12th December 2023

Dear NHSE CEO Amanda Pritchard, DHSC Sir Chris Wormald KCB, Permanent Secretary, Minister for Health and Social Care Victoria Atkins, Minister for Mental Health Maria Caulfield, CEO CQC Ian Trenholm,

Norfolk and Suffolk Foundation Trust Deaths

We are writing to express our dismay at the collective failure of NHS England, the Department for Health and Social Care (DHSC) and the Care Quality Commission (CQC) to carry out your duty of care to the people of Norfolk and Suffolk needing mental health support and treatment. We are shocked at the silence from all your organisations to the Grant Thornton report on the thousands of deaths and the fact that neither Norfolk and Suffolk Foundation Trust (NSFT) nor your organisations' know what those exact figures are. To our knowledge no public comments have been issued and no apologies given by your organisations for your part in this scandal. We believe this is the biggest deaths scandal and crisis in the history of the NHS.

You all have responsibility for oversight of NSFT. You have failed in your public duty. You have been asleep at the wheel and you have let the population of Norfolk and Suffolk down.

The Campaign to Save Mental Health services has been raising concerns over the deaths crisis at NSFT for over 10 years now. The so-called and reckless radical re-design led to the closure of services used by the most vulnerable patients and service users. This led to a completely needless rise in unnecessary deaths. This also led to the first of many failures of CQC inspections. NSFT has never recovered and the deaths kept on escalating and your organisations failed to address this crisis.

In April 2022, NSFT was rated 'inadequate' by the Care Quality Commission (CQC) for a fourth time and campaigners stated that there had been over 1,000 unexpected deaths since 2013. NSFT said they 'did not recognise' that figure. Clive Lewis MP raised this in Parliament. We presented our concerns to a group

of MPs, including the then Minister Gillian Keegan, in July 2022. We said that NSFT had 'lost count' of deaths because their systems, processes and governance were inadequate, and that reporting of deaths to the board and external bodies showed inconsistencies and gaps in data. Subsequent closer examination by campaigners of the documents in the public domain suggested that 1,000 figure was an underestimate, and we identified at least 2,600 deaths. However, Grant Thornton refer to a catastrophic 8,440 deaths in 3.5 years.

We were so concerned about this that three campaign members wrote: Forever Gone: Losing Count of Patient Deaths - an independent response to the Norfolk and Suffolk NHS Foundation Trust's mortality recording and reporting review by Grant Thornton (2023) by Caroline Aldridge, Anne Humphrys and Emma Corlett.

This report is dedicated to the people who have lost their lives and those left behind. It was written because of the poor quality of the very expensive Grant Thornton report and because the system, for which you are responsible, could not be trusted to tell the truth. We are also concerned about the 'horse trading' that went on between Grant Thornton presenting their first report to NSFT and the changes that were made when the much-delayed final report emerged.

The campaign's views are summed up in the open letter to Rt Hon Stephen Barclay MP (Secretary of State for Health and Social Care) and Rt Hon Maria Caulfield MP (Minister for Mental Health) at the beginning of the report:

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

The revelations, uncovered by BBC Newsnight recently, that NSFT and Grant Thornton colluded to change the report which was watered down 3 times from the original. These significant changes to the draft report were a desperate attempt by NSFT senior managers to limit the reputational damage from the exposure of the huge numbers of deaths and that they had lost count of the people who had died whilst under their care.

Rob Behrens, the Parliamentary and Health Service Ombudsman critisised this saying "I am concerned at the difference between the draft report and the published report, and because the differences in the texts at key points are so huge, that this is not just a bureaucratic drafting of the issue…" This is about trust and there is no trust in a leadership and governance system which puts their reputations above patient safety, duty of candour and transparency. It also again underlines the complete lack of scrutiny and failure by your bodies – NHSE, DHSC and the CQC - who are supposed to hold NSFT to account.
The Integrated Care Boards (ICBs) in both Norfolk and Suffolk have issued public apologies and seem to be accepting that something needs to be done. However, they cannot, by themselves, create the changes that are necessary. It appears that NHS England and the Ministers responsible are preventing positive change from happening. The ICBs also do not have the funding to guarantee parity of funding to mental health with other parts of the NHS.
Since publication, NSFT have added to our concerns. Their initial responses to the report were totally without professionalism or emotional intelligence, confirming what we have been saying for a decade, that they have not got the skills, culture or capability to fix this and need to be disbanded. They have further traumatised the bereaved families and the deaths keep on rising as recent inquests locally demonstrate. This completely unprofessional attitude to the lives and deaths of patients and service users illustrate why NSFT is not a fit organisation to run services for people in mental distress in Norfolk and Suffolk.

Rather than doing the right thing, disbanding NSFT and removing the senior managers and Board you chose to continue with the same leadership team which only last year 140 doctors from NSFT wrote a letter to the Chair expressing "lack of confidence in the organisation's leadership". The CQC chose to let NSFT 'off the hook' without taking evidence from patients, service users, carers and campaign members and ignoring these damning criticisms from the Trust's clinical leaders. The CQC also uprated your assessment of NSFT whilst the senior managers and Grant Thornton were changing their findings through 3 drafts to put the management and governance in a better light. This is a scandalous cover up where you were duped or complicit.
Now NSFT have been exposed spending the best part of £1m on a PR firm to con the Care Quality Commission (CQC) into raising their rating to avoid disillusionment. No amount of window dressing covers the continuing Coroners inquests and Prevention of Future Deaths (PFD) notices. NSFT

succeeded in pulling the wool over the eyes of the CQC but the bodies of their patients and service users keep on piling up.
The sacking of the latest failed CEO and the head hunting of a new interim CEO is another desperate attempt to buy more time. This is like parachuting in a new captain to the Titanic after it has hit the iceberg. We have had virtually one CEO a year (if you include interims) for the last 10 years and they have **ALL** failed to make an impact and turn things around. In fact, things continue to get worse.
We think the failure to disband NSFT and give them 'one last chance' was a huge mistake, one of many over the last decade of failure, by your organisation's who are supposed to have oversight and a duty of care. Every additional unnecessary death is on your watch and is your responsibility.
Throughout the Prevention of Future Death reports given to NSFT by the coroners, actions that need to be taken have also been brought up in recent CQC reports also under action to be taken and requirement notices under the Health and Social Care Act 2008 and under the fundamental standards below which care must not fall. In 2020, seven requirement notices were served that highlighted NSFT was failing to safeguard service users from improper treatment, failing to reach safe staffing levels and failing to provide safe care and treatment - these thematically and overarchingly link to the outcomes and action requested to be taken in most of the prevention of future death reports given to NSFT.

We know that a number of actions NSFT has been required to take, and have assured the coroners and CQC they have taken, have still not been done. For example in 2023, CQC highlighted that some staff had not completed mandatory training, there were wards where standards of care needed to significantly improve and staff were not always responsive at night on the wards. Staffing and care issues consistently come up in PFDs with training, lack of observations and staff shortages being most frequently mentioned.

In Theo Brennan-Hulme's PFD report, it was stated that no young person would be discharged without a face-to-face appointment. We know that in 2020, 300+ young people were discharged and off-rolled from the Youth Service by letter, this was put out as an error but then found to be a decision that was made strategically. In 2023, discharges without a face to face appointment were made via letter despite them saying in both the PFD and after the 2020 mass discharge that this wouldn't happen again.

We are so concerned at the continuing rise in deaths and repeated patterns from previous PFDs that we have written to the Chief Constables of Norfolk and Suffolk asking them to investigate and prosecute the deaths at NSFT, including making an assessment if the threshold for a charge of corporate manslaughter has been reached.
We are told that both potential service users and their loved ones are deterred from engaging with NSFT due to the repeated shocking shortfalls in care. Parents and Carers feel ignored and excluded.
We repeat again that patients, service users, family members, carers and bereaved relatives, of which there are far too many, are demanding an immediate independent statutory public inquiry and the replacement of the senior management team and Board of NSFT with a functioning team.
We are also demanding a meeting in Parliament at which all your organisations will be present and represented at the highest level, in front of the local Norfolk and Suffolk MPs, where we will coproduce an agreed action plan to stem tide of unnecessary and preventable deaths.

Yours sincerely,

Campaign to Save Mental Health Services in Norfolk and Suffolk