Essex Partnership University
NHS Foundation Trust

Freedom of Information Request

Reference Number: EPUT.FOI.23.2849
Date Received: 20 February 2023

Information Requested:
Can you please provide the following mortality data outlined in my questions 1 - 4?
This is only for mental health services.
For each question, can you please provide the annual data for the last 5 years (e.g. 2017/18, 2018/19, 2019/20, 2020/21, 2021/22).
The National Serious Incident and National Learning from Deaths Frameworks requires Trusts to count recently discharged mental health patient (within 6 months) deaths under 'inpatient', but I would like to see the figures separated out. Inpatients should include patients detained under the MHA and those that are voluntary patients.
To aid my research, can you please also provide a summary of the types of services that the Trust runs, and for inpatients the **current** number of beds overall. Similarly for outpatients, please provide the number of current patients overall.

Essex Partnership University NHS Foundation Trust has been responsible for providing a range of different services, including a range of different mental health services, across different localities at different points in time during the period that the information request covers. The services we currently provide you can find on our website https://eput.nhs.uk/our-services/.

The information presented within this return has been collated from the Trust's established mortality data collection and reporting processes under the Trust's Mortality Review Policy in place for the period the information request relates to. These processes enabled the provision of information mandated for report under the National Guidance on Learning from Deaths (March 2017) to the Board of Directors.

Explanatory notes have been included at various points within this document to explain the information that has been presented.

Deaths included within the scope of the Trust's Mortality Review Policy (and thus collated for data analysis purposes and reporting to the Board of Directors) for the period covered by this information request were as follows:

- All deaths in Trust inpatient services (including mental health, community health, learning disability and prison inpatient facilities).
- All deaths in a community setting of patients with a recorded learning disability.

- All deaths meeting the criteria for a serious incident, either inpatient or community based. From 2021/22, this was all deaths meeting the criteria for review under the Patient Safety Incident Response Framework (PSIRF) arrangements.
- Any patient deaths in a community setting, which have been the subject of a formal complaint and/or claim by bereaved families and carers.
- Any patient deaths in a community setting for which staff have raised a significant concern about the quality of care provision.
- Any deaths of patients deemed to have a severe mental illness (SMI) in a community setting. For the purposes of the Trusts policy, this is deemed to be any patient with a psychotic diagnosis (schizophrenia or delusional disorder) recorded on electronic clinical record systems who is recorded as having been under the care of the Trust for over 2 years.

The above deaths therefore form the basis of the data presented. However, as this information request asks for mental health services deaths only, deaths in scope of the above categories but within the following categories have been extracted from the data presented and are therefore NOT included in the totals:

- Community health services deaths (both inpatient and community based deaths)
- Nursing homes deaths
- Learning disability deaths (both inpatient and community based deaths)
- Prison healthcare deaths

In the National Guidance on Learning from Deaths (March 2017), it was recommended that inpatient deaths were included within the scope for mortality review (and thus data reporting) as a minimum. Mental Health and Community Care Trusts were advised to "carefully consider which categories of outpatient and/or community patient were to be within scope for review taking a proportionate approach". We have published the scope we set (as detailed above) within our Mortality Review Policy and reports to the Board of Directors. As there was no nationally mandated scope, the scope of deaths included in data reporting and review processes is likely to differ between Trusts.

The data collection and categorisation for the period covered by the information request did not include separate reporting of deaths of individuals occurring within 6 months of discharge from an EPUT inpatient facility. These deaths are therefore included within the "Community" totals.

1. The total number of deaths of patients recorded by the Trust as per the above categories A to E.

Please be advised for question 1 and 2, we have included data in scope of Essex Partnership University NHS Foundation Trust Mortality Review Policy (Mental Health Services Only)

Please note that the trust's policy is not to provide patient or staff numbers, where the response is less than or equal to five (≤5) as it would potentially allow identification of the individual patient/staff and would therefore be personal data. The trust considers that release of that information would breach GDPR/DPA18 principles on the grounds that it would not be fair in all the circumstances. This information is therefore exempt under section 40 of the FOI Act 2000.

Total number of deaths	2017/18	2018/19	2019/20	2020/21	2021/22
A) Total (entire Trust)	151	134	147	144	110
B) Total Community (outpatient)	107	120	124	133	98
C) Total Inpatient (including within 6 months of discharge)	Essex Partnership University NHS Foundation Trust do not record data separately for this category, deaths within the community of patients within 6 months of discharge from an Essex Partnership University NHS Foundation Trust inpatient facility are included in the above "Community" totals				
D) Total Inpatient (current in-patients only)	44	14	23	11	12
E) Total under 18 (across entire Trust)	≤5	0	≤5	0	≤5

2. The total number of deaths of patients recorded by the Trust as 'expected' and 'unexpected'.
   Please note that the trust's policy is not to provide patient or staff numbers, where the response is less than or equal to five (≤5) as it would potentially allow identification of the individual patient/staff and would therefore be personal data.
   The trust considers that release of that information would breach GDPR/DPA18 principles on the grounds that it would not be fair in all the circumstances. This information is therefore exempt under section 40 of the FOI Act 2000.

Total number of (un)expected deaths		2017/18	2018/19	2019/20	2020/21	2021/22
A) Total (entire Trust)	Expected	34	18	24	29	21
	Unexpected	109	90	100	90	59
B) Total Community (outpatient)	Expected	9	15	16	24	20
	Unexpected *	90	79	85	84	48
C) Total Inpatient (including within 6 months of discharge)	Expected	Essex Partnership University NHS Foundation Trust do not record data separately for this category, deaths within the community of patients within 6 months of discharge from an Essex Partnership University NHS Foundation Trust inpatient facility are included in the above "Community" totals				
	Unexpected					
D) Total Inpatient (current in-patients only)	Expected	25	≤5	8	≤5	≤5
	Unexpected	19	11	15	6	11
E) Total under 18 (across entire Trust)	Expected	0	0	0	0	0
	Unexpected	≤5	0	≤5	0	≤5
	Causes of death categorised as "unknown" **	8	26	23	25	30

* The reason that the figures for unexpected deaths in scope appear to be disproportionately higher than expected deaths is a result of the scope set by the Trust. Community based deaths included within the scope for mental health services is predominantly those meeting the definition of a "Serious Incident" (up to 2020/21) or "Patient Safety Incident Response Framework" incident (from 2021/22) and these deaths are likely to be unexpected.

** Causes of deaths are categorised as "Unknown" where the Trust has been unable to establish the formal cause of death (eg where Trust has been informed of a death in the community but has been unable to ascertain confirmed cause of death, no information is available from the Coroner etc).

3. The number of these deaths that were investigated as a serious incident.
   Please can you also confirm which method of investigation is preferred by your Trust and if this has changed over time.

The Trust is an early adopter of the new NHS Patient Safety Incident Response Framework (PSIRF) which replaces the Serious Incident Framework. The Trust implemented PSIRF on 1st May 2021 and therefore figures provided between January and April 2021 will refer to Serious Incidents and May 2021 onward will refer to Patient Safety Incidents. Please note that the thresholds for patient safety review and investigation is different under PSIRF. Under PSIRF, the Trust will review patient safety incidents and where there is potential for new and significant learning to be generated from conducting a review or investigation, a report will be commissioned.

Please note that the trust's policy is not to provide patient or staff numbers, where the response is less than or equal to five (≤5) as it would potentially allow identification of the individual patient/staff and would therefore be personal data.

The trust considers that release of that information would breach GDPR/DPA18 principles on the grounds that it would not be fair in all the circumstances. This information is therefore exempt under section 40 of the FOI Act 2000.

Please note that data for 2017 starts from 01/04/2017 as we don't hold the unexpected death data pre-merger on Datix

Total number of deaths investigated as serious incidents (or "reviewed") by the Trust	2017/18	2018/19	2019/20	2020/21	2021/22
A) Total (entire Trust)	65	82	75	69	70
B) Total Community (outpatient)	60	75	68	62	63
C) Total Inpatient (including within 6 months of discharge) **	≤5	≤5	≤5	≤5	≤5
D) Total Inpatient (current in-patients only) ***	≤5	≤5	≤5	≤5	6
E) Total under 18 (across entire Trust)	0	≤5	≤5	0	≤5

If there are any 'expected' deaths that were investigated as a serious incident or reviewed, please can you provide a note and a further breakdown, otherwise I will assume that all the above serious incidents investigations were in relation to "unexpected" deaths only.
** This is the number of patients that died within 6 months of discharge from an inpatient ward
*** We have included patients who were on leave from the ward, and those who had absconded from the ward at the time of their death

4. Please provide a breakdown of the number of "deaths considered more likely than not due to problems in care" based on the PRISM Score<=3 or equivalent measure.
Please note that the trust's policy is not to provide patient or staff numbers, where the response is less than or equal to five (≤5) as it would potentially allow identification of the individual patient/staff and would therefore be personal data.
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Number of "deaths considered more likely than not due to problems in care" based on the * PRISM Score<=3 or equivalent measure for deaths in scope of EPUT Mortality Review Policy (mental health services only)	2017/18 **	2018/19	2019/20	2020/21	2021/22 ***
A) Total (entire Trust)	≤5	≤5	≤5	0	0
B) Total Community (outpatient)	≤5	≤5	≤5	0	0
C) Total Inpatient (including within 6 months of discharge)	Essex Partnership University NHS Foundation Trust do not record data separately for this category, deaths within the community of patients within 6 months of discharge from an Essex Partnership University NHS Foundation Trust inpatient facility are included in the above "Community" totals				
D) Total Inpatient (current in-patients only)	≤5	≤5	≤5	0	0
E) Total under 18 (across entire Trust)	≤5	0	≤5	0	0

* The Trust set the following definitions for determining a "score" relating to problems in care – this followed research of definitions being used in other Trusts and consideration of information from Mazaars in a learning network attended by the Trust:
1 - Death **definitely more likely than not** to be due to problems in care provided by EPUT.

2 - **Strong evidence** – i.e. significantly more than 50:50 – that death more likely than not to be due to problems in care provided by EPUT.
3 - **Probably likely** – i.e. more than 50:50 – that death due to problems in care provided by EPUT.
4 - **Not very likely** – i.e. less than 50:50 – that death due to problems in care provided by EPUT.
5 - **Slight evidence** – i.e. significantly less than 50:50 – that death could be due to problems in care provided by EPUT.
6 - Death **definitely less likely than not** to be due to problems in care provided by EPUT.

The Trust does not use the term "avoidable mortality" in the context of mortality review, which is in accordance with the national guidance.

** Determining a "score" relating to problems in care was introduced on 1 October 2017 – the figures in the 2017/18 column therefore relate to deaths from 1 October 2017 – 31 March 2018

*** Investigations under the Patient Safety Incident Response Framework (PSIRF) focus on quality learning outcomes and no "score" is allocated under this methodology. This is reflected in the 2021/22 column in the table above.

* PRISM Scores of Deaths of Inpatients (current in-patients only) Mental health services only	2017/18 **	2018/19	2019/20	2020/21	2021/22 ***
Score 1 - Definitely avoidable	-	-	-	-	-
Score 2 - Strong evidence of avoid ability	-	-	-	-	-
Score 3 - Probably avoidable (more than 50:50)	≤5	≤5	≤5	-	-
Score 4 - Probably avoidable but not very likely	≤5	-	≤5	≤5	-
Score 5 - Slight evidence of avoid ability	-	≤5	≤5	-	-
Score 6 - Definitely not avoidable	16	11	15	7	≤5
Under determination	-	-	≤5	≤5	≤5
PSIRF	-	-	-	-	9

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Publication Scheme:

As part of the Freedom of Information Act all public organisations are required to proactively publish certain classes of information on a Publication Scheme. A publication scheme is a guide to the information that is held by the organisation. EPUT's Publication Scheme is located on its Website at the following link https://eput.nhs.uk