NHS
East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC
27 January 2022

Title	Annual Mortality Review Luton and Bedfordshire
Author/Role	Dr Angharad Ruttley, Acting Medical Director, Bedfordshire and Luton (Mental Health)
Accountable Executive Director	Dr Paul Gilluley, Chief Medical Officer

Purpose of the report

The national data on suicide shows that rates of suicide are higher in the East of England compared to London.

This paper reports on a thematic review of the unexpected deaths of service users under the care of ELFT in Luton and Bedfordshire for the year April 2020 – March 2021.

It identifies themes and trends in ELFT data on the characteristics of the people who have died, the services they used and the care and treatment that was provided to them.

The paper intends to provide assurance that learning from the review has been shared, acted on and used to inform ongoing work around suicide prevention in Luton and Bedfordshire.

Committees/meetings where this item has been considered

Date	Committee/Meeting
15.11.21	*SLT Quality Meeting – Luton and Bedfordshire*
08.12.21	*Trustwide Patient Safety Forum*
10.01.21	*Quality Assurance Committee*

Key messages

Findings

- There were 15 deaths as a result of completed suicide during this period, 6 in Luton and 9 in Bedfordshire. This is a reduction on the previous year.
- There is a downward trend in the number of serious incidents (SI) (including all deaths of service users in contact with ELFT Adult Mental Health and Wellbeing services) in both Luton and Bedfordshire over the last 5 years
- Suicide was more common in males, and the highest numbers for both sexes fell within the 40-49 year age group, Strangulation was the commonest method used.
- No deaths were recorded in the Black or Asian ethnicity categories, the majority of deaths being in the white ethnicity category, consistent with the Bedfordshire but not the Luton population demographic.
- Risks assessments were completed in all cases except one, where risk assessment was identified as a care delivery problem with resultant action plan, this is an improvement on the previous year when 3 cases highlighted insufficient risk assessment.
- Of the 30 STEIS cases reviewed half were felt not to be predictable or preventable by SI reviewers. As with the previous year most missed opportunities were around predictability (9 cases) rather than preventability (1 case).
- Where missed opportunities around predictability were identified, drug and/or alcohol use was often a factor in presentation, and service users were often in contact with addiction services. Service users were under the care of community mental health teams, often in contact with multiple teams or in the process of being discharged or transferred between teams.

- 4 of the 9 cases felt to have missed opportunities had recently been discharged from an inpatient setting. Follow up plans following discharge from the ward setting or following community review were sometimes missing, insufficient or not actioned.
- Actions plans for these SI reviews often had multiple actions and included improvements to policies, improved communication and interfaces, improved teaching and training and sharing learning through learning lessons events.
- Performance on 72 hour follow up for service users discharged from inpatient wards (which is identified as a risk period for suicide) was strong throughout the year.

Conclusions:

- The demographic characteristics of those that completed suicide reflect the national picture where males account for three quarters of suicide and the age demographic with the highest rates of suicide are the 45-64 year olds.
- Suicide rates fluctuate from year to year and it is not possible to draw conclusions on an individual years' data, however there is an overall downward trend in all serious incidents over time in both Luton and Bedfordshire. It is not possible to draw any conclusions about the effect of the pandemic at this early stage, other than to note that there was no increase in numbers compared to the previous year.
- There is continued progress in suicide prevention work in Luton and Bedfordshire. Progress on last year's actions including the accelerated expansion of crisis pathway services ahead of Long Term Plan ambition timelines. This improves access and responsiveness for people in mental health crisis in Luton and Bedfordshire who can now access a 24/7 crisis line, self-refer, and access to 24/7 crisis team care and treatment.
- Ongoing suicide awareness and response training rollout was severely impacted by the pandemic and no training took place during this year. The position is not favourable compared to last year however the training will restart with a virtual offer and trainers have been retrained to deliver this.
- A focus for further work for the next year is increasing our understanding of the needs of service users with addiction problems, which is a risk factor for increased risk of suicide, and builds on the work started this year in the inpatient setting providing brief interventions for addiction problems.

Strategic priorities this paper supports

Improved population health outcomes	☒	Learning from this review contributes to the knowledge base on the risks associated with completed suicide for people with serious mental illness in Luton and Bedfordshire. It helps inform suicide prevention work in Luton and Bedfordshire which aims to reduce the risk of suicide.
Improved experience of care	☒	The aim of undertaking the review is to provide improved care for service users.
Improved staff experience	☒	A theme in this review is the ongoing need for staff training which equips our staff with the clinical skills they need to provide high quality care.
Improved value	☒	By understanding the factors associated with suicide for this population, we aim to improve the quality of care through preventative interventions which improves efficiency and value for money for the NHS.

Implications

Equality Analysis	The report considers inequalities in mortality. Nationally Males and Females in the 45-49 year old age group have the highest age specific suicide rate and rates are higher for men than women. The report shows consistency with the national picture. It does not include a formal equity analysis.
Risk and Assurance	This paper provides assurance that services in Luton and Bedfordshire continue to review mortality data for themes and trends and that there is ongoing learning from findings to inform suicide prevention work.
Service User/ Carer/Staff	The paper identifies themes and trends for service users in contact with secondary mental health services in Luton and Bedfordshire. Thematic reviews inform improvements to services which affect service users in terms of the care they receive and staff who deliver care.
Financial	No financial implications identified
Quality	The report makes a recommendation to further understanding of the needs of in-patient service users with concurrent addiction and severe mental illness and continue improvements to care that can better meet the needs of this group.

1.0 Background/Introduction

1.1 This report reviews the unexpected deaths for Bedford between 1st April 2020 and 31st March 2021 and provides information on trends and themes identified in the review and how this information has been used to inform improvement, service development and suicide prevention work.

1.2 The report, unlike previous years, coincides with the onset COVID 19 Pandemic and the period includes three national lockdowns mandated by the Government.

1.3 National data on suicide rates by region show rates in the East of England are higher than in London. ELFT has been collecting data on serious incidents and conducting yearly mortality reviews for Luton and Bedfordshire since provision of services commenced in 2015.

1.4 Reviewing and learning from deaths is a key responsibility of NHS Trusts. The senior leadership team at ELFT Luton and Bedfordshire Mental Health and Wellbeing hold a regular Quality Meeting, with local quality meetings taking place at in each directorate (community mental health, inpatient and crisis) and learning lessons events for all staff run quarterly.

1.5 The Trust's processes for investigating incidents resulting in patient harm are in keeping with national guidance. We endeavour to identify root causes and to identify care and service delivery problems reducing the risk of similar incidents recurring. We are committed to transparent multiagency arrangements for the investigation of concerns relating to the Safeguarding of Vulnerable adults. Our SI Action Plans cover identified care and service delivery problems, and lessons learnt, even where they have not been directly contributory to the outcome. This paper complements the Trust's processes by identifying cross cutting themes and trends for those unexpected deaths occurring in Luton and Bedfordshire.

2.0 Method

2.1 In 2020 -2021 there were **70** unexpected deaths which were reported to the Clinical Commissioning Group (CCG) as serious incidents. After removing deaths that were expected or due to a physical health reason unrelated to psychiatric problems, we were left with **41** deaths. Of these, 30 deaths were reported as Strategic Executive Information System (STEIS) deaths.

2.2 Within this period, for Luton and Bedfordshire combined, there were 15 deaths of individuals in contact with our services, where death by suicide was suspected or confirmed. There were 6 deaths in Luton and 9 deaths in Bedford.

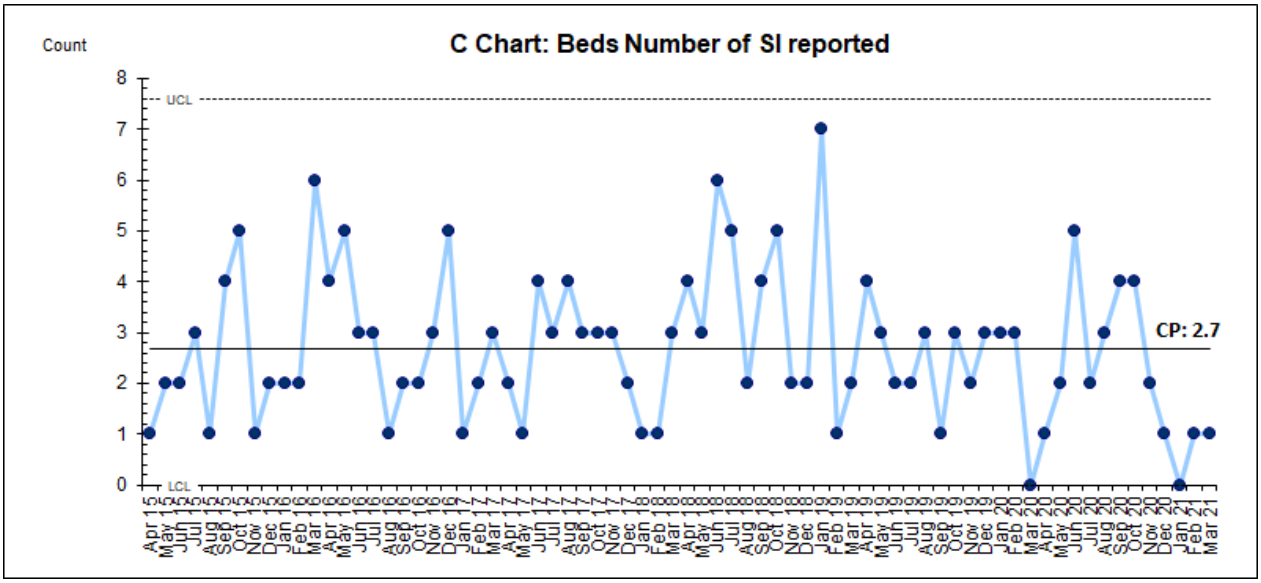
2.3 The remaining 15 **unexpected** deaths were reviewed to find the cause of death from the Datix database, 48-hour report, SI review or concise level 2 review.

2.4 The Serious Incident Review reports for the 30 STEIS reported deaths were reviewed by a clinical reviewer using a standardised format.

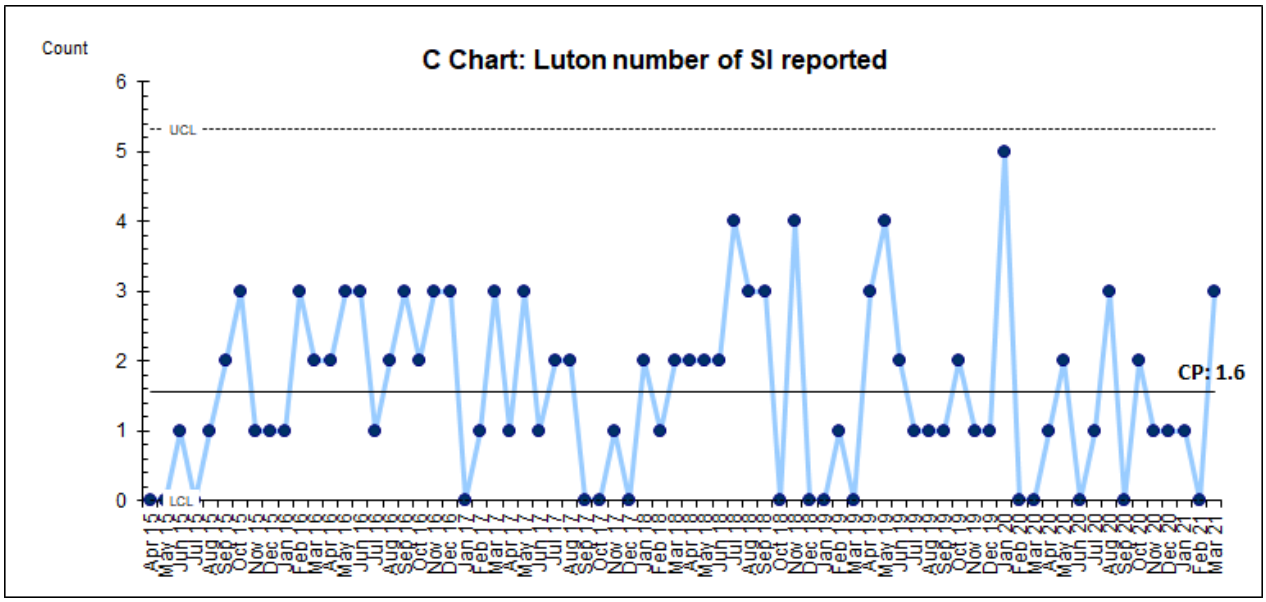
3.0 Serious Incident patterns over time

3.1 In order to understand the pattern over time, the charts below show all incidents that were later reported as a serious incident from April 2015 to **March 2021**. There is a downward trend in both Bedfordshire and Luton.

3.2 Bedfordshire - Looking at this reporting period, between April 2020 - March 2021, across Bedfordshire there were 4 data points where monthly reported incidents including all deaths, as an SI were above the mean (2.7). There were seven monthly data points where monthly reported incidents (including all deaths) were below the mean.



3.3 Luton - Looking at this reporting period, between April 2020 - March 2021, across Luton there were data points where 4 monthly reported incidents including all deaths, as an SI were above the mean (1.6). There were seven monthly data points where monthly reported incidents (including all deaths) were below the mean.



4.0 Demographic Data and Associated Themes

4.1.1 These data have been cross referenced with the ONS report on deaths by suicide registered in 2019.

4.2 Gender

4.2.1 Within the ONS 2019 national data, men accounted for approximately three quarters of deaths attributed to suicide. This has been the picture since the mid 1990's.

4.2.2 In Bedfordshire and Luton in 2020-21, 85.7% of suspected suicides were attributed to men, slightly higher than the national average.

Gender	Suspected Suicide	Unexpected death
Male	13	19
Female	2	7
Total	15	26

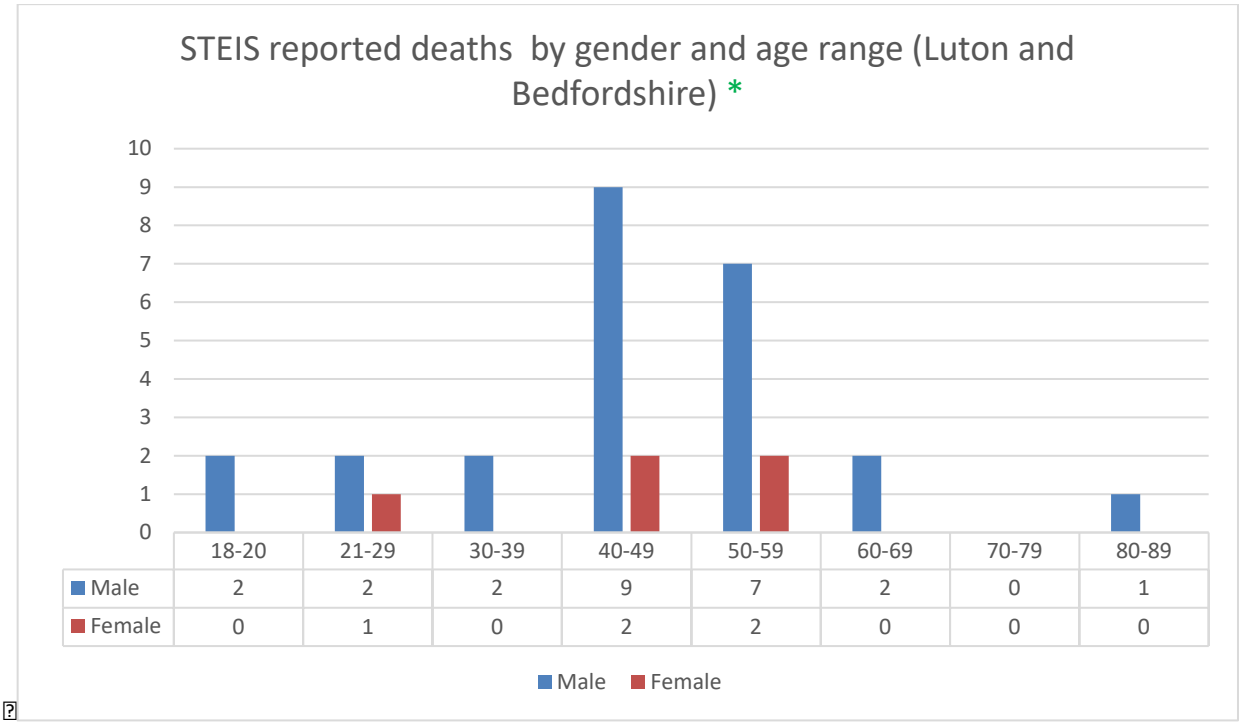
Directorate	Suspected Suicide	Unexpected death
Luton	6	5
Bedfordshire	9	10

4.3 Age and Gender

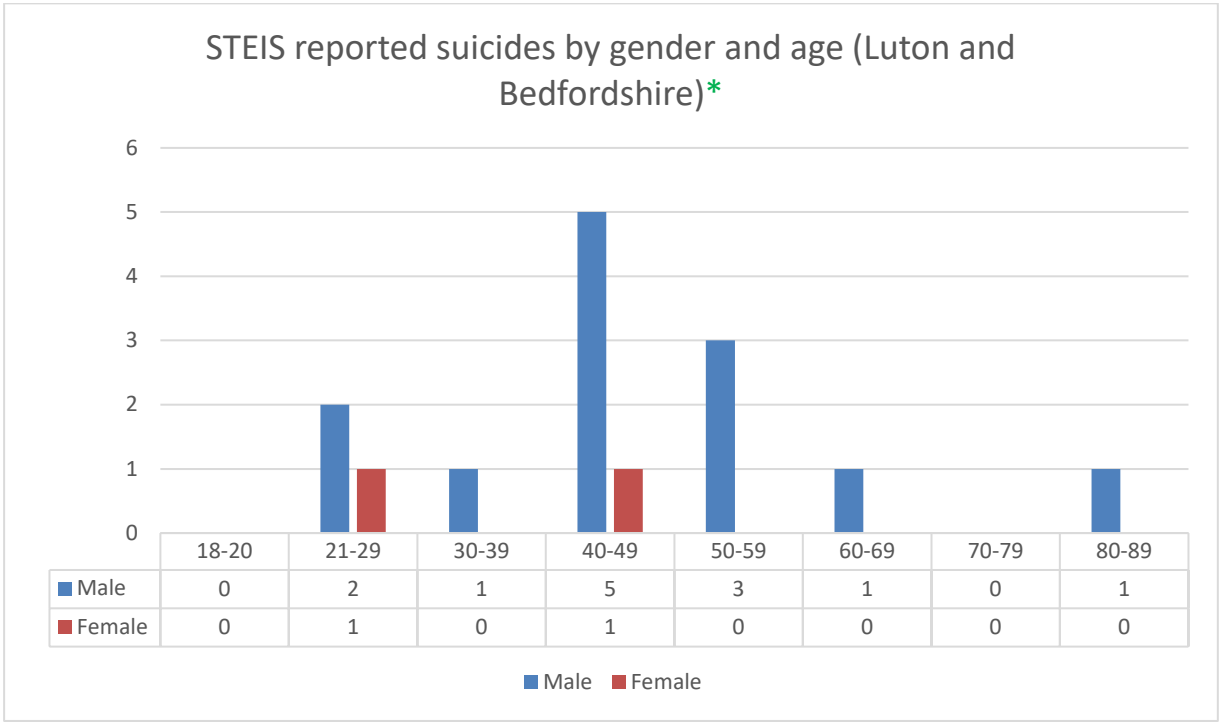
4.3.1 The ONS 2019 data demonstrate that in 2019, males aged 45 to 49 years had the highest suicide rate. For females, the highest rate was seen among those aged 50 to 54 years.

4.3.2 Looking at the age and gender of each death in Luton and Bedfordshire in 2020-21 we can see that highest female deaths were reported in the 50-59 age group,

followed jointly by 40-49 age group. In the male age group, the highest STEIS reported deaths are jointly 40-49 and 50-59 groups. If the unknown and physical causes of death are removed, leaving just suspected suicides the rate is highest in the 40-49-year olds both male and female.



	18-20	21-29	30-39	40-49	50-59	60-69	70-79	80-89
Male	2	2	2	9	7	2	0	1
Female	0	1	0	2	2	0	0	0



	18-20	21-29	30-39	40-49	50-59	60-69	70-79	80-89
Male	0	2	1	5	3	1	0	1
Female	0	1	0	1	0	0	0	0

**This graph includes STEIS/SI reported suicides only.*

4.4 Ethnicity

4.4.1 The chart below shows the percentage of deaths by ethnicity for Bedfordshire and Luton. The 2011 census percentage data on ethnicity for Bedfordshire is included for comparison on the chart below. It is important to note that the population of Bedfordshire has changed since 2011 as the population has increased, and the 2011 census may no longer accurately reflect ethnicity in 2020. 2021 census statistics have not been published yet (will be available May – Jun 22).

4.4.2 For both SI reported deaths and suspected suicide deaths, in Luton deaths were exclusively reported in the white category. In Bedfordshire most deaths were reported in the white category. Deaths were overrepresented in the Mixed/Multiple ethnic groups when compared to the census population data. No deaths were reported in the Asian/British Asian category in either Luton or Bedfordshire.

Ethnicity	2011 Census demographic make-up%	2020-21 STEIS reported death % (Luton)	2020-21 STEIS reported suspected suicide (Luton) 2
White	55%	100%	100%
Mixed	4%	0%	0%
Asian	30%	0%	0%
Black	10%	0%	0%
Other	2%	0%	0%

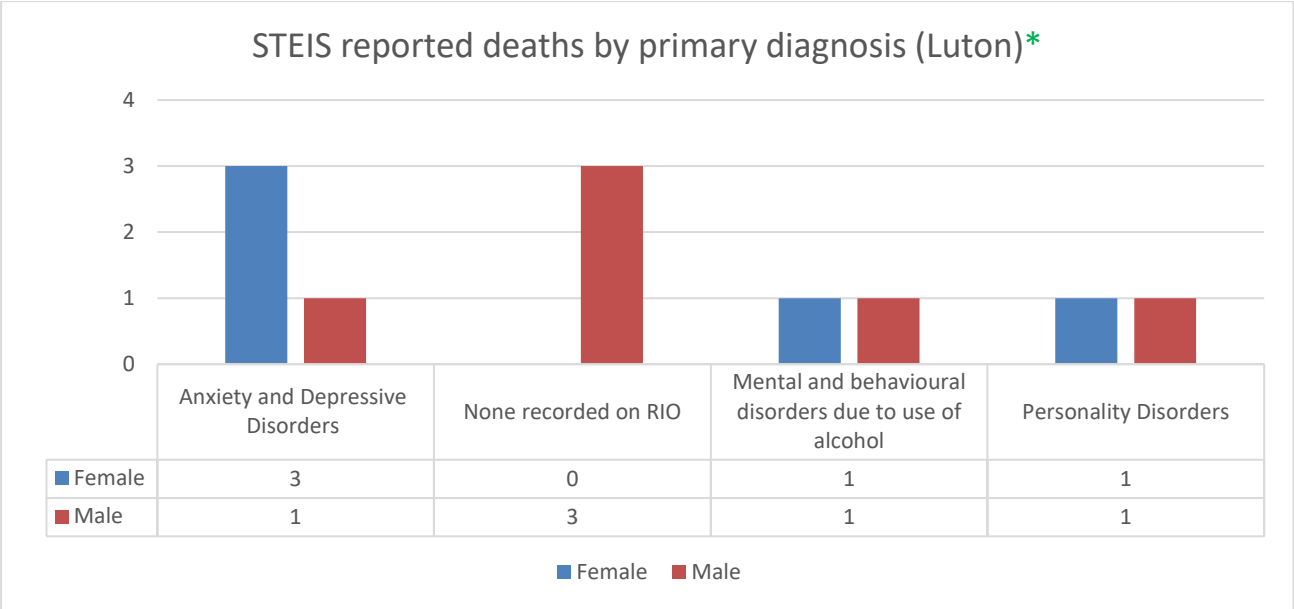
Ethnicity	2011 Census demographic make-up%	2020-21 STEIS reported death % (Bedfordshire)	2020-21 STEIS reported suspected suicide (Bedfordshire)
White	89%	89%	89%
Mixed	2%	11%	11%
Asian	6%	0%	0%
Black	2%	0%	0%
Other	0%	0%	0%

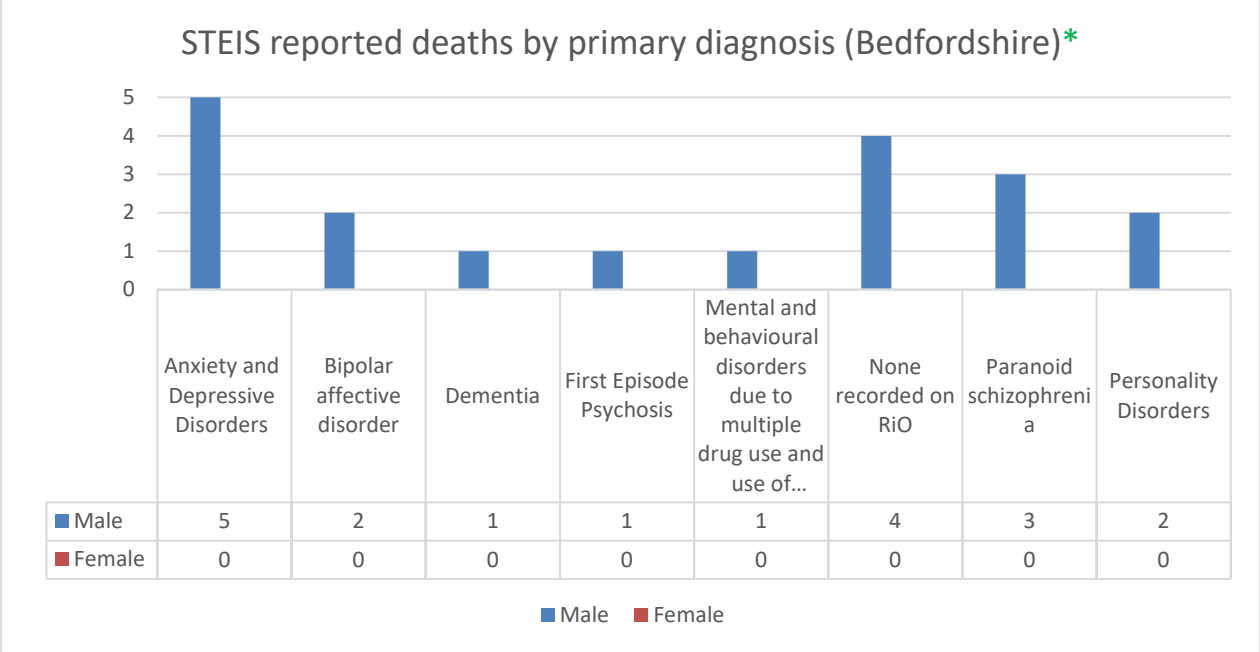
4.5 Recorded primary presenting problem/diagnosis

4.5.1 Across the unexpected deaths within this sample, as for the two previous years, depression of some form was the most common primary diagnosis. Personality disorder and psychotic illness and disorders associated with substance misuse also feature here. This is broadly consistent with the national picture.

4.5.2 Recorded diagnoses at the time of death are recorded in the table below.

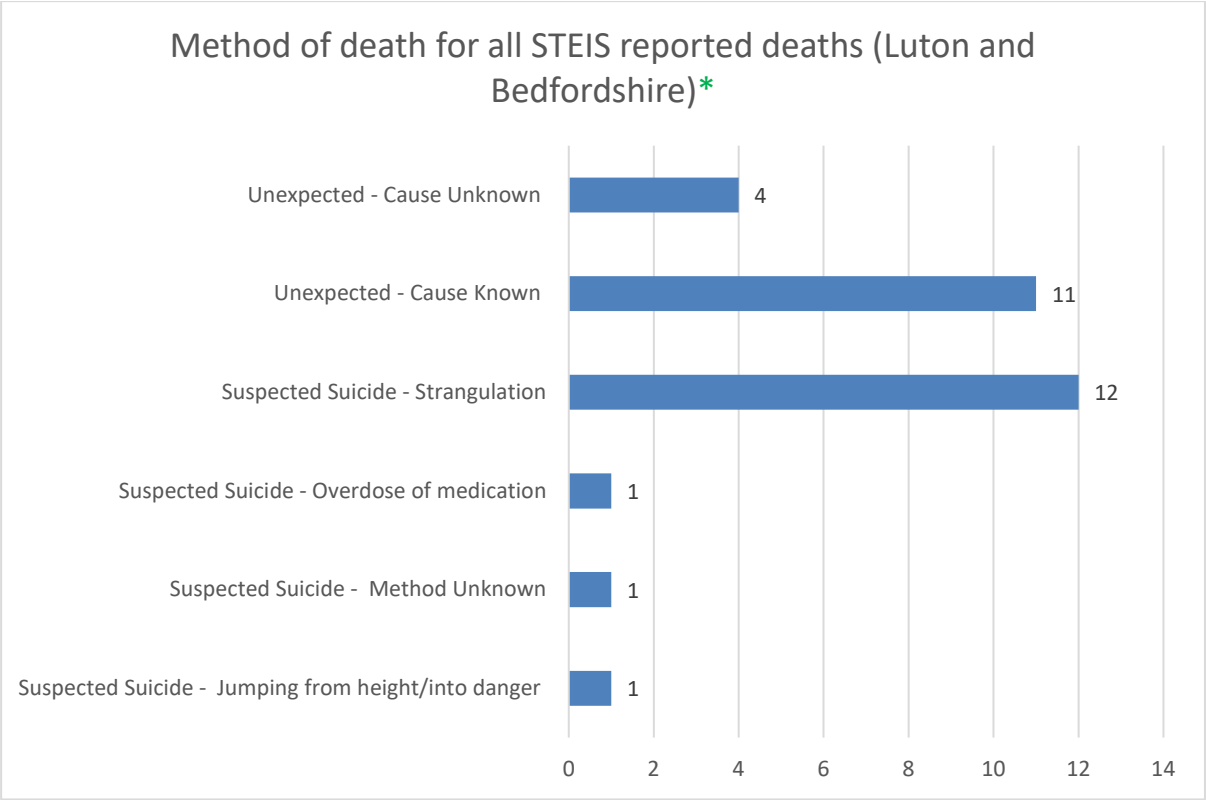
4.5.3 In Bedfordshire there were 3 males with diagnoses of paranoid schizophrenia (compared to 4 the previous year which was noted in last year's report).





4.6 Causes of Death

4.6.1 This graph shows the method of death recorded on the Datix incident reporting form for Luton and Bedfordshire combined. It includes data for all STEIS reported deaths from April 2020 to March 2021. National data reports hanging as the most common cause of death. This data is similar here with an n = 7, although the reporting categories on Datix are slightly different, classifying strangulation rather than hanging.



This graph includes all STEIS/SI reported cases (unexpected known, unknown and suspected suicide).

4.6.2 For unexpected deaths reported on Datix, the causes were further reviewed; often the cause became known as more information became available over time.

4.6.3 For those deaths recorded as unexpected – cause unknown it was established that the cause of death could not be ascertained in two cases and wasn't confirmed in two cases.

4.6.4 For those deaths recorded as unexpected - cause known a variety of causes were recorded, the majority including drug toxicity and cardiovascular disease:

- Fall from height;
- Service User took drugs but actual cause of death not confirmed;
- Extradural haemorrhage;
- Opiate and Benzodiazepine toxicity;
- Drug toxicity, LV hypertrophy and alcohol dependent syndrome;
- Aspiration pneumonitis and excessive use of cannabis, quetiapine and venlafaxine;
- Heroin toxicity;
- Severe coronary heart disease and caffeine toxicity;
- Bronchopneumonia and drug toxicity;
- COVID and Coronary Heart Disease and cardiac arrest;
- Cardiac failure and asphyxia and Heroin and Cocaine and Pneumonia.

4.7 Contact at Time of Death

4.7.1 There was an even spread of services in contact at the time of death, except for a slightly higher number who were in contact with the Bedford Crisis Resolution and Home Treatment team where 3 service users with suspected suicide were in contact at time of death.

4.7.2 There were no inpatient suspected suicides. Most suspected suicide service users who were in contact at time of death were in contact with community mental health teams, with an even spread across teams.

Bedfordshire	**All STEIS reported deaths**	**STEIS reported Suspected Suicide**
Inpatient Wards		
Fountain Court (Older Person Ward)	1	0
CMHT Teams		
Older Persons CMHT	1	1
South Bedfordshire Older Persons CMHT	1	1
Bedford East CMHT*	3	1
Bedford Recovery Service	2	1
Bedford West CMHT*	1	1
Court Liaison and Diversion Team	1	1
Dunstable CMHT	3	0
Early Intervention in Psychosis	1	0
Crisis Teams		
Beds and Mid Beds CRHT	5	3
TOTAL	19	9
Luton	**All STEIS reported deaths**	**STEIS reported Suspected Suicide**
Inpatient Wards		
Coral Ward	1	0
Onyx Ward	1	1
CMHT Teams		
Brantwood CMHT	2	2
Court Liaison & Diversion Team	1	0
Dallowsdown CMHT	1	1
Stockwood CMHT	1	0
Wardown CMHT	3	1
Crisis Teams		
Luton and South Bedfordshire CRHT	1	1
TOTAL	11	6

*These are historic team names which no longer exist. Since the reconfiguration of Bedford CMHT teams, they are now known collectively as:

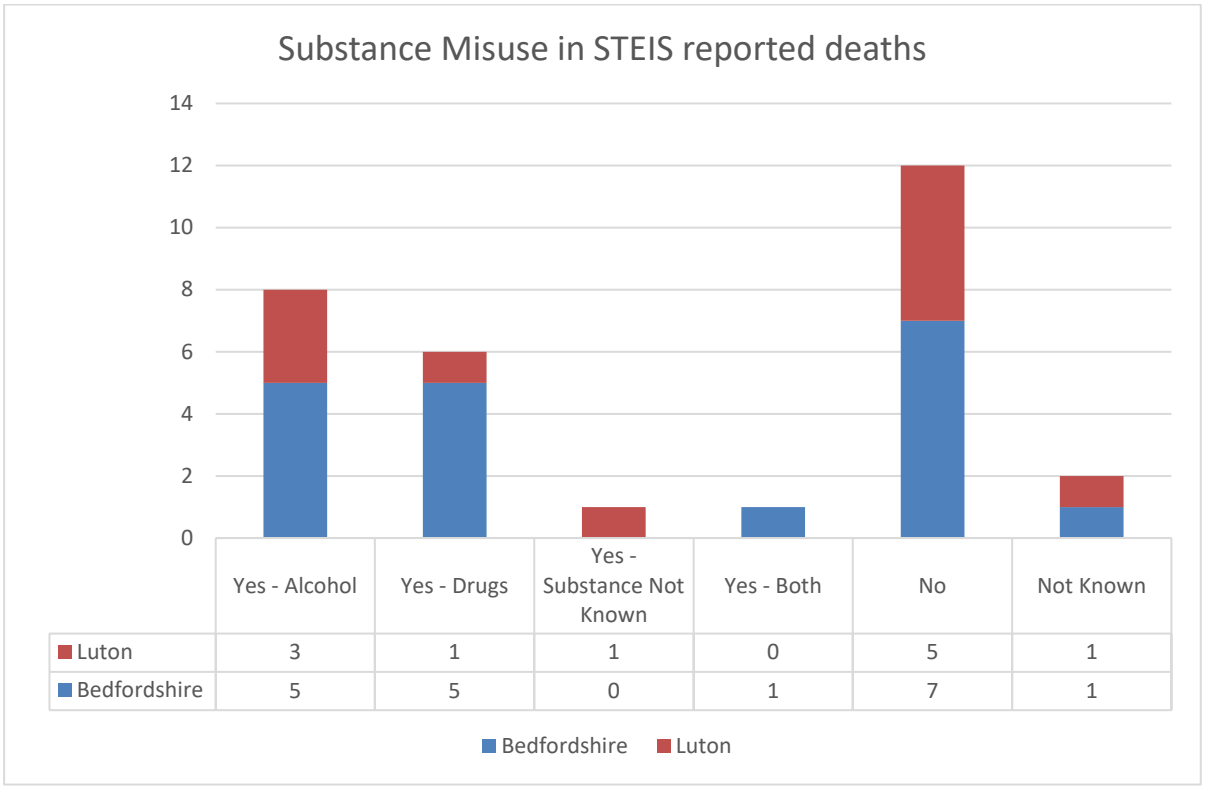
BD CMHT Adult Recovery
BD CMHT Non CPA MDT
BD CMHT Triage, Assessment and Brief Intervention.

4.8 **Unexpected Death and Relationship Status**

4.8.1 Single service users made up the largest proportion of deaths. Of the 15 STEIS reported deaths by suspected suicide 4 were married, 1 was separated, 3 were single and 4 were of unknown relationship status and 2 were co-habiting.

Relationship Status (Luton & Bedfordshire)	STEIS reported Deaths	STEIS reported suspected suicide
Co-Habiting	4	2
Married	6	4
Separated	1	1
Single	13	3
Unknown	5	4
Widowed/Surviving Civil Partner	1	1
Total	30	15

4.9 Substance misuse

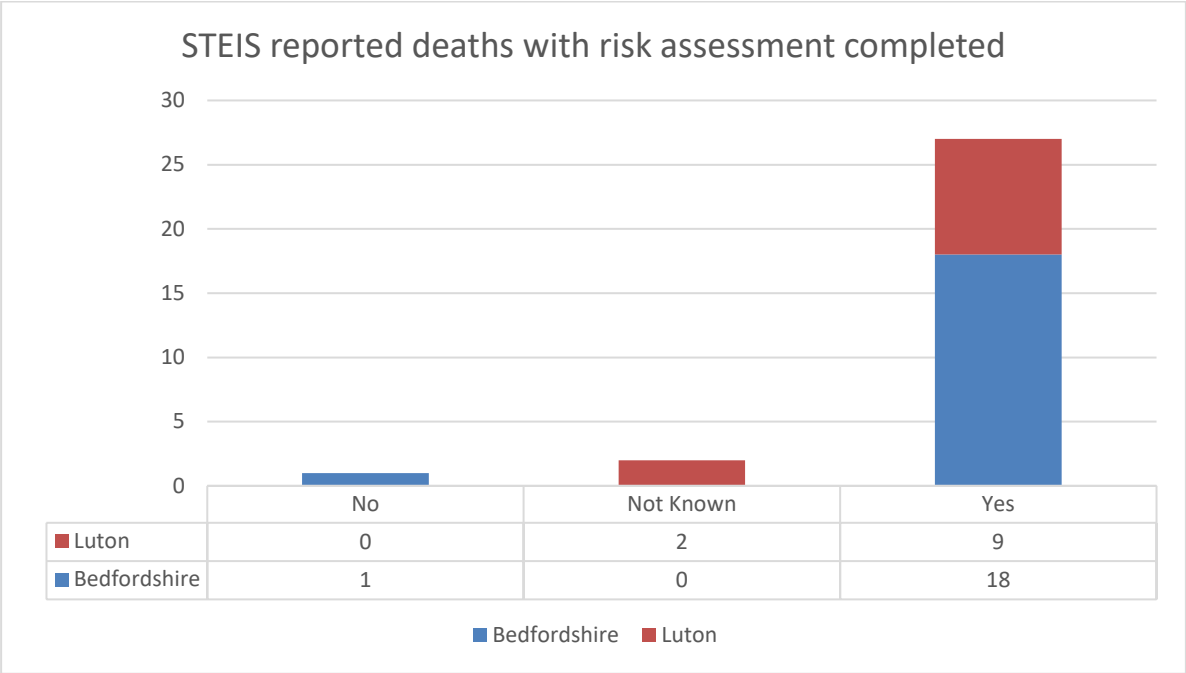


4.8.2 In this review, 1 service user was noted to have chronic gambling problems.

4.9 Homelessness

4.9.1 Homelessness was not reported for any STEIS reported deaths (including suspected suicide) across Luton and Bedfordshire for both male and female.

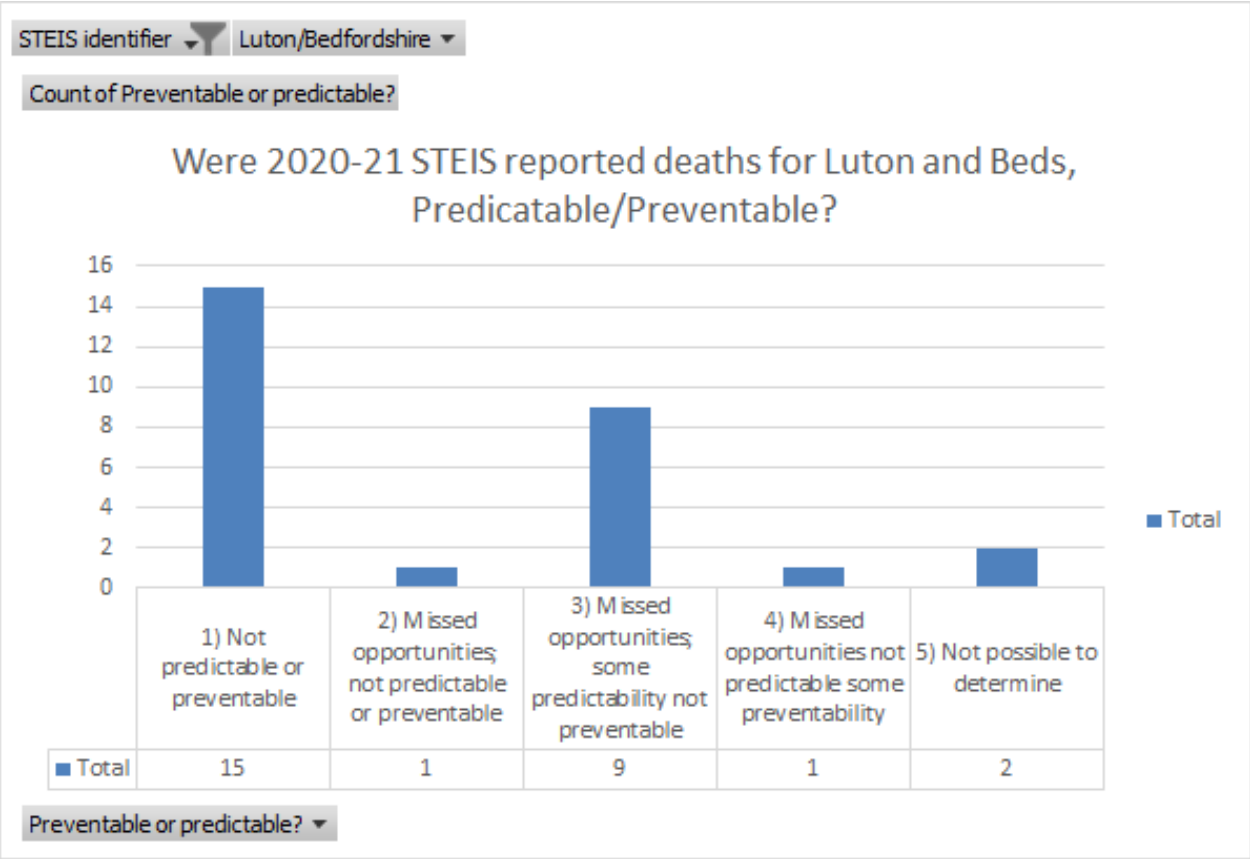
4.10 Risk Assessment



4.10.1 In 1 case, no formal documented risk assessment was identified in the SI report and the action plan included actions around risk assessment. In a further 2 cases, no risk assessment could be identified from review of the 48 hour or SI report but there was no further comment in the SI report about the presence or quality of risk assessment.

4.11 Preventability and Predictability

4.11.1 The Trust's SI reviews endeavour to determine root causes of any given incident and based upon these to assess for predictability and preventability. These are difficult determinations in many cases, and it is important to highlight the role of the Coroner in determining the details of deaths and where appropriate, measures necessary to prevent future deaths.



4.11.2 The reviewer looked for statements about predictability or preventability in the SI reports and classified into the 5 categories shown in the table.

4.11.3 Of the 30 STEIS cases, 15 were felt not to be predictable or preventable by the SI reviewers. In 10 cases, there were considered to have been missed opportunities where there was some predictability or preventability. As with the previous year most missed opportunities were around predictability (9) rather than preventability (1).

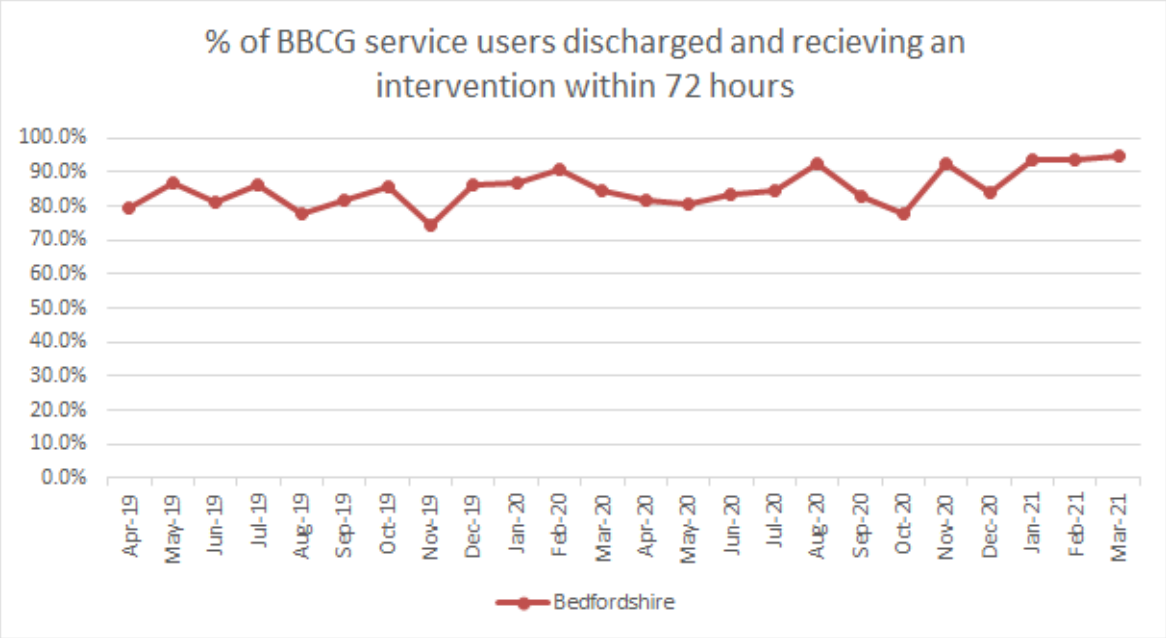
4.11.4 Of those 9 cases where missed opportunities were around predictability, drug and/or alcohol use was a factor in presentation in 7 cases and the service user was in contact with addiction services in 5 presentations. The dual diagnosis policy was not followed in 2 cases. Service users were all under the care of community mental health teams and often under the care of multiple teams or in the process of being discharged or transferred between teams. 4 of the 9 cases had recently been discharged from an inpatient setting; 3 of 4 did receive 72 hour follow up. Follow up plans following discharge from the ward setting or following community review were sometimes missing, insufficient or not actioned. 3 cases highlighted insufficient risk assessment.

4.11.5 Actions plans for these SI reviews often had multiple actions and included improvements to policies, improved communication and interfaces, improved teaching and training and sharing learning through learning lessons events.

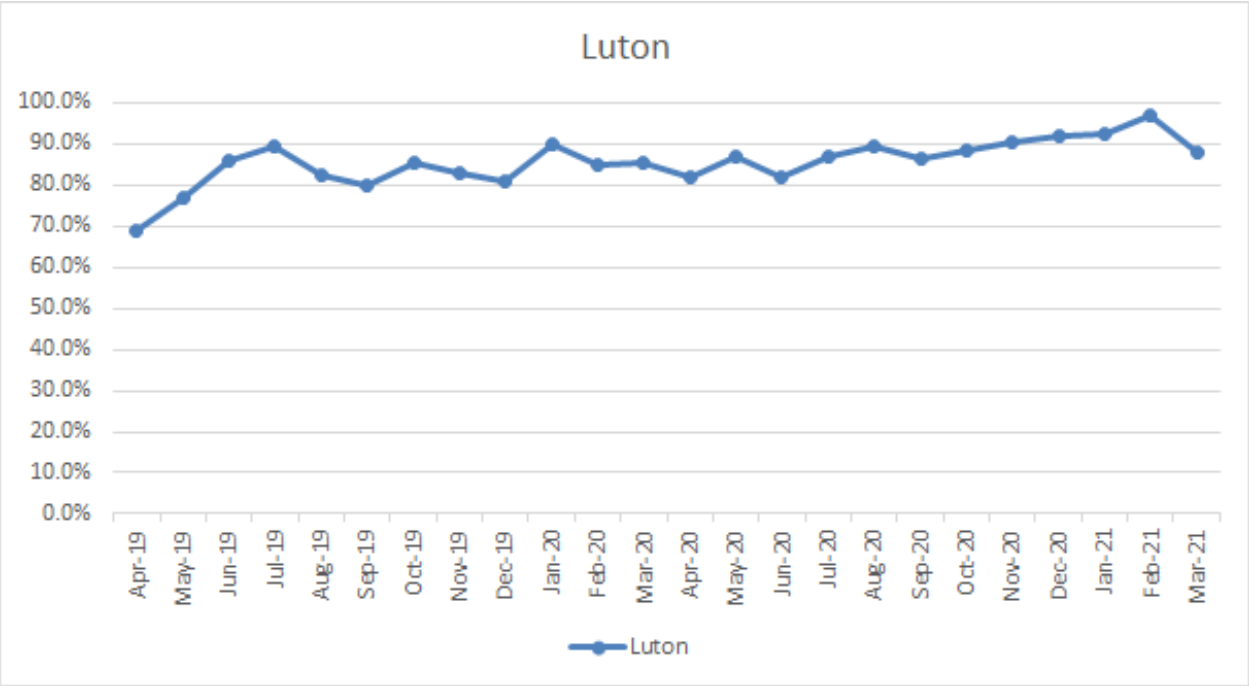
4.12 **Follow up after discharge from an inpatient ward**

4.12.1 It is well known that the risk of completed suicide is highest in the first three days following discharge.

4.12.2 Since April 2019 the Trust has been monitoring progress against a 72-hour follow-up window. This is in place for all patients discharged from the ward regardless of their CPA status. The graphs below illustrate the % of service users receiving an intervention with 72 hours.



This graph is showing us the % of Bedfordshire service users discharged and receiving an intervention within 72 hours. Between April 19 and March 21, the percentage of service users receiving an intervention within 72 hours has remained between 75% - 95%.



4.12.3 This graph is showing us the % of Luton service users discharged and receiving an intervention within 72 hours. Between April 19 and March 21, the percentage of service users receiving an intervention within 72 hours has remained between 68% - 97%.

5.0 Conclusions

5.1 Suicide rates fluctuate from year to year and it is not possible to draw conclusions on an individual years' data, however, there is an overall downward trend in all serious incidents over time in both Luton and Bedfordshire. It is not possible to draw any conclusions about the effect of the pandemic at this early stage, other than to note that there was no increase in numbers compared to the previous year.

5.2 The demographic characteristics of those that completed suicide reflect the national picture where males account for three quarters of suicide. The age demographic with the highest rates of suicide are the 45-64 year olds.

5.3 There is continued progress in suicide prevention work in Luton and Bedfordshire. Progress on last year's actions including the accelerated expansion of crisis pathway services ahead of Long Term Plan ambition timelines. This improves access and responsiveness for people in mental health crisis in Luton and Bedfordshire who can now access a 24/7 crisis line, self-refer, and access to 24/7 crisis team care and treatment.

5.4 Ongoing suicide awareness and response training rollout was severely impacted by the pandemic and no training took place during this year. The position is not

favourable compared to last year, however, the training will restart with a virtual offer and trainers have been retrained to deliver this.

5.5 Where SI reviews identified missed opportunities in predictability, the majority of the service users had co-morbid mental health and substance use problems. Further consideration of opportunities to improve care for people with dual diagnosis can be considered, building on the work already underway, for example, the inpatient addictions worker pilot.

6.0 Recommendations

6.1 Continue Crisis Pathway expansion with the rollout of Older Peoples' Crisis services and expansion of crisis café access. Progress on this is monitored through local healthcare governance group and Directorate Management Team.

6.2 Continue progress on the rollout of connecting with people suicide awareness and response training using the virtual training package.

6.3 Luton and Bedford DMT to continue to support the embedding of this approach to care for people with suicidality in everyday clinical practice (including protected time for trainers/lead, exploring RiO functionality for recording safety plans, building training into induction and rolling CPD programmes etc).

6.4 For the Inpatient Directorate, to review the cohort of service user cases with concurrent substance use and psychiatric disorders identified in this review and use any learning arising to inform ward-based addictions care developments.

7.0 Action Being Requested

7.1 The Board is asked to **NOTE** the assurance provided and **CONSIDER** any other sources of assurance required.