norfolk system.</strong></td>
<td><strong>Payment by results</strong>&lt;br&gt;<strong>This CQUIN outlines preparatory work for the implementation of Payment by Results in Mental Health, split into three areas</strong>&lt;br&gt;<strong>Achieved in Q1</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Payment by Results</strong>&lt;br&gt;<strong>This CQUIN outlines preparatory work for the implementation of Payment by Results in Mental Health, split into three areas</strong></td>
<td><strong>Personality Disorder</strong>&lt;br&gt;<strong>Community Focused Personality Disorder Management Plans:</strong>&lt;br&gt;<strong>Not achieved. Taken to formal dispute process</strong></td>
<td></td>
</tr>
<tr>
<td><strong>CAMHS (Not GtY&amp;W)</strong>&lt;br&gt;<strong>To improve the referral processes within the education system for young people with an eating disorder.</strong></td>
<td><strong>Enhanced efficiency and effectiveness of Dementia Assessments. (Not GtY&amp;W)</strong></td>
<td></td>
</tr>
</tbody>
</table>
Enhanced capacity for quality delivery of dementia assessments

(Central locality only)
The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

ANNUAL REPORT:
England, Northern Ireland, Scotland and Wales

JULY 2013
CONTENTS

REPORT AUTHORS

ACKNOWLEDGEMENTS

KEY FINDINGS

RECOMMENDATIONS FOR SERVICES

PRESENTATION OF FINDINGS

1. ENGLAND

1.1 Suicide
   1.1.1 Suicide in the general population
   1.1.2 Patient suicide

1.2 Homicide
   1.2.1 Homicide in the general population
   1.2.2 Homicide by mentally ill people in the general population
   1.2.3 Patient homicide

1.3 Sudden unexplained death in mental health in-patients (SUD)
2. NORTHERN IRELAND

2.1 Suicide
2.1.1 Suicide in the general population 54
2.1.2 Patient suicide 60

2.2 Homicide
2.2.1 Homicide in the general population 72
2.2.2 Homicide by mentally ill people in the general population 73
2.2.3 Patient homicide 73

3. SCOTLAND

3.1 Suicide
3.1.1 Suicide in the general population 75
3.1.2 Patient suicide 82

3.2 Homicide
3.2.1 Homicide in the general population 96
3.2.2 Homicide by mentally ill people in the general population 97
3.2.3 Patient homicide 97
REPORT AUTHORS

Louis Appleby  
Nav Kapur  
Jenny Shaw  
Isabelle M Hunt  
David While  
Sandra Flynn  
Kirsten Windfuhr  
Alyson Williams

A full list of Inquiry members of staff can be found on the Inquiry website: www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci

ACKNOWLEDGEMENTS

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness would like to acknowledge the assistance it has received from individuals throughout the NHS, government departments and other organisations, including: the Department of Health, the Home Office Statistics Unit of Home Office Science, the Office for National Statistics, Health Solutions Wales, the Scottish Government, the General Register Office for Scotland, the Scottish Crown Office and Procurator Fiscal Service, the Management Information Analysis Team at the Scottish Court Services, the Scottish Police Authority, the Northern Ireland Statistics and Research Agency (the General Register Office Northern Ireland), the Northern Ireland Courts and Tribunal Service, the Department of Health, Social Services and Public Safety in Northern Ireland, the Coroners Service for Northern Ireland, Hospital Episode Statistics, and Greater Manchester Police.

Responsibility for the analysis and interpretation of the data provided from government offices rests with the Inquiry and not with the original data provider.
KEY FINDINGS

• Homicide by mental health patients has fallen substantially since a peak in 2006, and the figures for the most recent confirmed years, 2009-2010, are the lowest since we began data collection in 1997 - 33 cases reported in 2010 (England). Delays in the Criminal Justice System and in data processing may have contributed but it is likely that this is a true fall in patient homicide. Clinical explanations may include improved management of dual diagnosis patients (in whom the rate had previously risen) and the community treatment order, introduced in 2008. A similar fall has been found for homicide by people with schizophrenia (22 in 2010) and for people with symptoms of mental illness at the time of the offence (36 in 2010).

• Suicide by mental health patients has risen - 1,333 deaths in 2011 (England). A change to the coding of causes of death has contributed to this figure and changes to the Mental Health Minimum Dataset (MHMDS) method make comparisons with earlier years difficult but it is likely that this is a true rise in patient suicide, following a previous fall. The rise probably reflects the rise in suicide in the general population, which has been attributed to current economic difficulties; the proportion of patients dying by suicide who were unemployed has risen in England and Northern Ireland.

An apparent rise in Scotland is largely explained by the same coding change but the adjusted figure for patient suicide is still comparatively high. Increases in Wales and Northern Ireland are based on small numbers and should be treated with caution.

• In recent years there have been more suicides under home treatment or crisis resolution than under in-patient care (all countries). A substantial proportion of these deaths occur in patients who live alone or have refused treatment - home treatment may not be suitable for these patients without close supervision.

• Hanging remains the main method in patient suicides in England, Northern Ireland and Wales and has risen in these countries during the period 2001-2010. In Scotland, figures for hanging and self-poisoning are similar with self-poisoning slightly more common.

• Opiates are now the main substances taken by patients in fatal overdose (all countries). We do not know enough about which drugs are used and from where they are obtained.

• There is a continuing problem of substance misuse in patient suicide: our figures are high for alcohol misuse (highest in Northern Ireland and Scotland), drug misuse (highest in Scotland) and dual diagnosis (in all countries). In homicide, the figures are even higher: alcohol misuse (highest in Northern Ireland), drug misuse (highest in Scotland) and dual diagnosis (highest in Scotland).

• CTOs may have contributed to reduced patient homicide (England): our figures show that homicides have fallen in all patients and in those with schizophrenia, including those who were refusing treatment or losing contact with the service. However, these are early figures and further monitoring is needed. The effect of CTOs on patient suicide is unclear. CTO suicides may follow treatment refusal or loss of contact which they are designed to prevent, suggesting they could be applied more effectively (England, Wales, and Scotland).

• Patient suicide is still frequently preceded by missed contact with services (England, Scotland and Wales) and in Northern Ireland the numbers of such cases increased during the report period. Northern Ireland is the only UK country not to introduce assertive outreach teams (or an equivalent) although in England these teams are in some places being reabsorbed into general Community Mental Health Teams (CMHTs).

• Suicides by in-patients continue to fall (all countries), including in detained patients and those who have absconded.

• Victims of patient homicide are more likely to be spouses or family members than strangers (all countries).
• Sudden Unexplained Death (SUD) in in-patients continues to be associated with previous poor physical health (England and Wales). A quarter of SUD patients are under 45 years - physical ill-health is also common in this group and polypharmacy is found in 20% (England).

• Comprehensive figures for homicide and mental illness show that in 2001-2010 an average of 74 patients per year were convicted of homicide in the UK. When people with symptoms of mental illness are added, the total rises to an average of 115 per year. These are perpetrators - the corresponding figure for victims, taking account of multiple homicides, is 122 per year. All these figures appear to be falling.

RECOMMENDATIONS FOR SERVICES

Services should:

• maintain services for dual diagnosis patients and the use of CTOs in the care of people with risk of violence

• address the economic difficulties of patients who might be at risk of suicide, ensuring they receive advice on debts, housing and employment

• improve safety in crisis resolution/home treatment (CR/HT) as a priority for suicide prevention in mental health care; particular caution is needed with patients who live alone or refuse treatment and when patients are discharged from hospital into CR/HT

• be vigilant about the suicide risk from opiates, currently the main self-poisoning method; clinicians should check patients’ access to opiates

• continue the successful safety focus on wards, including measures to prevent absconding and ensure safe detention

• strengthen specialist services and risk management for patients who are misusing alcohol or drugs

• use CTOs more effectively to address treatment refusal and loss of contact in patients at risk of suicide

• assess risk of violence to spouses and family members and collaborate with social care and child protection services

• ensure that all in-patients, including younger in-patients, are included in reviews of physical health and polypharmacy

• introduce or maintain assertive outreach services

• engage in the debate over public concerns about the risk of homicide and the potential and limits of prevention by mental health services.
PRESENTATION OF FINDINGS

In this report, findings are presented for England, Northern Ireland, Scotland, and Wales for:

- Suicide
- Homicide

Findings for the Sudden Unexplained Death study are presented for England and Wales only.

England and Wales

Method of data collection

The method of data collection for suicide, homicide, and sudden unexplained death is similar in England and Wales.

Suicide

This report covers deaths by suicide for the period January 2001 to December 2011. Information on all general population suicides (i.e. deaths by intentional self-harm and deaths from undetermined intent) by individuals aged 10 and over is collected from the Office for National Statistics (ONS).
Homicide

This report covers people convicted of homicide, presented by year of conviction between January 2001 and December 2011. The Inquiry is notified of all convictions for homicide by the Home Office Statistics Unit of Home Office Science. Homicides not leading to conviction are not included in this report. Identification of mental illness in non-patients relies on psychiatrists preparing a report for the court, which the Inquiry then obtain. Not all perpetrators who had symptoms of mental illness at the time of the offence were patients and not all patients had symptoms of mental illness at the time of the offence.

General population homicide conviction figures in sections 1.2 and 4.2 are provided for the period of the report as context for our data on homicides by people with mental illness. A full analysis of homicide offences recorded by police in England and Wales was published by the ONS in February 2013.
Sudden unexplained death

This report covers sudden unexplained death (SUD) in psychiatric in-patients for the period January 2001 to December 2011. To identify cases of SUD, data on all patient deaths within psychiatric and learning disabilities in-patient hospitals in England are provided by Hospital Episode Statistics (HES) 4, previously the NHS-Wide Clearing Service. For Wales, data are provided by Health Solutions Wales (HSW). 5 During the report period the number of all in-patient deaths notified to the Inquiry for England was 5,859 and in Wales 589.

A summary of our data collection processes are outlined in Figures A-C. A detailed description of data collection methods in England and Wales is available in previous reports: Annual Report (2009, 2010) 6,7, and Avoidable Deaths (2006) 8, which are accessible on our website www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci.

Information collected (including diagnosis) was based on the clinical judgement of the consultant caring for the patient.

Figure C: The stages of data collection for sudden unexplained death

1. Obtain national data
2. Identify consultant
3. Eligibility sheet completed by consultant
4. Criteria for SUD not met
5. Send questionnaire to consultant psychiatrist for completion
6. Criteria for SUD met
**Data completeness**

Data completeness for patient suicides is 97% for England and 98% for Wales in the report period 2001-2010. Completeness is lower in the final year reported (65% for England, 62% for Wales), reflecting the time required to process the data. For patient homicides, data completeness is 95% in England in the report period 2001-2010. Completeness was 37% in the final year reported for England.

For the final year of the patient suicide and homicide analysis we therefore estimate the final number of cases based on data completeness in previous years (presented as a dotted line in the figures). Projected figures are based on the average annual return of Inquiry questionnaires, i.e. adjusted to an assumed final figure of 97% for England and 98% for Wales, and for homicide in England, 95%. For homicide in Wales, numbers are too small to calculate projected figures. For sudden unexplained death, actual figures are shown, including those in the final year.

**Scotland**

### Method of data collection

#### Suicide

This report covers deaths by suicide for the period January 2001 to December 2011. Information on all general population suicides (as defined in England and Wales) is collected from the General Register Office for Scotland (GROS).9

#### Homicide

This report covers homicide convictions, presented by year of conviction between January 2001 and December 2011. Information is collected from the Management Information Analysis Team at the Scottish Court Service, with additional data (including relationship between perpetrator and victim) obtained from the Scottish Crown Office and Procurator Fiscal Service. Homicides not leading to conviction are not included in this report. Identification of mental illness in non-patients relies on psychiatrists preparing a report for the court, which the Inquiry then obtain. Not all perpetrators who had symptoms of mental illness at the time of the offence were patients and not all patients had symptoms of mental illness at the time of the offence.

**General population homicide conviction figures in section 3.2 are provided for the period as context for our data on homicides by people with mental illness. A full analysis of homicide offences recorded by police in Scotland was published by the Scottish Government in December 2012.10**

See Figures A-B for a summary description of our data collection processes. A detailed description of data collection methods in Scotland are described in a previous report for Scotland, Lessons for Mental Health Care in Scotland 11, accessible on our website www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci.

Information collected (including diagnosis) was based on the clinical judgement of the consultant caring for the patient.
**Data completeness**

Data completeness for patient suicides is 98% in the report period 2001-2010. Completeness is lower in the final year reported (85%), reflecting the time required to process the data. For patient homicide, data completeness is 95% in the report period 2001-2010 and 50% complete in the final year.

As in England and Wales, for the final year of the patient suicide and homicide analysis we estimate the final number of cases based on data completeness in previous years (presented as a dotted line in the figures). Projected figures are based on the average annual return of Inquiry questionnaires, i.e. adjusted to an assumed final figure of 98% complete for suicide and 95% for homicide.

**Northern Ireland**

**Method of data collection**

**Suicide**

This report covers deaths by suicide for the period January 2001 to December 2011. Information on all general population suicides (as defined in England and Wales) is collected from the Northern Ireland Statistics and Research Agency (NISRA).

**Homicide**

This report covers homicide convictions, presented by year of conviction between January 2001 and December 2011. Information is collected from the Northern Ireland Courts and Tribunal Service and the Coroners Service for Northern Ireland. Homicides not leading to conviction are not included in this report. Identification of mental illness in non-patients relies on psychiatrists preparing a report for the court, which the Inquiry then obtain. Not all perpetrators who had symptoms of mental illness at the time of the offence were patients and not all patients had symptoms of mental illness at the time of the offence.

General population homicide conviction figures in section 2.2 are provided for the period of the report as context for our data on homicides by people with mental illness. An analysis of homicide offences recorded by police in Northern Ireland was published by the Police Service of Northern Ireland in July 2012.

See Figures A-B for a summary description of our data collection processes. A detailed description of data collection methods in Northern Ireland are described in a previous report for Northern Ireland, *Suicide and Homicide in Northern Ireland*⁴, accessible on our website www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci.

Information collected (including diagnosis) was based on the clinical judgement of the consultant caring for the patient.

**Data completeness**

Data completeness for patient suicides is 99% in the report period 2001-2010. Completeness is lower in the final year reported (73%), reflecting the time required to process the data. As in England, Wales, and Scotland, for the final year of the patient suicide analysis we estimate the final number of cases based on data completeness in previous years (presented as a dotted line in the figures). Projected figures are based on the average annual return of Inquiry questionnaires, i.e. adjusted to an assumed final figure of 99% complete. For homicide in Northern Ireland, numbers are too small to calculate projected figures.
ANALYSIS

The following section describes how data were analysed in this report.

Trends over time

To examine for statistically significant time trends, trend tests were carried out using categorical data methods in Stata v12. Poisson models were fitted with the number of suicides or homicides per year as the outcome and year as a linear predictor. For rates, general population per year was the exposure. Within the patient sample, the exposure was the total number of suicides or homicides per year as the outcome and year as a linear predictor. For rates, general population per year was the exposure. Within the patient sample, the exposure was the total number of suicides or homicides per year. Tests for trends over time were calculated excluding the incomplete final year, i.e. 2001-2010 for suicide and homicide, for both general population and patients. For each model, the likelihood-ratio-test p-value and the predictor (and 95% confidence intervals) for year were examined.

Rates of suicide and homicide

General population and patient rates for suicide were calculated using mid-year population estimates revised in light of the 2011 census (age 10 and over) as denominators obtained from ONS and GROS. These were also used to calculate rates for suicide by NHS region (England) and Health Boards (Northern Ireland, Scotland, and Wales). The Health Board rates in Wales and Scotland reflect the new health area boundaries that came into place on 1 October 2009 (Wales) and 1 April 2006 (Scotland). Mid-year population estimates obtained from GROS have been revised for the period 2002 to 2011 only. Therefore rates by Scottish Health Boards are reported for this time period only. In April 2009, the former regional Health Boards of Northern Ireland were merged to form one Health and Social Care Board. However, in order to indicate geographical patterns of suicide, we present suicide rates for each of the Health and Social Care Trusts.

General population and NHS region rates were also calculated for homicide (England only).

Discrepancies may arise between Inquiry national numbers and rates and those presented by the ONS, the Department of Health, the Scottish Public Health Observatory website, and the NISRA website due to differences in measurement described in Avoidable Deaths, Lessons for Mental Health Care in Scotland, and Suicide and Homicide in Northern Ireland. The main reason for the difference in our general population numbers and rates compared to those published on the ONS, Scottish Public Health Observatory and NISRA websites is that our figures are based on the date of death occurrence while other figures are based on the date the death was registered. In England, Wales and Northern Ireland, the period of time between when a suicide occurs and when the death is registered can be a number of months. In Scotland delays in registration are minimal as deaths are required to be registered within 8 days.

Rates also differ because Inquiry calculations are based upon the number of people in the general population aged 10 and over. ONS rates include suicides aged 15 and over, whilst GROS and NISRA rates are based on the whole population (including those aged under 10) which means the denominator is bigger and the resulting rates are lower. Both ONS and GROS also calculate rates based on European age-standardised population data (to adjust for differences in age structure across countries). Further details regarding rate differences can be found in the reports Lessons for Mental Health Care in Scotland (page 27) and Suicide and Homicide in Northern Ireland (page 23).
In addition to general population suicide rates, the Mental Health Minimum Dataset (MHMDS) was used to ascertain rates of suicide in those in contact with NHS mental health services in England. Rates of suicide (for England only based on clinical denominators from the MHMDS) were calculated for the years that currently overlap with Inquiry data (2004-2011) (see section 1.1.2, Figure 7). During this period there was an average of 1,233,551 people in contact with NHS mental health services each year in England.

In April 2011 a new version of the MHMDS (version 4) was introduced with changes in data collection and processing. This has led to improvements in the accuracy of returns by providers and now also incorporates NHS funded services provided by Independent Sector Providers. This has resulted in a significant increase to overall numbers of people in contact with mental health services in 2011/2012.  

Changes to the coding of causes of death

In 2011, the introduction of a new version of the International Classification of Disease (ICD-10) software (version 2010) changed the coding rules for certain drug-related deaths. Consequently, some deaths from ‘drug abuse’ and ‘acute intoxication’ previously coded under ‘mental and behavioural disorders’ are now coded as ‘self-poisoning of undetermined intent’ and therefore included in suicide statistics. Both ONS and the National Records of Scotland (NRS) have implemented these changes to coding practice. The new coding rules have not made a significant impact to suicide figures in England and Wales; analysis by ONS showed a 2% increase in undetermined intent deaths. In contrast, it has made a significant difference to the number of suicides recorded in Scotland. Figures from the NRS, for example, show there were 772 registered suicides in 2011 using the old coding rules, and 889 suicides using the new rules (www.scotpho.org.uk). Comparisons between suicide numbers and rates in Scotland for 2001 to 2010, and 2011 should, therefore, be treated with caution as these two time periods are not directly comparable. More information on the change in coding rules can be found on the ONS website (www.ons.gov.uk) and the Scottish Public Health Observatory (ScotPHO) website (www.gro-scotland.gov.uk).

Narrative verdicts

Over the past decade, coroners have increasingly returned narrative verdicts. These record the circumstances of a death rather than providing a ‘short form’ verdict such as suicide, accident, or natural causes. Prior to 2011, some narrative verdicts were coded as accidental deaths where intent was not specified which may have led to an underestimation of suicide. However, in 2011 guidance was issued to coroners in England and Wales when returning narrative verdicts to provide clearer information on the intent of the deceased. This has led to improvements in the coding of narrative verdicts by the ONS coding team, and some cases which would previously be coded as accidental may now be coded as suicide. The impact of these changes, therefore, is to potentially increase the number of suicides in 2011, although the anticipated increase is likely to be small. Further information can be found on the ONS website (www.ons.gov.uk).

The Inquiry database is dynamic. Changes in annual figures will occur subject to further information received from coroners or as a result of additional court hearings, e.g. following a successful appeal against a homicide conviction.
1. ENGLAND

1.1 SUICIDE

Between 2001-2011, the Inquiry was notified of 48,814 deaths in the general population that received a suicide or undetermined verdict. These are referred to as suicides throughout the report.

1.1.1 Suicide in the general population

- There are usually 4,000-4,500 suicides per year, with a male to female ratio of 3:1 (Table 1).
- Our figures are based on date of death, unlike ONS who use date of death registration (see page 13).
- Delayed registration means that figures for the most recent years presented here will increase; the figure in 2010 which we published last year is now 7% higher. A 7% increase in 2011 would increase the figure to 4,388 suicides.
- This would represent a small increase over 2009-2010, although these figures may be low because of uncertainty in the coding of narrative verdicts.
- Rising figures for 2008 and 2011 are assumed, in part, to reflect financial pressures leading to unemployment and debt.
- Despite an increase in 2008, there was an overall fall in the number and rate of suicides between 2001 and 2010 (Table 1; Figure 1). This pattern was seen in both males and females.
- There was a fall in male suicide rates in those aged under 25, 25-34, and 65 and over but an increase in those aged 45-64 (Figure 2). In females, rates fell in those aged 25-34, 35-44, and 65 and over (Figure 3).

Table 1: Number of suicides in the general population, by gender

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3442</td>
<td>3439</td>
<td>3430</td>
<td>3427</td>
<td>3312</td>
<td>3197</td>
<td>3229</td>
<td>3466</td>
<td>3285</td>
<td>3225</td>
<td>3155</td>
</tr>
<tr>
<td>Female</td>
<td>1154</td>
<td>1187</td>
<td>1228</td>
<td>1241</td>
<td>1151</td>
<td>1024</td>
<td>1015</td>
<td>1146</td>
<td>1037</td>
<td>1078</td>
<td>946</td>
</tr>
<tr>
<td>Total</td>
<td>4596</td>
<td>4626</td>
<td>4658</td>
<td>4668</td>
<td>4463</td>
<td>4221</td>
<td>4244</td>
<td>4612</td>
<td>4322</td>
<td>4303</td>
<td>4101</td>
</tr>
</tbody>
</table>
Figure 1: Rates of suicide in the general population, by gender
Figure 2: Rates of male suicide in the general population, by age-group
Figure 3: Rates of female suicide in the general population, by age-group

Suicide rate per 100,000 population

- Under 25
- 25-34
- 35-44
- 45-64
- 65+

Year

**Variation in suicide by NHS region**

- There was some variation in suicide rates by region of residence (by NHS England boundaries) at the time of death (average rate 2009-2011). The highest rate of suicide was in the North of England at 9.9 per 100,000 population and the lowest in London at 8.0 per 100,000 population (Figure 4).

- These figures are based on populations aged 10 and over. ONS uses populations aged 15 and over as a denominator (see page 13) and our figures are therefore lower.

**Figure 4: Rate of suicide per 100,000 population by NHS region of residence (average rate 2009-2011)**
Method of suicide

- The most common methods of suicide were hanging/strangulation (referred to as hanging in the remainder of this report) (44%), self-poisoning (overdose) (23%), and jumping/multiple injuries (mainly jumping from a height or being struck by a train) (10%). Less frequent methods were drowning (5%), carbon monoxide (CO) poisoning (4%), cutting/stabbing (3%), and firearms (2%).

- Over the period 2001-2010 there were changes in method of suicide. Suicide deaths by hanging increased, although they have fallen since a peak in 2008 (Figure 5). Deaths by self-poisoning decreased over the report period, and those by jumping/multiple injuries did not change. Of the less common methods, deaths by drowning and CO poisoning decreased (Figure 6).

- The fall in CO poisoning deaths is related to the introduction of catalytic converters in 1993. 21

- Firearms account for 2% of all suicides. This is a more common method in countries with greater gun availability.

- The fall in drowning is unexplained.
Figure 6: Suicide in the general population: other causes of death
### 1.1.2 Patient suicide

**Patient suicide: numbers and rates**

- During 2001-2011, 13,469 deaths (28% of general population suicides) were identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. This represents an average of 1,224 patient suicides per year.

- Part of the increase in patient suicide in 2011 may reflect rising numbers of people under mental health care. To address this, we have calculated rates with figures from the Mental Health Minimum Dataset (MHMDS) as the denominator (Figure 7). Falling rates are seen from 2004. However, changes in MHMDS methodology means rates in 2011 are not directly comparable to earlier years (see page 14).

- Suicides in patients aged under 25 and those aged 25-44 fell in the report period. A rise in 2011 is projected for most age-groups but not in those aged under 25 (Figure 8).

- 88 (1%) patient suicides were aged under 18, an average of 8 per year, with no overall trend.

- In 2008-2010, a higher proportion of patients were unemployed (44%) compared to 2001-2003 (40%).

---

**Table 2: Number of patient suicides, by gender**

<table>
<thead>
<tr>
<th>Year</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>845</td>
<td>416</td>
<td>1261</td>
</tr>
<tr>
<td>2002</td>
<td>834</td>
<td>416</td>
<td>1250</td>
</tr>
<tr>
<td>2003</td>
<td>800</td>
<td>456</td>
<td>1256</td>
</tr>
<tr>
<td>2004</td>
<td>866</td>
<td>451</td>
<td>1317</td>
</tr>
<tr>
<td>2005</td>
<td>794</td>
<td>482</td>
<td>1276</td>
</tr>
<tr>
<td>2006</td>
<td>740</td>
<td>382</td>
<td>1122</td>
</tr>
<tr>
<td>2007</td>
<td>760</td>
<td>378</td>
<td>1138</td>
</tr>
<tr>
<td>2008</td>
<td>802</td>
<td>403</td>
<td>1205</td>
</tr>
<tr>
<td>2009</td>
<td>768</td>
<td>368</td>
<td>1136</td>
</tr>
<tr>
<td>2010</td>
<td>776</td>
<td>399</td>
<td>1175</td>
</tr>
<tr>
<td>2011</td>
<td>909</td>
<td>424</td>
<td>1333</td>
</tr>
</tbody>
</table>

* projected figure
Figure 7: Rates of suicide per 100,000 mental health service users †

† The Mental Health Minimum Dataset (MHMDS) was used to calculate rates for the available years (2004-2011). Changes in MHMDS methodology means rates between 2004-2010 and 2011 are not directly comparable.
Figure 8: Number of patient suicides, by age-group
Method of suicide by patients

- The most common methods of suicide by patients were hanging/strangulation (40%), self-poisoning (27%), and jumping/multiple injuries (16%).

- Hangings increased in number during 2001-2010 and a further rise is projected in 2011 (Figure 9).

- Self-poisoning fell overall in 2001-2010 but there has been no fall since 2006 (Figure 9). A projected rise in 2011 may be partly a re-coding effect (see page 14).

- Opiates were the most common type of drug in self-poisoning (708, 22%) (Figure 10). Of those who died using opiates, 18% had a primary diagnosis of drug dependence/misuse and 18% were under the care of drug services – this is high within our sample but still a minority. Twenty-seven percent of those aged under 25 who died by self-poisoning used opiates.

- The next most common substances used in deaths by self-poisoning were tricyclic antidepressants (15%) and paracetamol/opiate compounds (12%). The number of self-poisoning deaths by tricyclic antidepressants and paracetamol fell during 2001-2010 (Figure 10).
Figure 10: Patient suicide: main substances used in deaths by self-poisoning
In-patient suicide

- There were 1,447 in-patient deaths by suicide during the report period, 11% of patient suicides, an average of 132 per year.

- From 2001 to 2010, there was a 58% fall in the number of in-patient suicides (Figure 11). We are projecting a continuation of this trend in 2011- a fall to 5% of all patient suicides. A reduction in the rate of in-patient suicide has previously been found (i.e. taking into account admission figures and time under in-patient care). 22, 23

- Deaths by hanging/strangulation on the ward are usually from low-lying ligature points (i.e. strangulation). After little change from 2007, we are projecting a further fall in 2011 (Figure 11).
Detained in-patients

- There were 375 (26%) in-patients detained under the Mental Health Act who died by suicide, an average of 34 per year. The number of these deaths decreased between 2001 and 2010 but have remained at an average of 23 per year since 2008 (Figure 12).

- 139 (38%) detained in-patients died on the ward; in 40% this was an open ward.

- 30 (8%) detained patients died in the first week of admission (compared to 17% of other in-patient suicides).

Figure 12: Number of detained in-patients who died by suicide
Absconding

- There were 351 in-patients who died after absconding from the ward, 24% of all in-patient suicides, an average of 32 deaths per year.

- There was an overall fall in the number of suicides after absconding (Figure 13). Numbers have been substantially lower since 2006, and we are projecting a further fall in 2011.
Community Treatment Orders

- There were 20 suicide deaths among patients subject to a community treatment order (CTO) between 2008-2011, less than 1% of all patient suicides in this time period. In addition, 13 patients who died had previously been on a CTO but were not on a CTO at the time of suicide.

- The rate of suicide in patients under CTO was 1.5 per 1,000 CTOs in 2008-2011. This figure is higher than the suicide rate for all patients, as would be expected as CTO patients are selected for risk and in general are recently discharged. It is not clear whether CTOs have reduced risk.

- 12 of the 20 deaths under CTO occurred within 3 months of hospital discharge.

- 4 suicides subject to a CTO had refused drug treatment in the month before death and 5 had missed the last appointment with services, 2 of these 9 patients had both refused treatment and missed the last appointment. In around half of these deaths, the CTO had not worked as intended.
Crisis Resolution/Home Treatment

- There were 1,508 suicides in patients under crisis resolution/home treatment teams (CR/HT), 12% of the total sample, an average of 137 deaths per year. Since 2006, there have been 150-200 suicides per year under CR/HT (Figure 14).

- Since 2006 there have been more patient suicides under CR/HT than in in-patient care, reflecting a change in the nature of acute care. In the last 3 years over twice as many suicides have occurred under CR/HT.

- 462 (34%) CR/HT patients died within 3 months of hospital discharge. In many of these cases CR/HT will have been used to allow earlier discharge rather than as an alternative to admission. 181 (40%) of these patients died within 2 weeks of discharge.

- 198 (14%) CR/HT patients had refused drug treatment in the month before suicide.

- 628 (44%) CR/HT patients lived alone.
Patients recently discharged from hospital

- There were 2,480 suicides within 3 months of discharge from in-patient care, 18% of all patients and 21% of suicides by community patients, an average of 225 deaths per year.

- There was an overall fall in the number of post-discharge suicides between 2001-2010, although our projected figures show a rise in 2011 (Figure 15).

- Post-discharge suicides were most frequent in the first week after leaving hospital when 375 deaths occurred, an average of 34 per year, 15% of all suicides within 3 months of hospital discharge (Figure 16).
Figure 16: Number of patient suicides per week following discharge (2001-2011)
Treatment refusal

- There were 1,684 suicides in which the patient was known to have refused drug treatment in the month before death, 14% of the total sample, an average of 153 deaths per year.

- There has been no trend in 2001-2010 in the number or proportion of patient suicides characterised by recent treatment refusal. Numbers appeared to be falling in 2004-2007 but this fall has not been maintained (Figure 17).
Missed contact

- There were 3,115 suicides by people who missed their final service contact, 26% of the total sample, an average of 283 deaths per year.

- There was an overall fall in 2001-2010 in the number of patient suicides following missed contact, although there has been no continuing fall in 2010 and 2011 (Figure 18).
Alcohol and drug misuse

- There were 5,880 suicides in patients with a history of alcohol misuse, 45% of the total sample, an average of 535 deaths per year.

- 4,079 patient suicides had a history of drug misuse, 31% of the total sample, an average of 371 deaths per year.

- There were 7,055 patients who had a history of either alcohol or drug misuse or both, 54% of patient suicides, an average of 641 deaths per year.

- Between 2001 and 2010, the number of patient suicides with a history of alcohol or drug misuse did not change, although we project a rise in 2011 (Figure 19).

- 1,115 (8%) patient suicides had a primary diagnosis of alcohol dependence/misuse; 543 (4%) had drug dependence/misuse. The number with alcohol or drug dependence/misuse did not change over the report period.

- 1,970 (15%) patient suicides had severe mental illness and co-morbid alcohol or drug dependence/misuse (dual diagnosis), an average of 179 deaths per year. There was no trend during the report period overall (Figure 20) but numbers have fallen since a peak in 2004.

Figure 19: Patient suicide: number with a history of alcohol or drug misuse

[Graph showing suicide numbers over years with trends for alcohol misuse, drug misuse, and alcohol or drug misuse.]
Figure 20: Patient suicide: number with dual diagnosis (severe mental illness and alcohol or drug dependence/misuse)
Patients with schizophrenia

- There were 2,359 suicides by patients with a primary diagnosis of schizophrenia, 18% of the total sample, an average of 214 deaths per year.

- There was an overall fall in the number of suicides by patients with schizophrenia between 2001 and 2010 (Figure 21). In 2001-2005, the annual average number was 235 while in 2006-2010 it was 195.

- We are projecting an increase in suicides by patients with schizophrenia in 2011, consistent with the increase in patients overall (Table 2).

- 530 patients with schizophrenia had refused drug treatment in the month before death, 23% of the sample (excluding unknowns), an average of 48 deaths per year.

- 511 (27% excluding unknowns) had missed their last appointment with services, an average of 46 deaths per year.
1.2 HOMICIDE

The Inquiry was notified by Home Office Statistics of 6,065 homicide convictions in the report period, 2001-2011. A psychiatric report was obtained on 1,930 (32%) homicide perpetrators.

1.2.1 Homicide in the general population

- The annual number of convictions in the general population is shown in Figure 22. These figures are provided as context for our data on homicides by people with mental illness. More recent statistics are published (for England and Wales) by the Office for National Statistics.3

- There has been a decrease in the number of people convicted of homicide over the report period from a peak in 2008 (Figure 22).

- The apparent fall in homicide convictions is large and may have three components: (1) a true fall in homicide; (2) delays in the legal process; (3) delays in data notification following conviction. We are not aware of any fall in the rate of conviction.

- A recent fall in homicide incidents has been reported by the Office for National Statistics.3 However, the fall in convictions in 2011 is likely to be explained in part by delays in the legal process and/or in data notification. The figures for 2011 are likely to be incomplete to an unknown degree and trends in this report have excluded 2011 for this reason.

- The most common method was the use of a sharp instrument (40% of the total sample).
Figure 22: Number of homicide convictions in the general population, by gender of perpetrator
Relationship to victim of perpetrator

- The relationship of victim to perpetrator was: acquaintance (2,006, 41%); stranger (1,282, 26%); spouse/partner (including ex spouse/partner) (959, 20%); and other family member (634, 13%).

- There has been a fall in the number and proportion of victims who were family members and spouse/partners (including ex spouse/partners) over the report period.

- There has been an increase in the proportion of stranger homicides, but not in the number.

Variation in homicide by NHS region

- There was some variation in homicide conviction rates by NHS region of residence (2008-2010). The highest rate was in London and the lowest in the South of England region (Figure 23).
1.2.2 Homicide by mentally ill people in the general population

Perpetrators who had symptoms of mental illness at the time of the homicide

- The number of people during the report period with an abnormal mental state at the time of the homicide was 602, 10% of the total sample, an average of 55 per year.

- 358 were psychotic at the time of the offence, 6% of the total sample, an average of 33 per year.

- There has been a fall in homicide by people with mental illness, including people with psychosis; this follows a rise in the years up to 2004 (Figure 24).

- Although the figures for 2011 and, to a lesser extent, 2010 are incomplete, the fall since 2004 is large and can not be explained by legal or data delays.
1.2.3 Patient homicide

- During 2001-2011, 615 people convicted of homicide (10% of the total sample) were identified as patients, i.e. the person had been in contact with mental health services in the 12 months prior to the offence, an average of 56 homicides per year.

- The number of patient homicides has fallen since a peak in 2006, especially in 2009-2010. Numbers rose in the years up to 2006. The number of homicides in 2010 was the lowest recorded over the report period, although an increase was projected for 2011.

- The lower patient homicide figures in 2009-2010 are more pronounced in men, figures for females being already low (Figure 25), and are found across the age range (Figure 26).

- One homicide was committed by a patient subject to a community treatment order (CTO); another 1 by a patient who had previously been on a CTO.
Figure 26: Number of patient homicides, by age-group of perpetrator
Relationship of victim to perpetrator

- The relationship of victim to perpetrator was: acquaintance (214, 41%); family member (112, 21%); spouse/partner (including ex spouse/partner) (111, 21%); and stranger (89, 17%) (Figure 27).

- For male patients, the relationship of victim to perpetrator was: acquaintance (188, 44%); family member (79, 18%); spouse/partner (including ex spouse/partner) (84, 19%); and stranger (84, 19%).

- For female patients, the relationship of victim to perpetrator was: family member (33, 37%); spouse/partner (including ex spouse/partner) (27, 30%); acquaintance (26, 29%); and stranger (5, 6%).

- There were 89 (17%) stranger homicides, an average of 8 per year. The number of stranger homicides has fallen since a peak in 2006, having risen in the previous years.

- There were 79 (13%) homicides in which a male patient killed a female spouse, an average of 7 per year.
Treatment refusal

- There were 82 patients (16%) known to have refused drug treatment in the month before the homicide, an average of 7 per year.

- The numbers have been lower in 2009-2011, having risen in the period leading up to 2006 (Figure 28).

- In 2009-2011, treatment refusal was reported in 14% of patient homicides compared to 20% in 2006-2008. However, this difference does not reach statistical significance.
Missed contact

- There were 227 patients (40%) who missed their last appointment with services before the homicide occurred, an average of 21 per year.

- The numbers have been lower in 2009-2011, having risen in the years up to 2006 (Figure 29).

- In 2009-2011, missed final contact was reported in 35% of patient homicides, compared to 43% in 2006-2008. However, this difference does not reach statistical significance.
Crisis Resolution/Home Treatment

• 20 patients were under crisis resolution/home treatment teams (CR/HT) at the time of the homicide, 4% of the patient sample, an average of 2 per year, ranging between 0 and 6.

• 16 of these 20 occurred in the years 2005-2009. There has been 1 homicide by a patient under CR/HT notified to us in 2010-2011.

Alcohol and drug misuse

• There were 414 patients with a history of alcohol misuse, 74% of the patient sample, an average of 38 per year.

• 435 patients had a history of drug misuse, 76% of the patient sample, an average of 40 per year.

• There were 527 patients who had a history of either alcohol or drug misuse or both, 90% of patients, an average of 48 homicides per year.

• Between 2001 and 2010, there was a fall in the number of patients with a history of alcohol misuse. Whilst the number with drug misuse did not change overall, there has been a fall since a peak in 2006 (Figure 30).

72 (12%) patients had a primary diagnosis of alcohol dependence/misuse; 82 (14%) had drug dependence/misuse. The number with alcohol or drug dependence/misuse did not change over the report period.

144 (24%) patients had severe mental illness and co-morbid alcohol or drug dependence/misuse (dual diagnosis), an average of 13 per year. The number with dual diagnosis has fallen since a peak in 2005 but we predict an increase in 2011 (Figure 31).
Figure 30: Patient homicide: number with a history of alcohol or drug misuse
Figure 31: Patient homicide: number with dual diagnosis (severe mental illness and alcohol or drug dependence/misuse)
**Homicide and schizophrenia**

- There were 357 homicides by people with schizophrenia (based on lifetime history) over 2001-2011, 6% of the total sample, an average of 32 per year.

- There has been a decrease in the number of homicides by people with schizophrenia since 2004 (Figure 32).

- 191 (54%) were patients, an average of 17 per year (Figure 32).

- The figures for homicide by patients with schizophrenia in 2009-2011 are the lowest in the report period and the lowest since data collection began in 1997.

- 48 (28%) patients with schizophrenia had refused drug treatment in the month before the homicide.

- 68 (40%) patients with schizophrenia missed their last appointment with services before the homicide occurred, an average of 6 per year, with a peak of 13 in 2006.
1.3 SUDDEN UNEXPLAINED DEATH IN MENTAL HEALTH IN-PATIENTS (SUD)

- There were 355 SUD cases over the report period, an average of 32 per year (Figure 33).

- There was an overall fall in the number of SUD cases over the report period. However, due to a change in data provider, recent numbers are not strictly comparable with historical data.

- 162 (50%) had a history of cardiovascular disease; 82 (26%) had a history of respiratory disease; 48 (15%) had a history of cerebrovascular disease, and 29 (9%) had a history of epilepsy.

- 27 (8%) were receiving 2 or more antipsychotic drugs (i.e. polypharmacy).

- No SUD cases were receiving antipsychotic drug doses above British National Formulary (BNF) limits.

- There were 5 deaths within 1 hour of restraint over the report period.

Note: between 2006 and 2007 data providers changed from the NHS-Wide Clearing Service (NWCS) to Hospital Episode Statistics (HES), therefore the numbers before and after 2006 are not strictly comparable.
Patient ethnicity

- There were 45 SUD cases in patients from black and minority ethnic (BME) groups over the report period. The number of these deaths varied from 1-8 per year, and showed no clear pattern over time.

- There were 18 deaths within 24 hours of restraint between 2002 and 2011. The number ranged from 0-4 per year. Six of these post-restraint deaths were from a BME group. We do not know whether restraint caused these deaths.

- The number of post-restraint deaths is too small to identify a trend. In the last 5 years of data collection (2007-2011) there were 11 deaths within 24 hours, of which 4 were in BME patients.

Patients aged under 45

- There were 91 (26%) cases of SUD in patients under 45 years. There was no trend in these cases over the report period.

- Those aged under 45 were more likely to be male than older SUD cases (64 cases, 70% v. 152 cases, 58%) and more likely to be from a BME group (24 cases, 26% v. 21 cases, 8%).

- 18 (23%) had a history of cardiovascular disease; 15 (19%) had a history of respiratory disease and 9 (11%) had a history of epilepsy. There were no SUD cases aged under 45 with a history of cerebrovascular disease.

- 16 (20%) patients were receiving 2 or more antipsychotic drugs (i.e. polypharmacy).
2. NORTHERN IRELAND

2.1 SUICIDE

Between 2001-2011, the Inquiry was notified of 2,511 deaths in the general population that received a suicide or undetermined verdict. These are referred to as suicides throughout the report.

2.1.1 Suicide in the general population

- There was an overall increase in the number and rate of suicides over the 10-year period, although a fall is predicted in 2011 (Table 3; Figure 34).

- Our figure for 2010 has increased by 6% since it was estimated in last year’s report. If this year’s estimate for 2011 increases by the same percentage, it will reach 245, lower than in 2010 but in keeping with higher figures in recent years.

- The increase in 2001-2010 was observed in males and females overall (Figure 34). The increase was specifically found in men aged under 25, 35-44 and 45-64, and in women aged 35-44 (Figures 35 and 36).

Table 3: Number of suicides in the general population, by gender

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>139</td>
<td>159</td>
<td>123</td>
<td>175</td>
<td>180</td>
<td>173</td>
<td>195</td>
<td>203</td>
<td>172</td>
<td>226</td>
<td>175</td>
</tr>
<tr>
<td>Female</td>
<td>41</td>
<td>45</td>
<td>41</td>
<td>62</td>
<td>50</td>
<td>53</td>
<td>66</td>
<td>55</td>
<td>58</td>
<td>64</td>
<td>56</td>
</tr>
<tr>
<td>Total</td>
<td>180</td>
<td>204</td>
<td>164</td>
<td>237</td>
<td>230</td>
<td>226</td>
<td>261</td>
<td>258</td>
<td>230</td>
<td>290</td>
<td>231</td>
</tr>
</tbody>
</table>
Figure 34: Rates of suicide in the general population, by gender
Figure 35: Rates of male suicide in the general population, by age-group
Figure 36: Rates of female suicide in the general population, by age-group
Variation in suicide by region

- There was some variation in suicide rates by region (as determined by the Health and Social Care Trust of residence) at the time of death (2009-2011). The highest rate of suicide was in the Eastern Area, at 17.8 per 100,000 population, and the lowest in the Northern Area at 13.8 per 100,000 population (Figure 37).
Method of suicide

- The most common methods of suicide were hanging/strangulation (56%), self-poisoning (overdose) (23%), and drowning (8%). Less frequent methods were firearms (4%), carbon monoxide (CO) poisoning (2%), jumping/multiple injuries (mainly jumping from a height or being struck by a train) (2%), and cutting/stabbing (1%).

- Between 2001 and 2010 deaths by hanging and self-poisoning increased (Figure 38). However, hanging rose steadily to 2010 whilst self-poisoning reached a peak in 2004 and subsequently fluctuated.
### 2.1.2 Patient suicide

**Patient suicide: numbers and rates**

- During 2001-2011, 713 suicides (28% of general population suicides) were identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. This represented an average of 65 patient suicides per year.

- Despite the large increase in suicides in the general population, there was no overall change between 2001 and 2010 in the number or rate of suicide (using a general population denominator) (Table 4; Figure 39).

- The number of patient suicides increased in those aged 45-64 over the period 2001-2010 (Figure 40).

- 6 (1%) patient suicides were aged under 18.

- In 2008-2010, a higher proportion of patients were unemployed (47%) compared to 2001-2003 (36%).

### Table 4: Number of patient suicides, by gender

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>40</td>
<td>49</td>
<td>33</td>
<td>47</td>
<td>49</td>
<td>43</td>
<td>49</td>
<td>50</td>
<td>42</td>
<td>46</td>
<td>49</td>
</tr>
<tr>
<td>Female</td>
<td>17</td>
<td>17</td>
<td>12</td>
<td>26</td>
<td>15</td>
<td>17</td>
<td>27</td>
<td>25</td>
<td>21</td>
<td>20</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td>66</td>
<td>45</td>
<td>73</td>
<td>64</td>
<td>60</td>
<td>76</td>
<td>75</td>
<td>63</td>
<td>66</td>
<td>68</td>
</tr>
</tbody>
</table>

* projected figure
Figure 39: Rates of patient suicide, by gender
Figure 40: Number of patient suicides, by age-group
Method of suicide by patients

- The most common methods of suicide by patients were hanging/strangulation (49%), self-poisoning (31%), and drowning (11%).

- Deaths by hanging increased overall between 2001 and 2010, although the peak year was 2007 (Figure 41). Figures for other methods did not change. However, our projections for 2011 suggest that figures for hanging and self-poisoning will become closer.

- No patient suicide by firearms has been reported to us since 2005.

- The most common substances used in self-poisoning were opiates (24%), anti-psychotic drugs (12%), benzodiazepines/hypnotics (11%), and paracetamol/opiate compounds (9%). There were no trends in substances used in deaths by self-poisoning over the report period.
In-patient suicide

- There were 38 in-patient suicides during 2001-2011, 5% of patient suicides, an average of 3 deaths per year.

- The number of in-patient suicides peaked in 2002, after which there was a steady fall, with a smaller peak in 2009. No in-patient suicides were reported to us in 2011 (Figure 42).

- 6 patients died on the ward by hanging over the report period; this number fluctuated from 0 to 2 per year.

- 7 (18%) detained in-patients died by suicide over the report period.

- There were 13 in-patients who died after absconding from the ward, 34% of all in-patient suicides, an average of 1 death per year.

Figure 42: Patient suicide: number of mental health in-patients
Crisis Resolution/Home Treatment

- There were 33 suicides in patients under crisis resolution/home treatment teams (CR/HT), 5% of the total sample, an average of 3 deaths per year.

- From 2005 there have been 24 suicides in patients under CR/HT, compared to 16 in inpatient care.

- There was no overall trend in the number of suicides under CR/HT, but the highest figure was in 2007 (7 deaths).

- 14 (44%) CR/HT patients died within 3 months of discharge.

- 10 (31%) CR/HT patients lived alone. Three (9%) had refused drug treatment in the month before suicide.
Patients recently discharged from hospital

- There were 160 suicides within 3 months of discharge from in-patient care, 22% of all patients and 24% of suicides by community patients, an average of 15 deaths per year.

- There was an overall fall in the number of post-discharge suicides between 2001-2010, although there has been no fall since 2005 (Figure 43).

- Post-discharge suicides were most frequent in the first week after leaving hospital when 35 deaths occurred.
Treatment refusal

- There were 74 suicides in which the patient was known to have refused drug treatment in the month before death, 12% of the total sample, an average of 7 deaths per year.

- There was no overall trend in the number of patient suicides following treatment refusal, although in recent years numbers have fallen since a peak in 2007 (Figure 44).
Missed contact

- There were 192 suicides by people who missed their last appointment with services, 29% of the total sample, an average of 17 deaths per year.

- Between 2001 and 2010, there was an overall increase in the number of patient suicides following missed contact (Figure 45).

Figure 45: Patient suicide: number of patients who missed their last appointment with services
Alcohol and drug misuse

- There were 435 suicides in people with a history of alcohol misuse, 61% of the total sample, an average of 40 deaths per year.

- 252 patient suicides had a history of drug misuse, 37% of the total sample, an average of 23 deaths per year.

- There were 478 patients who had a history of either alcohol or drug misuse or both, 68% of patient suicides, an average of 43 deaths per year.

- Between 2001 and 2010, there was an overall increase in the number of patient suicides with a history of drug misuse, whilst the number with a history of alcohol misuse did not change (Figure 46).

- 138 (20%) patient suicides had a primary diagnosis of alcohol dependence/misuse; 45 (6%) had drug dependence/misuse. The number with alcohol or drug dependence/misuse did not change over the report period.

- 111 (16%) patient suicides had severe mental illness and co-morbid alcohol or drug dependence/misuse (dual diagnosis). The number with dual diagnosis peaked in 2008 but there was no trend over the report period (Figure 47).
Figure 47: Patient suicide: number with dual diagnosis (severe mental illness and alcohol or drug dependence/misuse)
Patients with schizophrenia

- There were 99 suicides by patients with a primary diagnosis of schizophrenia, 14% of the total sample, an average of 9 deaths per year.

- There was no overall trend in the number of suicides by patients with schizophrenia although numbers fell after a peak in 2007 and we project a continued fall in 2011 (Figure 48).

- 17 (18%) patients with schizophrenia had refused drug treatment in the month before death; 22 (24%) had missed their last appointment with services.
2.2 HOMICIDE

The Inquiry was notified by the Northern Ireland Courts and Tribunal Service of 199 homicide convictions in the report period, 2001-2011. A psychiatric report was obtained on 112 (56%) homicide perpetrators.

2.2.1 Homicide in the general population

- The number of homicide convictions in the general population notified to us is shown in Figure 49. These figures are provided as context for our data on homicides by people with mental illness. More recent homicide statistics are published by Police Service Northern Ireland.11

- There has been an apparent increase in homicide convictions over the report period (Figure 49). However, because of previous problems in data processes, this change should be treated with caution. Figures have been consistent since 2007.

- The most common method of homicide was the use of a sharp instrument (40% of the total population).

- The relationship of victim to perpetrator was: acquaintance (72, 41%); stranger (54, 31%); spouse/partner (including ex spouse/partner) (37, 21%); and other family member (12, 7%).
2.2.2 Homicide by mentally ill people in the general population

Perpetrators who had symptoms of mental illness at the time of the homicide

• 16 people had an abnormal mental state at the time of the offence, 8% of the total sample, ranging between 0 and 4 annually.

• 8 people over the report period (4% of the total sample) had symptoms of psychosis at the time of the offence, ranging between 0 and 2 annually.

2.2.3 Patient homicide

• During 2001-2011, 26 people convicted of homicide (13% of the total sample) were identified as patients, i.e. the person had been in contact with mental health services in the 12 months prior to the offence. This was an average of 2 patient homicides per year, ranging between 1 and 4 annually.

• The numbers fluctuated over the period of the report. In this section the numbers were too small to examine trends over time.

Relationship of victim to perpetrator: patient homicide

• The relationship of victim to perpetrator was: acquaintance (15, 63%); spouse/partner (including ex spouse/partner) (7, 29%); family member (1, 4%); and stranger (1, 4%).

• The victims for male patients were most likely to be acquaintances, whereas female patients killed a spouse/partner.

Treatment refusal

• 5 patients (25%) were known to have refused drug treatment in the month before the homicide.

Missed contact

• 12 patients (52%) had missed their last appointment with services before the offence, ranging between 0 and 2 annually.
**Alcohol and drug misuse**

- 24 patients had a history of alcohol misuse, 100% of the patient sample (excluding unknowns). This was an average of 2 patient homicides per year, ranging between 1 and 4 annually.

- 20 patients had a history of drug misuse, 83% of the patient sample, an average of 2 per year, ranging between 1 and 3 annually.

- There were 25 patients who had a history of either alcohol or drug misuse or both, 100% of patients, an average of 2 homicides per year.

- 7 (27%) patients had a primary diagnosis of alcohol dependence/misuse; 1 (4%) had drug dependence/misuse.

- 7 (29%) patients had severe mental illness and co-morbid alcohol or drug dependence/misuse (dual diagnosis).

**Homicide by people with schizophrenia**

- There were 7 homicides by people with schizophrenia (based on lifetime history) over the report period, 4% of the total sample.

- 4 (57%) people with schizophrenia were patients.

- 3 of the patients with schizophrenia were known to have refused drug treatment in the month before the homicide.

- 2 of the patients with schizophrenia missed their last appointment with services before the homicide.
3. SCOTLAND

3.1 SUICIDE

Between 2001-2011, the Inquiry was notified of 9,065 deaths in the general population that received a suicide or undetermined verdict. These are referred to as suicides throughout the report.

3.1.1 Suicide in the general population

- There was an overall fall in the rate and the number of suicides over the report period (Table 5; Figure 50). An apparent increase in 2011 occurred due to the introduction of new death coding rules (see page 14). Comparisons between suicide numbers and rates for 2001 to 2010, and 2011 should, therefore, be treated with caution as these two time periods are not directly comparable. Based on the old coding rules, we calculate there would have been 118 fewer suicides in 2011, making the total 775 and therefore closer to the figures seen in 2009 and 2010.

- The fall in rates over 2001-2010 was seen in males and females (Figure 50).

- The fall in gender-specific rates occurred particularly in the youngest and oldest groups – in men, those aged under 25, 25-34, and 65 and over; in women, those aged 65 and over (Figures 51 and 52).

- In males, numbers but not rates rose in those aged 45-64.

Table 5: Number of suicides in the general population, by gender using the new death coding rules

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>633</td>
<td>670</td>
<td>576</td>
<td>620</td>
<td>560</td>
<td>594</td>
<td>622</td>
<td>628</td>
<td>559</td>
<td>581</td>
<td>640</td>
</tr>
<tr>
<td>Female</td>
<td>240</td>
<td>220</td>
<td>218</td>
<td>224</td>
<td>220</td>
<td>174</td>
<td>214</td>
<td>213</td>
<td>205</td>
<td>201</td>
<td>253</td>
</tr>
<tr>
<td>Total</td>
<td>873</td>
<td>890</td>
<td>794</td>
<td>844</td>
<td>780</td>
<td>768</td>
<td>836</td>
<td>841</td>
<td>764</td>
<td>782</td>
<td>893</td>
</tr>
</tbody>
</table>

† This figure would fall to 775 using the old death coding rules
Figure 50: Rates of suicide in the general population, by gender

Note: figures for 2011 include suicides using the new death coding rules (see page 14)
Figure 51: Rates of male suicide in the general population, by age-group

Note: figures for 2011 include suicides using the new death coding rules (see page 14)
Figure 52: Rates of female suicide in the general population, by age-group

Note: figures for 2011 include suicides using the new death coding rules (see page 14)
Variation in suicide by region

- There was some variation in suicide rates by Health Board of residence at the time of death (2009-2011). The highest rate of suicide was in the Shetlands, at 25.3 per 100,000 population but the small numbers and small population there make it difficult to compare with other Health Boards (Figure 53). The lowest rate was in the Western Isles at 12.7 per 100,000 population, but again small numbers and populations may lead to large fluctuations in rates.
Method of suicide

- The most common methods of suicide were hanging/strangulation (36%), self-poisoning (overdose) (32%), and jumping/multiple injuries (mainly jumping from a height or being struck by a train) (10%). Less frequent methods were drowning (9%), carbon monoxide (CO) poisoning (3%), firearms (2%), and cutting/stabbing (2%).

- Over the period 2001-2010 there were changes in method of suicide. Suicide deaths by hanging increased steadily (Figure 54). The apparent increase in suicides by self-poisoning in 2011 is the result of additional cases arising from the new rules for death coding (see page 14).

- Deaths by drowning and CO poisoning decreased (Figure 55).

- The fall in CO deaths reflects the lower toxicity of modern cars. The fall in drowning, by which numbers have fallen by almost half, is unexplained.

Figure 54: Suicide in the general population: main causes of death

Note: using the old death coding rules, we estimate the number of self-poisonings in 2011 to be 248.
Figure 55: Suicide in the general population: other causes of death
### 3.1.2 Patient suicide

#### Patient suicide: numbers and rates

- During 2001-2011, 2,678 suicides (30% of general population suicides) were identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. This represents an average of 243 patient suicides per year.

- The increase in suicide figures for the general population, resulting from a coding change (see page 14), has also led to an apparent rise in patient suicides in 2011. Based on the old coding rules, we calculate there would have been 55 fewer suicides in 2011, making the total 255 – this is still one of the highest annual figures in the report period.

- There was no overall trend in the number of patient suicides in 2001-2010, or in the rate (using a general population denominator) (Table 6; Figure 56).

- The number of patient suicides did not change in any gender or age-group between 2001-2010 – our projected rises in 2011 in those aged 25-44 and 45-64 are the result of re-coding in cause of death (Figure 57).

- 32 (1%) patient suicides were aged under 18, an average of 3 per year, with no overall trend.

- In 2008-2010, 49% of patients were unemployed compared to 46% in 2001-2003. This difference is not statistically significant.

#### Table 6: Number of patient suicides, by gender

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>142</td>
<td>164</td>
<td>164</td>
<td>161</td>
<td>135</td>
<td>136</td>
<td>181</td>
<td>161</td>
<td>131</td>
<td>151</td>
<td>201</td>
</tr>
<tr>
<td>Female</td>
<td>96</td>
<td>74</td>
<td>82</td>
<td>90</td>
<td>83</td>
<td>73</td>
<td>101</td>
<td>69</td>
<td>90</td>
<td>84</td>
<td>110</td>
</tr>
<tr>
<td>Total</td>
<td>238</td>
<td>238</td>
<td>246</td>
<td>251</td>
<td>218</td>
<td>209</td>
<td>282</td>
<td>230</td>
<td>221</td>
<td>235</td>
<td>310†</td>
</tr>
</tbody>
</table>

* projected figure
† This figure would fall to 255 using the old death coding rules
Figure 56: Rates of patient suicide, by gender
Figure 57: Number of patient suicides, by age-group
Method of suicide by patients

• The most common methods of suicide by patients were self-poisoning (37%) and hanging/strangulation (34%). There was no change in deaths by these methods over the period 2001-2010 (Figure 58).

• The number of deaths by carbon monoxide (CO) poisoning and drowning decreased during the reporting period (Figure 58). Figures 58 and 59 show the marked effect of a coding change in cause of death which has caused an apparent increase in self-poisoning deaths using opiates. Under the old coding rules we estimate that these figures would have been consistent with previous years.

• The most common substances used in deaths by self-poisoning were opiates (33%), tricyclic antidepressants (14%) and paracetamol/opiate compounds (12%).

• Between 2001 and 2010, there was an increase in suicides by overdose of opiates and antipsychotics, and a fall in suicides by overdose of tricyclic antidepressants (Figure 59).
Figure 59: Patient suicide: main substances used in deaths by self-poisoning

- Opiates
- SSRI/SNRIs
- Tricyclic antidepressants
- Paracetamol
- Antipsychotics

Number of suicides

Year


0 10 20 30 40 50 60 70 80
In-patient suicide

- There were 194 in-patient deaths by suicide during 2001-2011, 7% of patient suicides, an average of 18 deaths per year.

- There was no overall trend in the number of in-patient suicides between 2001 and 2010, although numbers have fallen since a peak in 2007 (Figure 60). The projected figure for 2011 is higher than for the previous 3 years.

- Over the 11-year period, there were 38 patients who died on the ward by hanging; this number fluctuated from 1 to 7 per year.

- The ligature points in 15 of these related to doors or windows; in 15 a belt was used as the ligature.

- There were 49 (25%) detained in-patients who died by suicide, an average of 4 per year. The number of detained suicides did not change over the report period.

Figure 60: Patient suicide: number of mental health in-patients
Absconding

- There were 49 in-patients who died after absconding from the ward, 25% of all in-patient suicides, an average of 4 deaths per year.

Compulsory Treatment Orders in the community

- There were 25 suicide deaths among patients subject to a compulsory treatment order (CTO) in the community between 2006-2011, 2% of all patient suicides. The highest annual number was in 2008 (8 patients).

- 7 suicides subject to a CTO had refused drug treatment in the month before death, and 3 had missed the last appointment with services (none had refused treatment and missed the last appointment).

- 16 suicides (64%) among patients subject to a CTO in the community were living alone.

Crisis Resolution/Home Treatment

- There were 189 suicides who had been under crisis resolution/home treatment teams (CR/HT), 8% of the total sample, an average of 17 deaths per year.

- Suicides under CR/HT rose in the early part of the report period, reflecting increasing services of this kind. There has been no overall rise since 2005 (Figure 61).

- 74 (42%) CR/HT suicides occurred within 3 months of hospital discharge, 25 (34%) within 2 weeks.

- 101 (55%) patients under CR/HT lived alone. 25 (14%) refused treatment in the month before suicide.
Figure 61: Patient suicide: number of patients under crisis resolution/home treatment services

![Graph showing the number of suicides per year from 2001 to 2011. The x-axis represents the years, and the y-axis represents the number of suicides. The data points are as follows:
- 2001: 8
- 2002: 17
- 2003: 9
- 2004: 16
- 2005: 25
- 2006: 13
- 2007: 23
- 2008: 16
- 2009: 19
- 2010: 21
- 2011: 22]
Patients recently discharged from hospital

- There were 515 suicides within 3 months of discharge from in-patient care, 19% of all patients and 21% of suicides by community patients, an average of 47 deaths per year.

- There was an overall fall in the number of post-discharge suicides between 2001-2010, although our projected figures show a rise in 2011 (Figure 62).

- Post-discharge suicides were most frequent in the first week after leaving hospital when 91 deaths occurred.
Treatment refusal

- There were 275 suicides in which the patient was known to have refused drug treatment in the month before death, 12% of the total sample, an average of 25 deaths per year.

- There were fluctuations in the number of suicides in patients who refused drug treatment, with no clear trend. However the highest number was seen in 2010 with a similar number projected for 2011 (Figure 63).
Missed contact

- There were 709 suicides by people who missed their last appointment with services, 29% of the total sample, an average of 64 deaths per year.

- The number of patient suicides following missed contact fluctuated over the 10-year period (Figure 64).

Figure 64: Patient suicide: number of patients who missed their last appointment with services
**Alcohol and drug misuse**

- There were 1,535 suicides in people with a history of alcohol misuse, 58% of the total sample, an average of 140 deaths per year.

- 1,098 patient suicides had a history of drug misuse, 42% of the total sample, an average of 100 deaths per year.

- There were 1,823 patients who had a history of either alcohol or drug misuse or both, 69% of patient suicides, an average of 166 deaths per year.

- Between 2001 and 2010, the number of patient suicides with a history of alcohol or drug misuse did not change, although we project rises in 2011 (Figure 65).

- 448 (17%) patient suicides had a primary diagnosis of alcohol dependence/misuse; 285 (11%) had drug dependence/misuse. The number with alcohol or drug dependence/misuse did not change over the report period.

- 405 (15%) patient suicides had severe mental illness and co-morbid alcohol or drug dependence/misuse (dual diagnosis), an average of 37 deaths per year. The number of patient suicides with dual diagnosis fell in 2009-2010 although we project an increase in 2011 (Figure 66).
Figure 66: Patient suicide: number with dual diagnosis (severe mental illness and alcohol or drug dependence/misuse)
Patients with schizophrenia

- There were 423 suicides by patients with a primary diagnosis of schizophrenia, 16% of the total sample, an average of 38 deaths per year.

- There was no overall trend in the number of suicides by patients with schizophrenia (Figure 67). Although we project an increase in 2011, this figure should be treated with caution because of changes in the coding of cause of death (see page 14).

- There were 81 suicides by patients with schizophrenia who had refused drug treatment in the month before death, 20% of the sample, an average of 7 deaths per year.

- A similar proportion (80, 22%) had missed their last appointment with services.

Figure 67: Patient suicide: number of patients with a primary diagnosis of schizophrenia
3.2 HOMICIDE

The Inquiry was notified by the Management Information Analysis Team at the Scottish Court Service of 951 homicide convictions in the report period, 2001-2011. A psychiatric report was obtained on 712 (75%) homicide perpetrators.

3.2.1 Homicide in the general population

• The number of homicide convictions in the general population is shown in Figure 68. These figures are provided as context for our data on homicides by people with mental illness. More recent homicide statistics are published by the Scottish Government. 10

• There has been a fall in the number of homicide convictions since a peak in 2004 (Figure 68). The number of homicides in 2010 was the lowest recorded over the report period, although an increase has been recorded in 2011.

• The most common method of homicide was the use of a sharp instrument (56% of the total sample).
Relationship to victim of perpetrator

- The relationship of victim to perpetrator was: acquaintance (506, 59%); stranger (167, 20%); spouse/partner (including ex spouse/partner) (101, 12%); and other family member (80, 9%).

- There has been a fall in the number of victims who were spouse/partners (including ex spouse/partners) and a fall in the number who were strangers and acquaintances over the report period.

3.2.2 Homicide by mentally ill people in the general population

Perpetrators who had symptoms of mental illness at the time of the homicide

- 52 people had an abnormal mental state at the time of the offence, 5% of the total sample, an average of 5 per year, ranging between 2 and 8 annually, with no overall trend.

- 25 people, 3% of the total sample, had symptoms of psychosis at the time of the offence, an average of 2 per year, ranging between 0 and 5 annually, with no overall trend.

3.2.3 Patient homicide

- During 2001-2011, 132 people convicted of homicide, 14% of the total sample, were identified as patients, i.e. the person had been in contact with mental health services in the 12 months prior to the offence. This was an average of 12 patient homicides per year.

- Patient homicides in Scotland are therefore a slightly higher proportion of comparatively high population homicide figures.

- The numbers fluctuated over the period of the report, and no overall trend was found (Figure 69). Numbers for 2010 were comparatively low but our projection for 2011 is similar to figures for previous years.

- There were no trends in the number of patient homicides by age-group.

- No patients were subject to a compulsory treatment order (CTO) at last discharge or at the time of the offence.
Figure 69: Number of patient homicides, by gender of perpetrator

The number of patient homicides, by gender of perpetrator, is shown in the graph. The graph displays the number of homicides for each year from 2001 to 2011. The total number of homicides for each year is indicated by the square symbol, while the number of male and female homicides are shown by triangle and circle symbols, respectively.

Key:
- Total
- Male
- Female
Relationship of victim to perpetrator: patient homicide

- The relationship of victim to perpetrator was: acquaintance (65, 55%); family member (21, 18%); spouse/partner (including ex spouse/partner) (20, 17%); and stranger (17, 14%).

- The number of stranger homicides by patients fluctuated over the report period, and ranged between 0 and 3 annually, with no overall trend.

- The victims for male patients were most likely to be acquaintances whereas for females, spouses/partners (including ex spouses/partners) and acquaintances were equally common.

Treatment refusal

- 14 patients (13%) were known to have refused drug treatment in the month before the homicide, ranging between 0 and 3 annually, with no overall trend.

Missed contact

- 51 patients (41%) had missed their last appointment with services before the offence, an average of 5 per year, ranging between 2 and 7 annually.

Crisis Resolution/Home Treatment

- 3 patients had been under crisis resolution/home treatment teams (CR/HT) at the time of the homicide, 3% of the patient sample.

- All patients were male, 2 lived alone. One refused drug treatment in the month before the homicide.

Alcohol and drug misuse

- 102 patients had a history of alcohol misuse, 86% of the patient sample. This was an average of 9 patient homicides per year, ranging between 5 and 13 annually.

- 110 patients had a history of drug misuse, 89% of the patient sample, an average of 10 per year, ranging between 4 and 16 annually.

- There were 121 patients who had a history of either alcohol or drug misuse or both, 95% of patients, an average of 11 homicides per year.

- There was no trend in the number of patient homicides with alcohol or drug misuse over the report period.

- 22 (17%) patients had a primary diagnosis of alcohol dependence/misuse; 39 (30%) had drug dependence/misuse.

- 23 (18%) patients had severe mental illness and co-morbid alcohol or drug dependence/misuse (dual diagnosis).

Homicide and schizophrenia

- There were 30 homicides by people with schizophrenia (based on lifetime history), 3% of the total sample, an average of 3 per year.

- 17 (57%) people with schizophrenia were patients, ranging between 0 and 4 annually.

- 2 patients with schizophrenia were known to have refused drug treatment in the month before the homicide.

- 5 patients with schizophrenia missed their appointment with services before the homicide.
4. WALES

4.1 SUICIDE

Between 2001-2011, the Inquiry was notified of 3,450 deaths in the general population that received a suicide or undetermined verdict. These are referred to as suicides throughout the report.

4.1.1 Suicide in the general population

• There was a fall in the number and rate of suicides between 2001 and 2010, although figures fluctuated (Table 7; Figure 70). Falls in rates over the report period were observed in both males and females (Figure 70), although the number of female suicides did not change.

• Our figure for 2010 has increased by 5% since it was estimated in last year’s report. Our figure for 2011 is already higher than for recent years and may rise further once delayed notifications are added.

• Rates fell in males aged under 25 and 25-34 (Figure 71). Female rates fell in those aged under 25 (Figure 72).

<table>
<thead>
<tr>
<th>Table 7: Number of suicides in the general population, by gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
Figure 70: Rates of suicide in the general population, by gender
Figure 71: Rates of male suicide in the general population, by age-group
Figure 72: Rates of female suicide in the general population, by age-group
Variation in suicide by region

- There was some variation in suicide rates by Health Board of residence at the time of death (2009-2011). The highest rate of suicide was in Powys Teaching, at 14.9 per 100,000 population, and the lowest in Aneurin Bevan at 8.6 per 100,000 population and Hywel Dda at 8.7 per 100,000 population (Figure 73).
Method of suicide

- The most common methods of suicide over 2001-2011 were hanging/strangulation (49%) and self-poisoning (overdose) (22%). Less frequent methods were jumping/multiple injuries (mainly jumping from a height or being struck by a train) (7%), drowning (6%), carbon monoxide (CO) poisoning (4%), firearms (3%), and cutting/stabbing (3%).

- Over the period 2001-2010 there were changes in method of suicide. Suicide deaths by hanging increased, whilst deaths by self-poisoning decreased (Figure 74). Of the less common methods, deaths by CO poisoning, drowning, and firearms decreased (Figure 75).
Figure 75: Suicide in the general population: other causes of death
4.1.2 Patient suicide

Patient suicide: numbers and rates

- During 2001-2011, 802 suicides (23% of general population suicides) were identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. This represented an average of 73 patient suicides per year.

- There was an overall decrease between 2001 and 2010 in the number and rate of patient suicide (using a general population denominator), although recent figures suggest an increase (Table 8; Figure 76).

- Rates fell overall for males and females but have risen in males since 2008 (Figure 76). Numbers for individual age-groups fluctuated but fell overall for those aged under 25 (Figure 77).

- 13 (2%) patient suicides were aged under 18, with no overall trend over the report period.

- In 2008-2010, 43% of patients were unemployed compared to 38% in 2001-2003. This difference is not statistically significant.

Table 8: Number of patient suicides, by gender

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>63</td>
<td>51</td>
<td>54</td>
<td>45</td>
<td>59</td>
<td>38</td>
<td>49</td>
<td>38</td>
<td>49</td>
<td>54</td>
<td>58</td>
</tr>
<tr>
<td>Female</td>
<td>22</td>
<td>25</td>
<td>30</td>
<td>27</td>
<td>30</td>
<td>21</td>
<td>22</td>
<td>17</td>
<td>21</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>76</td>
<td>84</td>
<td>72</td>
<td>89</td>
<td>59</td>
<td>71</td>
<td>55</td>
<td>70</td>
<td>68</td>
<td>73†</td>
</tr>
</tbody>
</table>

* projected figure
† Numbers do not tally due to rounding.
Figure 76: Rates of patient suicide, by gender
Figure 77: Number of patient suicides, by age-group
Method of suicide by patients

- The most common methods of suicide by patients were hanging/strangulation (44%) and self-poisoning (24%).

- Suicides by hanging fell overall until 2008 but rose in 2009 and 2010, and our projection for 2011 suggests a further rise (Figure 78). Deaths by CO poisoning decreased while figures for other methods did not change between 2001-2010.

- The most common substances used in deaths by self-poisoning were opiates (21%), tricyclic antidepressants (14%) and paracetamol/opiate compounds (13%). Numbers are too small for statistical analysis but there were 6 self-poisonings with opiates in 2001-2003 and 12 in 2009-2011.

Figure 78: Patient suicide: main causes of death

- Hanging/strangulation
- Self-poisoning
- CO poisoning
- Jumping/multiple injuries
- Drowning

The most common methods of suicide by patients were hanging/strangulation (44%) and self-poisoning (24%).

Suicides by hanging fell overall until 2008 but rose in 2009 and 2010, and our projection for 2011 suggests a further rise (Figure 78). Deaths by CO poisoning decreased while figures for other methods did not change between 2001-2010.

The most common substances used in deaths by self-poisoning were opiates (21%), tricyclic antidepressants (14%) and paracetamol/opiate compounds (13%). Numbers are too small for statistical analysis but there were 6 self-poisonings with opiates in 2001-2003 and 12 in 2009-2011.
In-patient suicide

- There were 93 in-patient deaths by suicide during the report period, 12% of patient suicides, an average of 8 deaths per year.

- There was an overall fall in the number of in-patient suicides despite a rise in 2009-2010 (Figure 79).

- There were 22 patients who died on the ward by hanging/strangulation over the 11-year period; this number fluctuated from 0 to 6 per year. The number of deaths by hanging on the ward fell between 2001-2010.

- There were 21 (23%) detained in-patients who died by suicide, an average of 2 per year, with no trend over the report period.

Absconding

- There were 27 in-patients who died after absconding from the ward, 29% of all in-patient suicides, an average of 2 deaths per year. The number fell between 2001-2010, with only 6 deaths following absconding since 2004.
Community Treatment Orders

- There were 4 suicide deaths among patients subject to a community treatment order (CTO) between 2009-2011, 2% of all patient suicides in this time period.

- One suicide subject to a CTO had refused drug treatment in the month before death and missed the last appointment with services.

Crisis Resolution/Home Treatment

- There were 54 suicides who had been under crisis resolution/home treatment teams (CR/HT), 7% of the total sample, an average of 5 deaths per year.

- There was an overall increase in the number of suicides under CR/HT (Figure 80); 20 of these deaths occurred in 2009-2010. There are now more suicides under CR/HT than in in-patient care.

- 16 (34%) CR/HT patients died within 3 months of hospital discharge, of whom 7 died within 2 weeks.

- 22 (42%) CR/HT patients lived alone; 9 (17%) refused treatment in the month before suicide.
Patients recently discharged from hospital

- There were 160 suicides within 3 months of discharge from in-patient care, 20% of all patients and 23% of suicides by community patients, an average of 15 deaths per year.

- There was an overall fall in the number of post-discharge suicides between 2001-2010, although there has been no fall since 2006 (Figure 81).

- Post-discharge suicides were most frequent in the 2 weeks after leaving hospital when 48 deaths occurred.

Figure 81: Patient suicide: number who died within 3 months of in-patient discharge
Treatment refusal

- There were 85 suicides in which the patient was known to have refused drug treatment in the month before death, 12% of the total sample, an average of 8 deaths per year.

- There was no overall trend in the number of suicides in patients who refused drug treatment (Figure 82); the highest number was in 2004.

Figure 82: Patient suicide: number of patients who refused drug treatment

- There were 85 suicides in which the patient was known to have refused drug treatment in the month before death, 12% of the total sample, an average of 8 deaths per year.

- There was no overall trend in the number of suicides in patients who refused drug treatment (Figure 82); the highest number was in 2004.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report July 2013
Missed contact

- There were 198 suicides by people who missed their last appointment with services, 28% of the total sample, an average of 18 deaths per year.

- Over the period 2001-2010 there was a significant fall in the number of patient suicides following missed contact (Figure 83).

Figure 83: Patient suicide: number of patients who missed their last appointment with services
Alcohol and drug misuse

- There were 380 suicides in people with a history of alcohol misuse, 48% of the total sample, an average of 35 deaths per year.
- 258 patient suicides had a history of drug misuse, 33% of the total sample, an average of 23 deaths per year.
- There were 442 patients who had a history of either alcohol or drug misuse or both, 56% of patient suicides, an average of 40 deaths per year.
- Between 2001 and 2010, the number of patient suicides with a history of alcohol or drug misuse did not change, although we project a rise in patient suicides with alcohol misuse in 2011 (Figure 84).
- 84 (11%) patient suicides had a primary diagnosis of alcohol dependence/misuse; 32 (4%) had drug dependence/misuse. The number with alcohol or drug dependence/misuse did not change over the report period.
- 117 (15%) patient suicides had severe mental illness and co-morbid alcohol or drug dependence/misuse (dual diagnosis), an average of 11 deaths per year. The number of dual diagnosis patient suicides has remained lower since a peak in 2005 (Figure 85).
Figure 85: Patient suicide: number with dual diagnosis (severe mental illness and alcohol or drug dependence/misuse)
Patients with schizophrenia

- There were 126 suicides by patients with a primary diagnosis of schizophrenia, 16% of the total sample, an average of 11 deaths per year.

- There was no overall trend in the number of suicides by patients with schizophrenia, although figures were generally higher up to 2005 and have been lower since a 2005 peak (Figure 86).

- There were 17 (15%) suicides by patients with schizophrenia who had refused drug treatment in the month before death.

- 27 (28%) had missed their last appointment with services.

**Figure 86: Patient suicide: number of patients with a primary diagnosis of schizophrenia**
4.2 HOMICIDE

The Inquiry was notified by Home Office Statistics of 265 homicide convictions in the report period 2001-2011. A psychiatric report was obtained on 108 (41%) homicide perpetrators.

4.2.1 Homicide in the general population

- The number of homicide convictions in the general population is shown in Figure 87. These figures are provided as context for our data on homicides by people with mental illness. More recent data are published for England and Wales by the Office for National Statistics.  

- There was no overall trend in the number of homicide convictions over the report period.

- The most common method of homicide was the use of a sharp instrument (36% of the total sample).

- The relationship of victim to perpetrator was: acquaintance (107, 46); spouse/partner (including ex spouse/partner) (60, 26%); stranger (38, 16%); and other family member (30, 13%).
4.2.2 Homicide by mentally ill people in the general population

Perpetrators who had symptoms of mental illness at the time of the homicide

- 30 people had an abnormal mental state at the time of the homicide, 11% of the total sample, an average of 3 per year, ranging between 1 and 4 annually.

- 19, 7% of the total sample, had symptoms of psychosis at the time of the offence, an average of 2 per year, ranging between 0 and 4 annually.

4.2.3 Patient homicide

- During 2001-2011, 29 people convicted of homicide, 11% of the total sample, were identified as patients, i.e. the person had been in contact with mental health services in the 12 months prior to the offence, an average of 3 per year, ranging between 1 and 5 annually.

- The number of cases fluctuated. In this section the numbers were too small to examine trends over time.

- No patients were subject to a community treatment order (CTO) at the time of last discharge or at the time of the homicide.

Relationship of victim to perpetrator: patient homicide

- Victims were most commonly an acquaintance (13, 46%), followed by a spouse/partner (including ex spouse/partner) (7, 25%), family member (6, 21%), and stranger (2, 7%).

Treatment refusal

- 5 patients (20%) were known to have refused drug treatment in the month before the homicide.

Missed contact

- 9 patients (31%) missed their last appointment with services before the homicide.

Crisis Resolution/Home Treatment

- 1 patient was under crisis resolution/home treatment care (CR/HT) at the time of the homicide.
Alcohol and drug misuse

• 17 patients had a history of alcohol misuse, 71% of the patient sample, ranging between 0 and 4 annually.

• 20 patients had a history of drug misuse, 74% of the patient sample, ranging between 1 and 4 annually.

• There were 23 patients who had a history of either alcohol or drug misuse or both, 85% of patients, an average of 2 homicides per year.

• 3 (11%) patients had a primary diagnosis of alcohol dependence/misuse; 2 (7%) had drug dependence/misuse.

• 6 (21%) patients had severe mental illness and co-morbid alcohol or drug dependence/misuse (dual diagnosis).

Homicide and schizophrenia

• There were 18 homicides by people with schizophrenia (based on lifetime history), 7% of the total sample, an average of 2 homicides annually.

• 9 (50%) people with schizophrenia were patients, ranging between 0 and 2 annually.

• 3 patients with schizophrenia were known to have refused drug treatment in the month before the homicide.

• 3 patients with schizophrenia missed their last appointment with services before the homicide.

4.3 SUDDEN UNEXPLAINED DEATH IN MENTAL HEALTH IN-PATIENTS (SUD)

• There were 29 deaths meeting criteria for SUD over the report period, an average of 3 per year. Numbers fluctuated between 1 and 6 and there was no trend.

• No patients were from a black and minority ethnic (BME) group.

• There was one death within one hour of restraint reported in 2006. We do not know whether restraint caused this death.

• 4 (14%) were aged under 45.

• 11 (39%) had a history of cardiovascular disease; 8 (29%) had a history of respiratory disease; 5 (18%) had a history of cerebrovascular disease, and 1 (4%) had a history of epilepsy.

• 2 (7%) were receiving 2 or more antipsychotic drugs (i.e. polypharmacy).
UK COMPARISONS

5.1 SUICIDE

Rates

- Scotland and Northern Ireland continue to have the highest general population suicide rates (Figure 88).

- Differences in rates between countries over the report period were greatest in the youngest age-groups. Rates in Scotland were highest in all age-groups from 20-24 to 80-84 (Figure 89).

- Patterns in age and gender groups varied by country.

Male rates:

- fell in those aged under 25 and 25-34 in England, Scotland, and Wales

- rose in those aged 45-64 in England and Northern Ireland

- fell in those aged 65 and older in England and Scotland.

Figure 88: Suicide rates in the general population, by UK country
**Female rates:**

- fell in those aged under 25 in Scotland and Wales
- rose in those aged 35-44 in Northern Ireland
- fell in those aged 65 and older in England and Scotland.

**Figure 89: Suicide rates in the general population, by age-group and UK country (2001-2011)**

![Figure 89: Suicide rates in the general population, by age-group and UK country (2001-2011)]
Method

- The number and proportion of hangings in the general population increased in all countries over the report period 2001-2010, although numbers fell in 2011 in England and Northern Ireland (Table 9).
- Between 2001 and 2010, the number of patient suicides by hanging increased in England and Northern Ireland and was stable in Wales and Scotland (Table 10).
- Patient suicides by self-poisoning using opiates increased in Scotland in 2011 due to the coding change in cause of death (Figure 90). The projected rise in opiate deaths in England may also be a re-coding effect.

Table 9: Suicides in the general population by hanging, by UK country

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N. Ireland</td>
<td>96</td>
<td>103</td>
<td>85</td>
<td>118</td>
<td>130</td>
<td>116</td>
<td>149</td>
<td>161</td>
<td>145</td>
<td>175</td>
<td>140</td>
</tr>
<tr>
<td>Scotland</td>
<td>283</td>
<td>306</td>
<td>267</td>
<td>325</td>
<td>259</td>
<td>285</td>
<td>291</td>
<td>339</td>
<td>327</td>
<td>328</td>
<td>329</td>
</tr>
<tr>
<td>Wales</td>
<td>124</td>
<td>152</td>
<td>167</td>
<td>131</td>
<td>144</td>
<td>145</td>
<td>156</td>
<td>172</td>
<td>151</td>
<td>167</td>
<td>182</td>
</tr>
</tbody>
</table>

Table 10: Patient suicide: number of suicides by hanging, by UK country

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011*</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>433</td>
<td>456</td>
<td>456</td>
<td>515</td>
<td>487</td>
<td>456</td>
<td>472</td>
<td>535</td>
<td>437</td>
<td>526</td>
<td>569</td>
</tr>
<tr>
<td>N. Ireland</td>
<td>26</td>
<td>26</td>
<td>23</td>
<td>30</td>
<td>36</td>
<td>32</td>
<td>39</td>
<td>38</td>
<td>35</td>
<td>34</td>
<td>31</td>
</tr>
<tr>
<td>Scotland</td>
<td>84</td>
<td>92</td>
<td>79</td>
<td>88</td>
<td>67</td>
<td>61</td>
<td>103</td>
<td>87</td>
<td>85</td>
<td>80</td>
<td>86</td>
</tr>
<tr>
<td>Wales</td>
<td>37</td>
<td>36</td>
<td>36</td>
<td>31</td>
<td>33</td>
<td>23</td>
<td>30</td>
<td>21</td>
<td>31</td>
<td>37</td>
<td>43</td>
</tr>
</tbody>
</table>

* projected figure
Figure 90: Patient suicide: number of patients who died by self-poisoning using opiates, by UK country
5.2 HOMICIDE

Homicide by people with mental illness

The contribution of mental illness to homicide figures can be calculated in different ways. Figures in Table 11 are presented for mental health patients and people with mental illness, for the UK as a whole and for each UK country. The number of victims by patients or people with mental illness is presented in Table 12. All are based on convictions and are presented by year of conviction. Figures are for 2001-2010.

Patient homicide

- Patient homicide refers to perpetrators in contact with mental health services within 12 months of the offence.

- The average number of patients committing homicide per year in the UK (2001-2010) was 74 (Table 11).

- The primary diagnoses for patient homicide are presented by country in Figure 91. Many patients did not have severe mental illness and had a primary diagnosis of personality disorder or drug/alcohol misuse.
**Perpetrators who had symptoms of mental illness at the time of the homicide**

- People who experienced symptoms of hypomania, depression, delusions, hallucinations, or other psychotic symptoms (e.g. passivity, thought insertion) of all severity, were defined as mentally ill at the time of the offence.

- Although symptoms were present, we do not know if these symptoms led directly to the homicide.

- On average, 67 people per year committed homicide whilst experiencing an abnormal mental state (Table 11).

- Most of these people were not under mental health care; therefore most were not preventable by mental health services.

- These cases provide an indication of the total “contribution” to homicide from mental illness.

**Combined definition**

- Table 11 shows the number of homicide by either patients or people who were mentally ill at the time of the offence.

- In the UK, on average 115 patients or people experiencing symptoms of mental illness committed homicide per year (Table 11).

- There was limited overlap between these two groups. Combined UK figures show 35% patients were mentally ill at the time of offence; 38% of those who were mentally ill at the time of offence were patients.
## Table 11: Number of homicides by patients or people who had symptoms of mental illness at the time of the offence by UK country

### Patients

<table>
<thead>
<tr>
<th>Year of conviction</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>Total</th>
<th>Average per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>55</td>
<td>44</td>
<td>70</td>
<td>64</td>
<td>72</td>
<td>74</td>
<td>53</td>
<td>66</td>
<td>38</td>
<td>33</td>
<td>569</td>
<td>57</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>252</td>
<td>3</td>
</tr>
<tr>
<td>Scotland</td>
<td>9</td>
<td>8</td>
<td>12</td>
<td>18</td>
<td>14</td>
<td>10</td>
<td>8</td>
<td>16</td>
<td>17</td>
<td>5</td>
<td>117</td>
<td>12</td>
</tr>
<tr>
<td>Wales</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>27</td>
<td>3</td>
</tr>
<tr>
<td>UK</td>
<td>71</td>
<td>58</td>
<td>87</td>
<td>87</td>
<td>92</td>
<td>90</td>
<td>66</td>
<td>86</td>
<td>61</td>
<td>40</td>
<td>738</td>
<td>74</td>
</tr>
</tbody>
</table>

### Perpetrators with symptoms of mental illness at the time of the offence

<table>
<thead>
<tr>
<th>Year of conviction</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>Total</th>
<th>Average per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>54</td>
<td>59</td>
<td>75</td>
<td>79</td>
<td>66</td>
<td>51</td>
<td>48</td>
<td>57</td>
<td>48</td>
<td>36</td>
<td>573</td>
<td>57</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Scotland</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>8</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>50</td>
<td>5</td>
</tr>
<tr>
<td>Wales</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>28</td>
<td>3</td>
</tr>
<tr>
<td>UK</td>
<td>64</td>
<td>68</td>
<td>83</td>
<td>95</td>
<td>75</td>
<td>58</td>
<td>57</td>
<td>67</td>
<td>57</td>
<td>42</td>
<td>666</td>
<td>67</td>
</tr>
</tbody>
</table>

### Combined definition

<table>
<thead>
<tr>
<th>Year of conviction</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>Total</th>
<th>Average per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>91</td>
<td>83</td>
<td>113</td>
<td>118</td>
<td>108</td>
<td>103</td>
<td>81</td>
<td>93</td>
<td>71</td>
<td>58</td>
<td>919</td>
<td>92</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>34</td>
<td>3</td>
</tr>
<tr>
<td>Scotland</td>
<td>13</td>
<td>11</td>
<td>16</td>
<td>23</td>
<td>16</td>
<td>13</td>
<td>11</td>
<td>19</td>
<td>22</td>
<td>6</td>
<td>150</td>
<td>15</td>
</tr>
<tr>
<td>Wales</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>8</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>46</td>
<td>5</td>
</tr>
<tr>
<td>UK</td>
<td>115</td>
<td>102</td>
<td>135</td>
<td>151</td>
<td>133</td>
<td>125</td>
<td>100</td>
<td>119</td>
<td>100</td>
<td>69</td>
<td>1149</td>
<td>115</td>
</tr>
</tbody>
</table>
Victims of homicide by patients or perpetrators with symptoms of mental illness at the time of the offence

- Our figures are about prevention of homicide by people in contact with mental health services, and therefore focus on perpetrators rather than victims.

- However, Table 12 shows the number of victims of either patients or people with mental illness at the time of the offence who were convicted of homicide.

- Over the period 2001-2010, there were on average 122 victims of homicide by people with mental illness per year in the UK.

Table 12: Number of homicide victims of patients or people with mental illness at the time of the offence by UK country

<table>
<thead>
<tr>
<th>Year of conviction</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>Total</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>95</td>
<td>87</td>
<td>122</td>
<td>125</td>
<td>110</td>
<td>113</td>
<td>83</td>
<td>101</td>
<td>77</td>
<td>72</td>
<td>985</td>
<td>99</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>35</td>
<td>4</td>
</tr>
<tr>
<td>Scotland</td>
<td>13</td>
<td>11</td>
<td>17</td>
<td>25</td>
<td>16</td>
<td>13</td>
<td>11</td>
<td>19</td>
<td>22</td>
<td>9</td>
<td>156</td>
<td>16</td>
</tr>
<tr>
<td>Wales</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>50</td>
<td>5</td>
</tr>
<tr>
<td>UK</td>
<td>120</td>
<td>106</td>
<td>145</td>
<td>163</td>
<td>135</td>
<td>135</td>
<td>103</td>
<td>127</td>
<td>106</td>
<td>76</td>
<td>1216</td>
<td>122</td>
</tr>
</tbody>
</table>
Homicide followed by suicide

- Numbers for homicide followed by suicide are presented for England and Wales only. We only include cases where the suicide occurred within 3 days of the homicide. In these cases there was no conviction for homicide. Numbers are presented by year of offence.

- Table 13 shows the number of homicide-suicide incidents and the number committed by patients between 2001 and 2010.

- As these perpetrators did not undergo a psychiatric assessment after the offence, we do not have information regarding symptoms of mental illness at the time of the offence. Therefore, these cases cannot be added to other perpetrators with mental illness at the time of the homicide.

- Few homicide-suicide cases involved patients under the care of mental health services prior to the offence.

Table 13: Number of homicide-suicide perpetrators, patients and patient victims in England and Wales, by year of offence

<table>
<thead>
<tr>
<th>Year of offence</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>Total</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicide-suicide perpetrators</td>
<td>19</td>
<td>16</td>
<td>19</td>
<td>16</td>
<td>19</td>
<td>21</td>
<td>24</td>
<td>19</td>
<td>21</td>
<td>15</td>
<td>189</td>
<td>19</td>
</tr>
<tr>
<td>Homicide-suicide patients</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Number of victims killed by homicide-suicide patients</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>1</td>
</tr>
</tbody>
</table>
6. RECENT PUBLICATIONS FROM THE INQUIRY

A full list of Inquiry reports and publications can be found on the Inquiry website: www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/publications/


7. REFERENCES


FUNDING

The National Confidential Inquiry into Suicide and Homicide is based at the University of Manchester and is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of the NHS England, NHSSPS Northern Ireland, the Scottish Government, the Welsh Government, and the Channel Islands.
For further information about this publication contact:
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
Centre for Mental Health and Risk
Jean McFarlane Building
University of Manchester
Oxford Road
Manchester
M13 9PL
Telephone: 0161 275 0700/1

All Inquiry reports are available to download from our website:
http://www.bbmh.manchester.ac.uk/cmhr/research/centreforsuicideprevention/nci/reports/