Hertfordshire Partnership University NHS Foundation Trust

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Our Ref: FOI/04137

Thank you for your request concerning Patient Deaths.

Your request has been considered and processed in accordance with the requirements of the Freedom of Information (FOI) Act 2000.

1. What was the total number of patient deaths, by financial year, from 2015/16 to 2020/21 inclusive?

Financial Year	Number of Service User Deaths
2015/2016	189
2016/2017	301
2017/2018	373
2018/2019	444
2019/2020	460
2020/2021	637

2. For patient deaths in 2019/20 and 2020/21, what was the total number (i) where a Root Cause Analysis (RCA) report only was written, (ii) where a Serious Incident Report (SIR) report only was written, (iii) where both an RCA and an SIR report were written and (iv) where neither an RCA or an SIR were written?

Caveat: The Trust's Incident and Serious Incident Reporting policy is in keeping with the Serious Incident Framework, 2015. We are working to the principles of the Patient Safety Incident Response Framework ahead of its implementation in 2022/23. The Trust completes investigations using Root Cause Analysis methodology and this is the only definition used. Therefore, data has been provided showing number of deaths that were reported as Serious Incidents and the number that were not reported and did not have an investigation.

Financial Year	RCA/SIR written	RCA/SIR not written
2019/2020	50	354
2020/2021	49	588

3. For patient deaths in 2019/20 and 2020/21 how many in total were, at the time of death: (i) involuntary inpatients sectioned under Mental Health Act, (ii) voluntary inpatients (iii) patients within the community/outpatients.

Caveat: The Trust uses Datix, as our incident reporting system and this does not capture the detention status of a service user at the time of their death. We are therefore unable to provide this data without going into each individual electronic patient record.

However, under Section 16 – Duty to provide advice and assistance, please see below table for the total number of patients deaths within the specified year.

Financial Year	Inpatient	Community
2019/2020	19	385
2020/2021	52	585

4. Please provide patient deaths by financial year from 2015/16 to 2020/21 broken down by mortality scoring index category or other equivalent measure.

Please see attached spreadsheet.

Caveat: Data has been provided by the Mortality Team with the following narrative:

Time line:
2017: National guidance on deaths was issued
2018: HPFT adopted the above methodology and formed a separate mortality governance structure

Death categories:

Although the Trust has adopted the national Royal College of Psychiatry categories for recording deaths, it is not possible to assign a category to people where we have insufficient information about the circumstances of their death. This is the case for anyone who is open to our services but who is also receiving care for physical health conditions from another NHS trust or healthcare provider. The 'no value' column includes deaths in people for whom we have insufficient information on the cause of death. The 'Unascertainable' category was introduced at to include people where we have been able to review the record but have not been able to categorise the cause of death. Data capture has improved since it became possible to cross check live data with the national Spine since 2020.

Other points to note:

- Numbers of deaths include reporting for people under the Trust's care and deaths we are informed of that occurred within 12 months of discharge from our care
- The total case load in the Trust fluctuates over time because of changes in commissioning arrangements and the introduction of more robust data collection via the national Spine
- Data is derived from a live data base and the number can fluctuate as more data is received
- Some data around the category of death may be delayed if the death is subject to a coroner's inquest

5. How many patient suicides (confirmed and suspected) were there, by year of death, from 2015/16 to 2020/21?

Caveat: The below data reflects the number of deaths where a service user is known to the Trust that have received Suicide or Open conclusions at Inquest, as only the Coroner can make this determination. These figures may change following the Coroner inquest.

Financial year	Killed Self, Suicide or Open conclusion at inquest
2015/2016	34
2016/2017	35
2017/2018	40
2018/2019	49
2019/2020	30
2020/2021	13

Should you require further clarification, please do not hesitate to contact me.

Please find enclosed an information sheet regarding copyright protection and the Trust's complaints procedure in the event that you are not satisfied with the response.

Yours sincerely

Sue Smith

Sue Smith
Information Rights Officer

Enc: Copyright Protection and Complaints Procedure Information Leaflet.

If you would like to complete a short survey in relation to your Freedom of Information request please scan the QR code below or click here.