Care Quality Commission

Learning, candour and accountability

A review of the way NHS trusts review and investigate the deaths of patients in England

DATA ANNEXES

DECEMBER 2016

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

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Annex 1: CQC public questionnaire questions

1. When your relative died, did you/your family have concerns that you wished to be investigated?
    a. Yes
    b. No
2. When did your relative die?
    a. In the last year
    b. Between one and two years ago
    c. Between two and three years ago
    d. More than three years ago
3. Where did your relative die? (for example, in a hospital, at home)

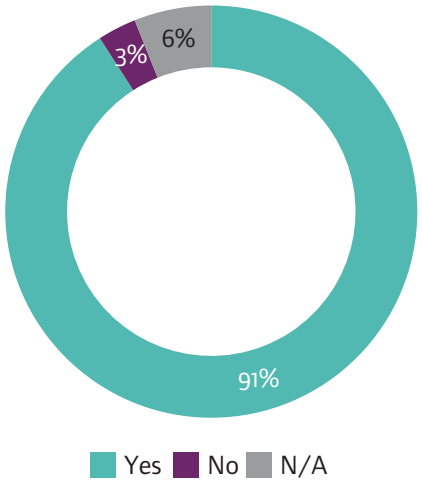
    (Free text – 150 characters)
4. How soon after your relative's death were you told an investigation would take place?
    a. Within 48 hours
    b. Between 48 hours and two weeks
    c. Between two weeks and one month
    d. More than one month after
    e. Not told until after the investigation was complete
    f. Not aware that any investigation has taken place (if f, skip to question 17)
5. Were you told how long the investigation would take?
    a. Yes
    b. No
6. If you answered yes to question 5, was the investigation report completed on time?
    a. Earlier than expected
    b. In the time expected
    c. Later than expected (if later than expected, how much later)
7. Was it made clear to you why an investigation was happening?
    a. Yes
    b. No
8. Was it made clear to you what would happen during the investigation?
    a. Yes
    b. No
9. Were you offered a family liaison officer or named point of contact from the trust for the investigation process?
    a. Yes
    b. No
10. Do you feel you had the right level of involvement in the investigation?
    a. Not enough
    b. Right amount
    c. Too much
11. Were you invited to comment/factual accuracy check the final report?
    a. Yes
    b. No
12. Do you feel that the investigation went into enough detail?
    a. Yes
    b. No
13. To what extent do you feel you/your family were treated with care and respect?
    a. Treated with less care and respect than would have liked
    b. Treated with as much care and respect would have liked

14. Do you feel that the investigation made a positive difference?
    a. Yes
    b. No
    c. Don't know
15. Was it made clear to you what had been learned as a result of the investigation?
    a. Yes
    b. No
16. Was it made clear to you what had been changed as a result of the investigation?
    a. Yes
    b. No
17. Which parts, if any, do you feel the trust did well during the investigation?
    (max 3,500 characters)
18. Which parts, if any, do you feel the trust did poorly during the investigation?
    (max 3,500 characters)

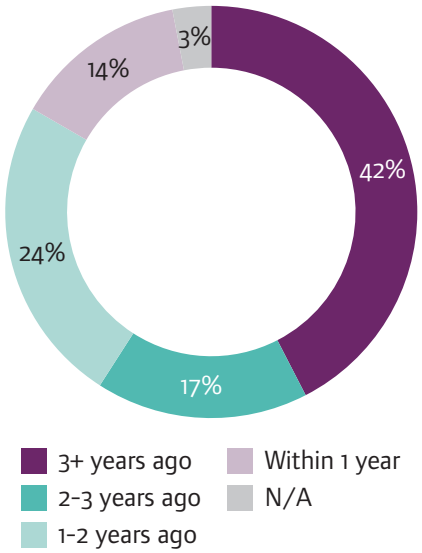
Annex 2: CQC public questionnaire summary

The public questionnaire was available on the CQC website for three weeks and was promoted through twitter and CQC bulletins. There were 66 respondents, of whom 60 (91%) had concerns that they wished to be investigated when their relative died. Respondents had the option to fill out either the full questionnaire on their experiences of an NHS investigation into the death of a service user, or to respond to the free text questions only. We received 42 responses to the full version of the questionnaire. The questionnaire was delivered as an open consultation and respondents were self-selecting volunteers. Given the challenges of identifying a robust sample of people who have experienced NHS investigations, this method was more appropriate than using surveying or sampling tools in the timeframe available. However, it should be noted that the resulting findings may not be representative of all investigations.

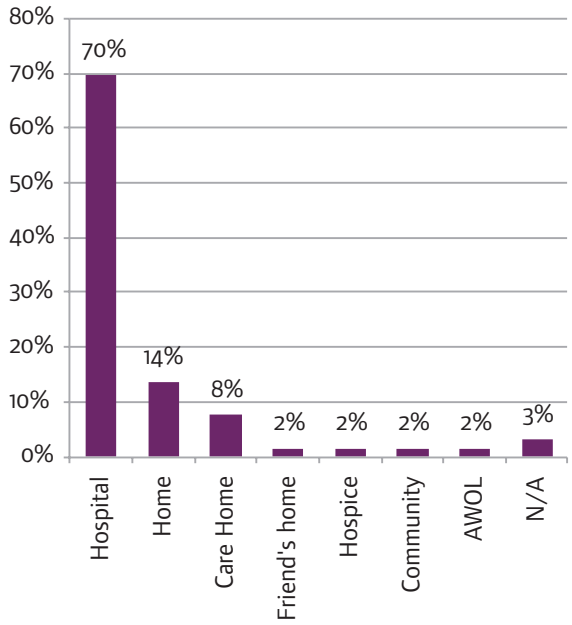
1. WHEN YOUR RELATIVE DIED, DID YOU/YOUR FAMILY HAVE CONCERNS THAT YOU WISHED TO BE INVESTIGATED?



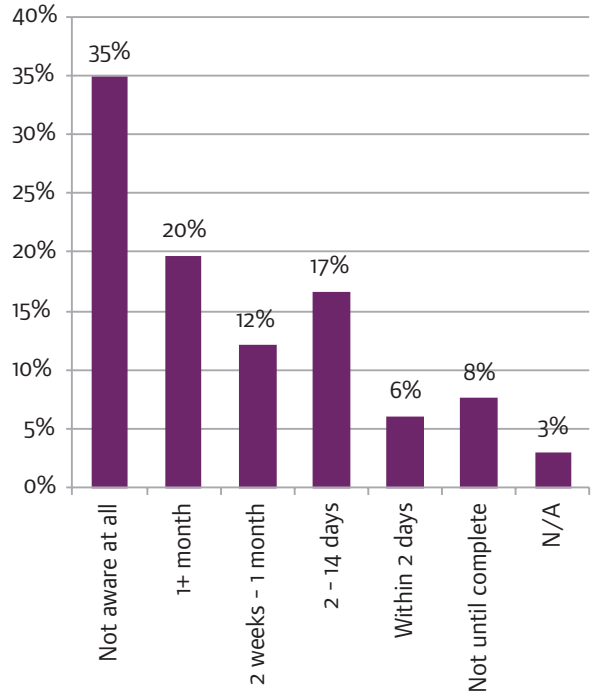
2. WHEN DID YOUR RELATIVE DIE?



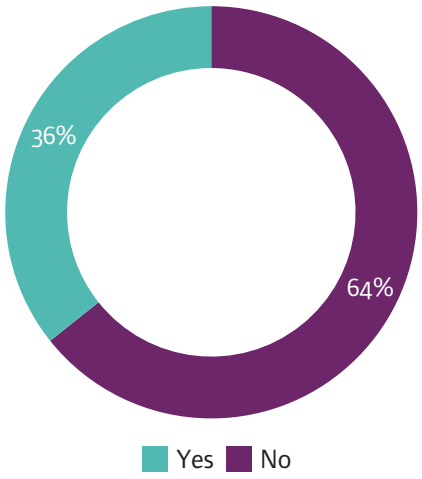
3. WHERE DID YOUR RELATIVE DIE?



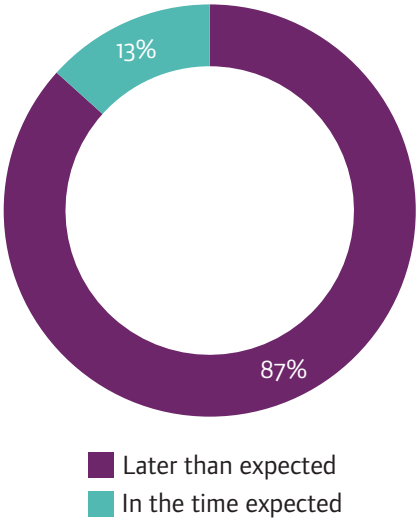
4. HOW SOON AFTER YOUR RELATIVE'S DEATH WERE YOU TOLD AN INVESTIGATION WOULD TAKE PLACE?



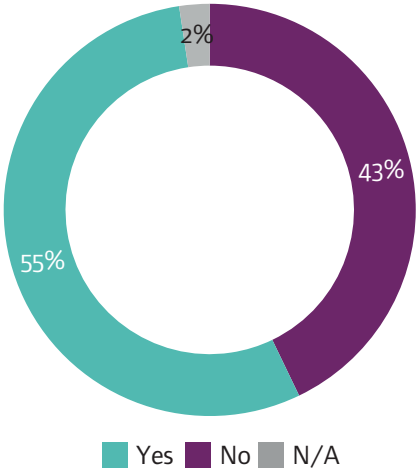
5. WERE YOU TOLD HOW LONG THE INVESTIGATION WOULD TAKE?



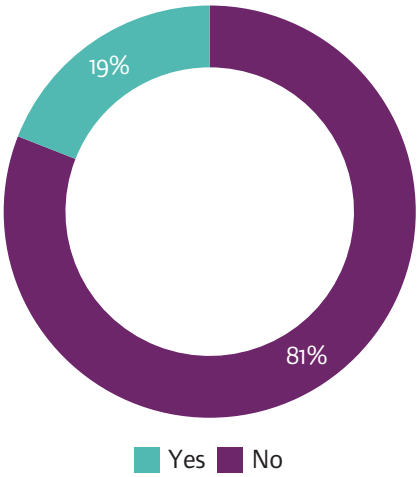
6. IF YOU ANSWERED YES TO Q. 5, WAS THE INVESTIGATION REPORT COMPLETED ON TIME?



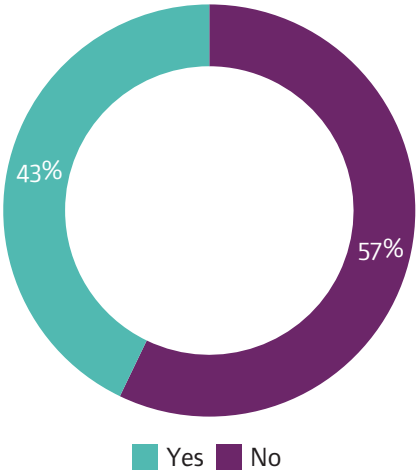
7. WAS IT MADE CLEAR TO YOU WHY AN INVESTIGATION WAS HAPPENING?



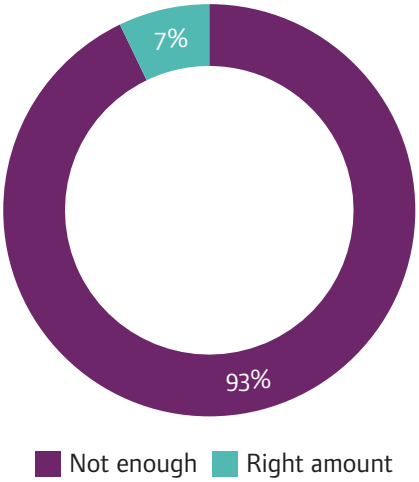
8. WAS IT MADE CLEAR TO YOU WHAT WOULD HAPPEN DURING THE INVESTIGATION?



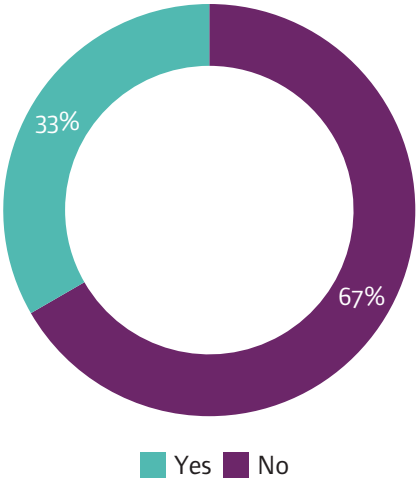
9. WERE YOU OFFERED A FAMILY LIAISON OFFICER OR NAMED POINT OF CONTACT FROM THE TRUST FOR THE INVESTIGATION PROCESS?



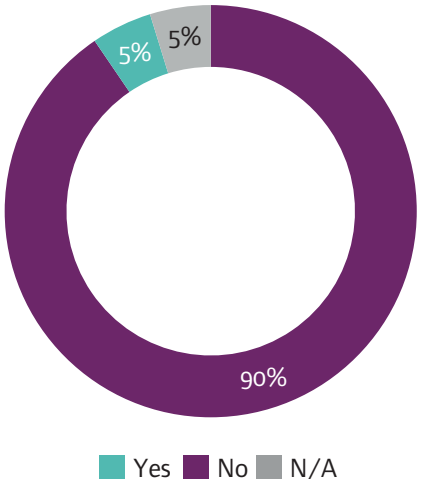
10. DO YOU FEEL YOU HAD THE RIGHT LEVEL OF INVOLVEMENT IN THE INVESTIGATION?



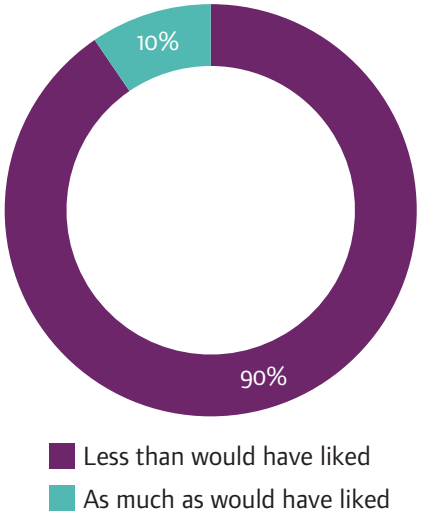
11. WERE YOU INVITED TO COMMENT/FACTUAL ACCURACY CHECK THE FINAL REPORT?



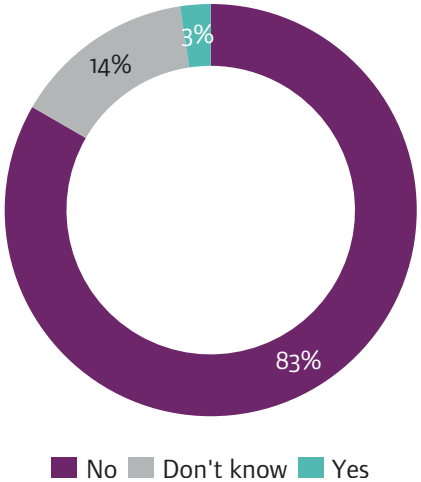
12. DO YOU FEEL THAT THE INVESTIGATION WENT INTO ENOUGH DETAIL?



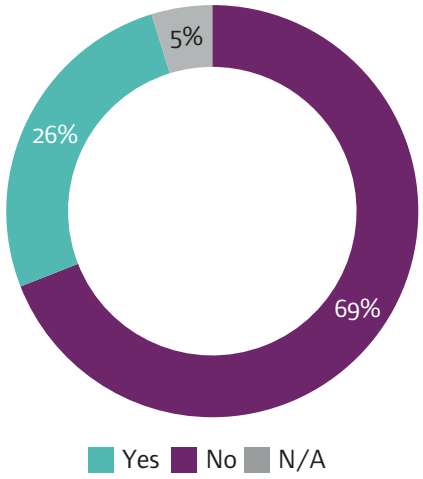
13. TO WHAT EXTENT DO YOU FEEL YOU/YOUR FAMILY WERE TREATED WITH CARE AND RESPECT?



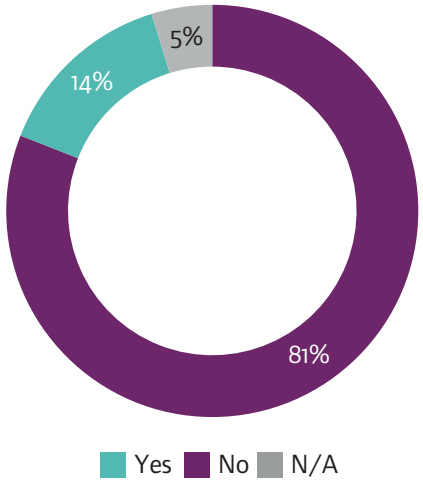
14. DO YOU FEEL THAT THE INVESTIGATION MADE A POSITIVE DIFFERENCE?



15. WAS IT MADE CLEAR TO YOU WHAT HAD BEEN LEARNED AS A RESULT OF THE INVESTIGATION?



16. WAS IT MADE CLEAR TO YOU WHAT HAD BEEN CHANGED AS A RESULT OF THE INVESTIGATION?



Annex 3: CQC provider information request questions

1. What was the total number of deaths recorded between 1 April 2015 and 31 March 2016 of people who had contact with the trust?
2. What was the total number of deaths between 1 April 2015 and 31 March 2016 reported as an incident on the National Reporting and Learning System (NRLS)?
3. What was the total number of deaths recorded between 1 April 2015 and 31 March 2016 reported on Strategic Executive Information System (STEI)S?
4. How many deaths recorded between 1 April 2015 and 31 March 2016 had an initial review completed? (see FAQ document for further details)
5. How many deaths recorded between 1 April 2015 and 31 March 2016 had a Level 1 Concise internal investigation? (see FAQ document for further details)
6. How many deaths recorded between 1 April 2015 and 31 March 2016 had a Level 2 – Comprehensive internal investigation? (see FAQ document for further details)
7. How many deaths recorded between 1 April 2015 and 31 March 2016 had a Level 3 – Independent investigation? (see FAQ document for further details)
8. For recorded deaths that occurred between 1 April 2015 and 31 March 2016 and had a level 1 or level 2 investigation; (see FAQ document for further details)
    a) How many investigations have been completed and submitted to commissioners?
    b) How many had, or offered, family and carer involvement in the investigation process?
    c) What is the average length of time for completion of the investigation?
    d) Of the completed investigations, in how many were families informed of the results of the investigation?
9. For deaths recorded between 1 April 2015 and 31 March 2016, how many complaints regarding death investigations has the trust received?
10. For deaths recorded between 1 April 2015 and 31 March 2016, how many complaints regarding the decision not to investigate a death has the trust received?
11. Please explain any caveats which must be considered when analysing the data provided by your trust. (e.g. data availability issues)
12. What would you say were the main things that work well with your trust's approach to identifying which deaths should be investigated?
13. In your opinion, what are the main barriers the trust faces in identifying which deaths should be investigated?
14. What would you say were the main things that work well with your trust's approach to undertaking investigations?
15. What do you believe are the biggest challenges and risks to the trust when undertaking investigations?
16. Can you describe the main ways in which lessons learned from any investigations that have been undertaken have been put into practice in the trust?
17. What single change do you think would have the biggest impact in allowing learning to be embedded from death investigations?

18. What would you say were the main things that work well with your trust's approach to involving families and carers in death investigations?

Trusts were asked to provide responses for the following groups of people who use services:

Acute trusts:

1. Service users who died as an inpatient or in an A&E setting
2. Service users who died within six months of contact

Community trusts:

1. Service users who died whilst receiving ongoing care
2. Service users who died within six months of receiving care

Mental Health trusts:

1. Service users who died within an inpatient setting, or in an acute setting following transfer from a Mental Health setting
2. Service users in the community who died whilst receiving ongoing care
3. Service users who died within six months of receiving care

All trusts were asked to provide their answers broken down as follows for each care setting:

1. All
2. Service users in receipt of care from secondary mental health services
3. Service users with a learning disability diagnosis, or in receipt of care from learning disability services
4. Service users in receipt of care from secondary mental health services who also had either a learning disability diagnosis, or were in receipt of care from learning disability services

Annex 4: CQC provider information request supporting information document

Frequently asked questions

Why is this data being requested?

CQC is carrying out a review of how NHS trusts identify, report, investigate and learn from deaths of people using their services, following a request from the Secretary of State for Health.

CQC's review will consider the quality of practice in relation to identifying, reporting and investigating the death of any person in contact with a health service managed by an NHS trust; whether the person is in hospital, receiving care in a community setting or living in their own home. The review will pay particular attention to how NHS trusts investigate and learn from deaths of people with a learning disability or mental health problem. Information provided through this survey will form a vital part of this review.

How will this data be used?

The data will be analysed nationally and regionally, providing evidence with which to inform a picture of the current practice in the investigation of deaths across NHS trusts and forming a key part of the national report scheduled to be published in December 2016. The submitted data will also provide valuable context for staff completing a small sample of site visits as part of this review.

Will responses remain anonymous?

Yes, provider responses will remain anonymous and will not be published in the final report.

However, if a provider demonstrates a particularly good process or policy which the CQC would like to use as an example of good practice in the published report, then the CQC will be in contact to gain permission for this, and to find out more details. If any major concerns were identified, inspectors may be asked to follow up, but would notify you in advance.

Will this data be used to select the site visits?

No, the sites we will be visiting as part of this project have already been selected based on data already available to the CQC. The visits are scheduled to take part in July and August and those trusts selected have been notified.

What do we do if we do not have the data available?

The survey will not allow you to leave any answers blank. If you do not have the quantitative data available for any questions please enter 'NK' into the corresponding answer box. Please do not use 0 for unknown answers. There is space to provide data caveats at the end of the quantitative questions, to explain any 'NK' answers given.

Definitions

Word/phrase	Survey meaning
Deaths recorded in 2015/16	All deaths which occurred between 01/04/2015 and 31/03/2016. This includes deaths where the last contact between the trust and patient was prior to 01/04/2015.
Contact	This includes: • Inpatient spell (up to date of discharge) • Attended outpatient appointment • A&E attendance • Care given by the provider in patients own home, care home or any other location • Any face-to-face contact between provider and patient • Telephone appointment • Contact with any of the providers mental health support teams (including crisis support, substance misuse, mother and baby services, assertive outreach teams) This does not include: • Telephone calls to discuss appointments
Initial Review	As defined in the NHS Serious Incident Framework (for more information, see **https://www.england.nhs.uk/patientsafety/serious-incident/**). An initial 72-hour review to confirm if a serious incident has occurred and the level of investigation required, if any.
Level 1 Concise Internal Investigation	As defined in the NHS Serious Incident Framework (for more information, see **https://www.england.nhs.uk/patientsafety/serious-incident/**). Concise/compact investigation reports are conducted by the provider organisation where the incident occurred which includes the essentials of a credible investigation. Suitable for less complex incidents which can be managed by individuals or small groups at a local level and must be completed within 60 working days.
Level 2 Comprehensive Internal Investigation	As defined in the NHS Serious Incident Framework (for more information, see **https://www.england.nhs.uk/patientsafety/serious-incident/**). Comprehensive investigation reports are conducted by the provider organisation with all the elements of a credible investigation, possibly with the additional involvement of independent members as part of the investigation team for additional scrutiny and objectivity. Suitable for complex issues which should be managed by multidisciplinary teams and must be completed within 60 working days.
Level 3 Independent Investigation	As defined in the NHS Serious Incident Framework (for more information, see **https://www.england.nhs.uk/patientsafety/serious-incident/**). Comprehensive investigation reports are conducted by a lead investigator and investigation team who must all be independent to the provider. This is required when the integrity of the investigation may be challenged or where it will be difficult for the organisation to objectively conduct an investigation internally, this may include to capacity or capability concerns. To be completed within six months of the investigation being commissioned.
Mental health diagnosis	Patients in receipt of any secondary mental health services

Word/phrase	Survey meaning
Learning disability diagnosis	Patients with any learning disability
Family and carer involvement	The family and/or carer of the patient were either involved in the review and contributed their experiences of the events or were invited and formally declined to be involved in the process.
NRLS	National Reporting and Learning System
STEIS	Strategic Executive Information System
Family liaison officer	Member of staff whose role includes the following duties: • Give advice to answer concerns about the service and care • Liaise with NHS staff and support groups to find ways to answer family concerns • Help distressed families understand and follow the NHS complaints procedure • Provide information on how to get independent help with a complaint
Learning Disability liaison officer	Member of staff whose role is to support patients with learning disabilities when they are accessing NHS care as well as supporting staff in the delivery of appropriate support and care.
Time for completion of investigation	Total number of days taken from the date of decision to investigate to the date the investigation was submitted to commissioners.
Complaints	Formal written complaint received
Caveats	Where you have been unable to answer any question, we ask that you give a brief explanation to improve our understanding any quality issues with this data collection. We would also welcome feedback where you have answered the question, but there are data issues we should be aware of. The following list is not exhaustive, but issues encountered could include: • Mental health and/or learning disability diagnosis data not available to provide accurate breakdown • Date of death data and notifications unreliable for post-care deaths • Trust did not have available resources to complete data requests

Annex 5: CQC provider information request response summary table

- *One mental health trust reported 0 inpatient deaths, which we believe is correct
- Total responses = count of responding trusts
- Total count = sum of deaths/reviews/investigations from all responding trusts
- Average count = average number of deaths/reviews/investigations from responding trusts
- Median, mean, lower and upper quartiles have been calculated from the rate of reviews/ investigations of all deaths, from the responding trusts.

For example, an acute trust reporting not knowing how many inpatient deaths had a level 1 investigation will not contribute to the total responses, total count, average count, mean, median, lower or upper quartiles for the acute inpatient level 1 investigation statistics. However, if the same trust provided the number of level 2 investigations completed into inpatient deaths then they would be included in the total responses, total count and average count. If the number of inpatient deaths had also been provided the trust's rate of inpatient deaths which received a level 2 investigation would be used in calculating the mean, median, lower and upper quartiles.

		Acute non-specialist		Mental health			Community	
		Inpatient/ A&E	Six-months post-discharge	Inpatient	Community	Six-months post-discharge	Ongoing care	Six-months post-discharge
Total deaths	**Total responses (excl. NK or 0)**	128	85	51	51	39	16	9
	Total count	207,633	233,942	1,987	40,635	19,343	25,842	8,517
	Average count	1,622	2,752	39	797	496	1,615	946
NRLS deaths	**Total responses (excl. NK or 0)**	120	32	46	50	29	11	3
	Total count	2,474	266	311	2,924	427	230	15
	Average count	21	8	7	58	15	21	5
	Median rate	0.7%	0.0%	32.5%	6.8%	3.0%	0.7%	0.0%
	Mean rate	2.2%	3.6%	39.0%	18.6%	24.3%	8.8%	12.5%
	Lower quartile	0.4%	0.0%	10.4%	2.8%	0.1%	0.0%	0.0%
	Upper quartile	1.5%	0.3%	62.5%	21.4%	37.3%	2.2%	0.1%
STEIS deaths	**Total responses (excl. NK or 0)**	122	38	52	52	36	12	3
	Total count	1,386	154	238	1,991	414	123	15
	Average count	11	4	5	38	12	10	5
	Median rate	0.6%	0.0%	30.1%	7.6%	4.7%	0.5%	0.0%
	Mean rate	0.7%	3.6%	38.7%	15.7%	25.0%	8.1%	11.1%
	Lower quartile	0.3%	0.0%	13.8%	3.3%	0.8%	0.0%	0.0%
	Upper quartile	0.9%	0.2%	57.4%	20.5%	32.0%	1.8%	0.0%
Initial reviews	**Total responses (excl. NK)**	120	62	53	53	41	15	10
	Total count	15,539	2,104	466	6,069	768	383	8
	Average count	129	34	9	115	19	26	1
	Median rate	0.8%	0.0%	62.5%	16.3%	6.1%	2.2%	0.0%
	Mean rate	9.2%	6.1%	59.0%	36.7%	30.4%	16.7%	11.1%
	Lower quartile	0.4%	0.0%	16.7%	4.2%	0.5%	0.5%	0.0%
	Upper quartile	1.9%	0.2%	100.0%	72.3%	58.6%	8.4%	0.0%

		Acute non-specialist		Mental health			Community	
		Inpatient/ A&E	Six-months post-discharge	Inpatient	Community	Six-months post-discharge	Ongoing care	Six-months post-discharge
Level 1 investigations	**Total responses (excl. NK)**	118	64	53	53	42	16	10
	Total count	1,498	75	87	860	151	105	5
	Average count	13	1	2	16	4	7	1
	Median rate	0.1%	0.0%	0.0%	1.0%	0.1%	0.6%	0.0%
	Mean rate	0.8%	3.5%	13.6%	8.0%	10.1%	3.4%	0.0%
	Lower quartile	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Upper quartile	0.4%	0.0%	16.7%	10.0%	5.2%	2.8%	0.0%
Level 2 investigations	**Total responses (excl. NK)**	125	66	53	52	41	16	11
	Total count	1,163	111	175	1,204	232	109	14
	Average count	9	2	3	23	6	7	1
	Median rate	0.5%	0.0%	24.6%	2.6%	0.8%	0.0%	0.0%
	Mean rate	0.6%	0.2%	28.9%	8.0%	14.4%	4.8%	7.4%
	Lower quartile	0.2%	0.0%	8.2%	0.6%	0.0%	0.0%	0.0%
	Upper quartile	0.8%	0.2%	37.8%	8.8%	18.9%	0.8%	0.0%
Level 3 investigations	**Total responses (excl. NK)**	117	77	52	51	46	15	10
	Total count	23	5	14	10	4	17	1
	Average count	0	0	0	0	0	1	0
	Median rate	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Mean rate	0.0%	0.0%	3.5%	0.2%	0.0%	0.1%	3.3%
	Lower quartile	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Upper quartile	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Annex 6: Acute trust CQC provider information request summary table (specialist and non-specialist trusts)

Please note: Response count includes all numerical responses and total counts may include duplicates (e.g. a patient counted as a post-discharge death from one trust may be recorded as an inpatient death in another trust).

		Inpatient/A&E				Six-months post-discharge			
		All	Mental health	Learning disability	Mental health and learning disability	All	Mental health	Learning disability	Mental health and learning disability
Total deaths	**Total count**	209,439	2,946	1,070	61	249,234	1,837	974	78
	Response count	143	45	107	48	98	29	69	31
NRLS deaths	**Total count**	2,540	23	14	0	269	22	2	0
	Response count	140	62	88	65	75	56	65	56
	Mean rate	3.1%	3.0%	2.0%	0.0%	3.2%	4.2%	2.2%	0.0%
STEIS deaths	**Total count**	1,424	15	15	1	162	11	2	0
	Response count	141	71	96	72	77	61	68	60
	Mean rate	1.4%	0.9%	0.9%	0.0%	3.3%	2.5%	0.3%	0.0%
Initial reviews	**Total count**	16,162	64	90	9	2,362	24	15	0
	Response count	134	63	91	64	71	56	63	54
	Mean rate	11.5%	4.8%	8.7%	1.3%	5.6%	4.6%	5.8%	0.0%
Level 1 investigations	**Total count**	1,661	32	28	1	75	7	9	0
	Response count	132	93	107	92	74	66	69	65
	Mean rate	1.3%	1.6%	1.9%	1.2%	3.1%	0.3%	2.0%	0.0%
Level 2 investigations	**Total count**	1,279	9	10	1	115	4	2	0
	Response count	140	78	99	79	76	62	68	62
	Mean rate	1.5%	0.6%	0.7%	0.0%	0.2%	0.5%	0.3%	0.0%
Level 3 investigations	**Total count**	25	5	1	0	6	2	1	0
	Response count	131	122	126	121	87	86	87	86
	Mean rate	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%

Annex 7: Mental health trust CQC provider information request summary table

Please note: Response count includes all numerical responses and total counts may include duplicates (e.g. a patient counted as a post-discharge death from one trust may be recorded as an inpatient death in another trust). See table on page 18.

		Inpatient				Community care				Six-months post-discharge			
		All	Mental health	Learning disability	Mental health and learning disability	All	Mental health	Learning disability	Mental health and learning disability	All	Mental health	Learning disability	Mental health and learning disability
Total deaths	**Total count**	1,987	704	25	9	40,635	25,600	823	86	19,343	12,301	203	35
	Response count	52	50	43	36	52	50	42	35	42	40	36	28
NRLS deaths	**Total count**	311	237	17	6	2,924	2,493	127	10	427	333	24	4
	Response count	53	51	46	37	52	49	41	31	38	36	31	23
	Mean rate	39.0%	39.8%	10.3%	10.8%	18.6%	18.5%	13.5%	9.7%	24.3%	19.9%	3.5%	4.3%
STEIS deaths	**Total count**	238	206	3	2	1,991	1,814	24	7	414	371	1	0
	Response count	53	52	42	34	53	51	41	33	41	39	33	23
	Mean rate	38.7%	41.9%	7.1%	5.9%	15.7%	16.7%	9.2%	5.3%	25.0%	24.1%	0.2%	0.0%
Initial reviews	**Total count**	466	364	19	5	6,069	5,162	174	29	768	629	38	4
	Response count	53	52	42	34	53	51	42	34	41	39	34	25
	Mean rate	59.0%	61.6%	17.9%	8.8%	36.7%	36.1%	25.0%	21.8%	30.4%	27.0%	9.0%	4.0%
Level 1 investigations	**Total count**	87	75	3	1	860	770	29	5	151	133	5	1
	Response count	53	52	48	44	53	52	47	42	42	41	37	32
	Mean rate	13.6%	14.1%	4.3%	2.3%	8.0%	7.6%	8.0%	6.0%	10.1%	12.4%	4.3%	0.8%
Level 2 investigations	**Total count**	175	152	1	1	1,204	1,137	10	3	232	205	1	0
	Response count	53	52	43	36	52	51	44	37	41	38	35	27
	Mean rate	28.9%	31.2%	2.3%	2.8%	8.0%	8.9%	3.6%	1.1%	14.4%	9.7%	0.1%	0.0%
Level 3 investigations	**Total count**	14	9	1	0	10	7	3	1	4	2	0	0
	Response count	52	51	50	50	51	51	51	50	46	46	45	45
	Mean rate	3.5%	3.8%	1.0%	0.0%	0.2%	0.1%	0.5%	0.7%	0.0%	0.0%	0.0%	0.0%

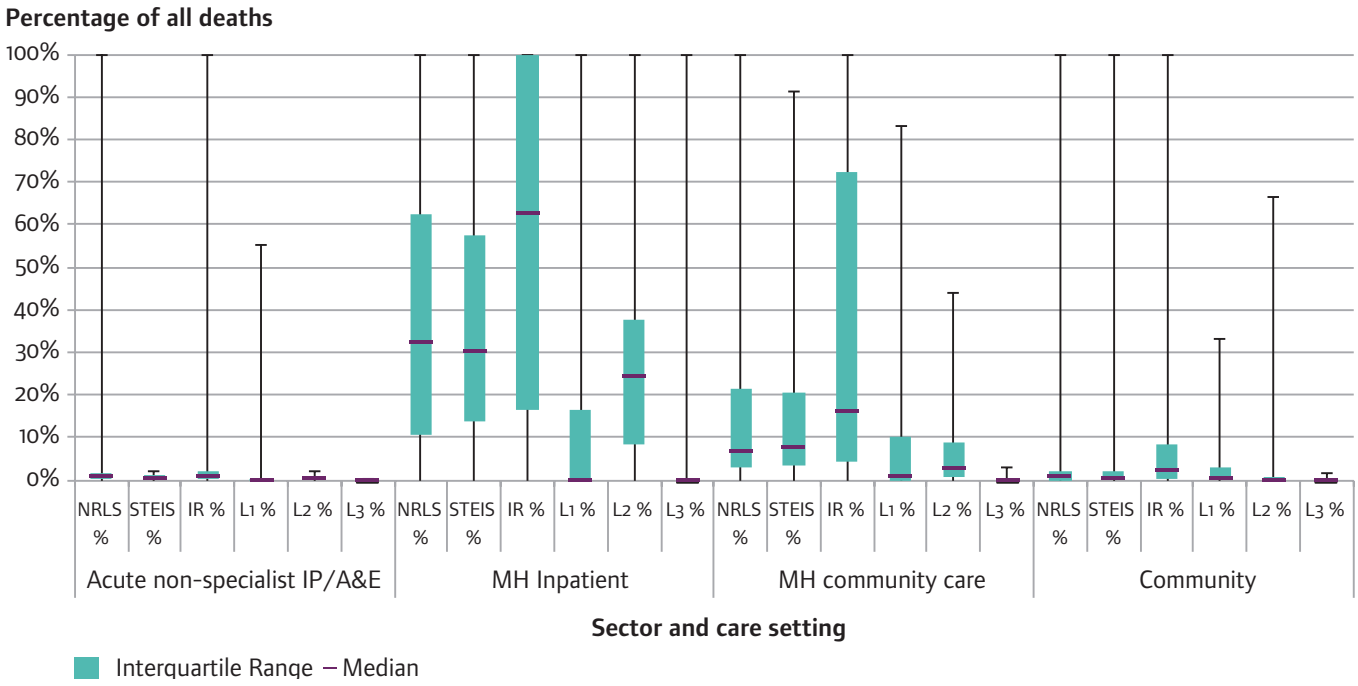
Annex 8: Community trust CQC provider information request summary table

Please note: Response count includes all numerical responses and total counts may include duplicates (e.g. a patient counted as a post-discharge death from one trust may be recorded as an inpatient death in another trust).

		Ongoing care				Six-months post-discharge			
		All	Mental health	Learning disability	Mental health and learning disability	All	Mental health	Learning disability	Mental health and learning disability
Total deaths	**Total count**	25,842	534	42	2	8,517	471	26	0
	Response count	16	10	13	11	12	10	10	10
NRLS deaths	**Total count**	230	72	5	0	15	7	1	0
	Response count	16	12	13	13	10	10	10	10
	Mean rate	8.8%	3.4%	8.5%	0.0%	12.5%	0.5%	0.0%	0.0%
STEIS deaths	**Total count**	123	50	3	0	15	7	1	0
	Response count	16	13	14	14	11	11	11	11
	Mean rate	8.1%	2.4%	3.6%	0.0%	11.1%	0.4%	0.0%	0.0%
Initial reviews	**Total count**	383	17	0	0	8	0	1	0
	Response count	15	10	11	11	10	10	10	10
	Mean rate	16.7%	0.8%	0.0%	0.0%	11.1%	0.0%	0.0%	0.0%
Level 1 investigations	**Total count**	105	17	1	0	5	0	1	0
	Response count	16	12	12	12	10	10	10	10
	Mean rate	3.4%	0.7%	2.3%	0.0%	0.0%	0.0%	0.0%	0.0%
Level 2 investigations	**Total count**	109	33	2	0	14	7	1	0
	Response count	16	15	15	15	11	11	11	11
	Mean rate	4.8%	1.7%	1.4%	0.0%	7.4%	0.5%	0.0%	0.0%
Level 3 investigations	**Total count**	17	0	0	0	1	0	0	0
	Response count	15	13	13	13	10	10	10	10
	Mean rate	0.1%	0.0%	0.0%	0.0%	3.3%	0.0%	0.0%	0.0%

Annex 9: CQC provider information request data variation

PERCENTAGE OF DEATHS RECORDED AS INCIDENTS, REVIEWED AND INVESTIGATED BY SECTOR AND CARE SETTING



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