Essex Partnership University
NHS Foundation Trust

Freedom of Information Request

Reference Number: EPUT.FOI.25.4009
Date Received: 26th February 2025

Information Requested:

As of 2017, data detailing the number of patients who have died due to problems in care is required to be published by NHS trusts in England. This is set out in this press release: https://www.gov.uk/government/news/nhs-becomes-first-healthcare-system-in-the-world-to-publish-numbers-of-avoidable-deaths and in this reporting guidance: https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-deaths-in-the-nhs/.

Under the Freedom of Information Act please could you provide the total number of deaths considered to have been due to problems in care in Essex Partnership University NHS Foundation Trust for the periods:

1st April 2019 to 31st March 2020
1st April 2020 to 31st March 2021
1st April 2021 to 31st March 2022
1st April 2022 to 31st March 2023
1st April 2023 to 31st March 2024

To clarify, this is not a request asking for the total number of deaths but is specifically concerning those which are deemed to be due to problems in care.

1st April 2019 to 31st March 2020 - * 5
1st April 2020 to 31st March 2021 - * 1
1st April 2021 to 31st March 2022 - * & ** 0
1st April 2022 to 31st March 2023 - *** 3
1st April 2023 to 31st March 2024 - *** 0

Explanatory notes in relation to the above figures:

* For the period 01/04/19 – 31/03/22, the Trust used a 6 point scale for assessing problems in care. The above figures represent those deaths that were assigned a 1, 2 or 3 on that scale – ie those deaths deemed more than 50:50 likely to be due to problems in care provided by EPUT.

** From 01/05/21, on introduction of the Patient Safety Incident Response Framework (PSIRF) arrangements meant that any review would have addressed problems in care, although PSIRF is more about system learning. PSIRF reviews can identify problems in care, however the process does not align itself to apply the problems in care scoring process, but by the time a review is completed, any problems in care will be identified in a systems lense with safety actions identified. To ensure that the process was strengthened, EPUT as an early adopter site, raised this with the local ICB who facilitated a meeting with the national PSIRF team who

agreed to review the guidance to ensure trusts had clear guidance on how to manage problems in care in the PSIRF process.

*** Under the Trust's current learning from deaths arrangements, implemented from 01/04/22, the previous 6 point scale for assessing problems in care was replaced with the Royal College of Psychiatrists structured judgement review tool version, which requires determination of whether a death was "more likely than not to have resulted from problems in care delivery or service provision" by EPUT. As above, the introduction of the Patient Safety Incident Response Framework (PSIRF) arrangements meant that any review would have addressed problems in care. PSIRF reviews can identify problems in care, however the process does not align itself to apply the problems in care scoring process, but by the time a review is completed, any problems in care will be identified in a systems lense with safety actions identified. Locally, EPUT has worked with ICBs who facilitated a meeting with the national team who agreed to review the PSIRF guidance to strengthen the process.

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