

12 December 2023

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Our Ref: FOI/04615

Thank you for your request concerning Mortality Data.

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

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).

Can you also please provide the data for each question broken down into four categories:

- A. The total across all mental health services.**
- B. Broken down into Community (outpatient) and Inpatient mental health services**
- D. Mental Health Services by Age - those over 18 and those under 18 (CAMHS).**
- E. For mental health inpatient deaths, can you please provide a further breakdown for the deaths that occurred whilst patients were under the care of inpatient services and those who had recently been discharged (e.g. within 6 months).**

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.

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

Table 1 total number of deaths, amongst mental health service users, broken down into Community (outpatient) and Inpatient mental health services.

Financial Year	Inpatient	Community	Total
2017/18	53	713	766
2018/19	29	505	534
2019/20	27	428	455
2020/21	41	411	452
2021/22	12	439	451
Total	162	2496	2658

Table 2. All Mental Health service users deaths by age

Financial year	a. Age <18	b. Age 18 +	Age 65 +	No DOB recorded	Total
2017/18	3	97	666		766
2018/19	2	86	446		534
2019/20	2	67	385	1	455
2020/21	1	65	385	1	452
2021/22	0	92	359		451
Total	8	407	2241	2	2658

Table 3. Inpatient deaths: Mental Health service users by age

Financial year	a. Age <18	b. Age 18 +	Age 65 +	No DOB recorded	Total
2017/18	0	1	52	0	53
2018/19	0	2	27	0	29
2019/20	0	2	24	1	27
2020/21	0	6	35	0	41
2021/22	0	0	12	0	12
Total	0	11	150	1	162

Table 4. Mental Health service users who were discharged from inpatient units and died within 6 months where the Service user was under HPFT care on Date of Death.

Financial year	a. Age <18	b. Age 18 +	Age 65 +	No DOB recorded	Total
2017/18	0	9	14	0	23
2018/19	0	8	21	0	29
2019/20	0	5	7	0	12
2020/21	0	3	3	1	7
2021/22	0	6	6	0	12
Total	0	31	51	1	83

As of 28/11/23 we have 28,761 out-patient mental health and learning disability service users and 385 in-patient beds.

2. **The total number of deaths of patients recorded by the Trust as ‘expected’ and ‘unexpected’.**

We do not categorise deaths as expected in our incident reporting system or our electronic patient recording system.

Again, under Section 16 – Duty to provide advice and assistance we have provided mortality data under the categories available on our incident reporting system.

Total number of unexpected deaths		2017/18	2018/19	2019/20	2020/21	2021/22
Total (entire Trust)	Unexpected	59	74	65	70	94
Total Community	Unexpected	58	71	65	69	93
Total Inpatient (including within 12 months of discharge)	Unexpected	1	3	0	1	1
Total Inpatient (current in-patients only)	Unexpected	0	2	0	1	0
Total under 18	Unexpected	1	2	2	1	0

3. **The number of these deaths that were investigated as a serious incident (eg. The number of Root Cause Analysis Investigations or Structured Judgement Reviews, or whichever method is undertaken by the Trust as this can vary). This can also be referred to as "deaths reviewed" as per the National Framework terminology.**

Please can you also confirm which method of investigation is preferred by your Trust and if this has changed over time.

Under the current Serious Incident framework (2015) the Trust reports all deaths that meets serious incident reporting criteria. Alongside this the Trust also undertakes a Structured Judgement review on a case by case basis for deaths that meet “Red Flag” criteria in keeping with the National Learning from Deaths process. The Trust will be reviewing its current decision making process as part of the transition to the NHS Patient Safety Incident Response Framework (PSIRF) by autumn 2023.

Total number of deaths reviewed as Structured Judgement Review or Serious Incident by the Trust	2017/18	2018/19	2019/20	2020/21	2021/22
Total (entire Trust)	49	62	95	109	133
Total Community (outpatient)	48	58	85	82	124
Total Inpatient (including within 6 months of discharge)	* This information is not recorded on our incident reporting system.				
Total Inpatient (including within 12 months of discharge)	3	3	0	3	2
Total Inpatient (current in-patients only)	1	4	10	27	9
Total under 18 (across entire Trust) (HPFT NOTE: Total CAMHS deaths reported)	1	2	2	1	0

Please can the data for each year ideally be recorded as per the date of death, not the date the investigation started.

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.

The table below shows the breakdown of Natural/Accidental Deaths investigated as Serious Incidents:

Total number of Natural/Accidental Deaths investigated as serious incidents (or "reviewed") by the Trust	2017/18	2018/19	2019/20	2020/21	2021/22
Total (entire Trust)	6	2	9	5	10
Total Community (outpatient)	5	1	9	3	8
Total Inpatient (including within 6 months of discharge)	* This information is not recorded on our incident reporting system.				
Total Inpatient (including within 12 months of discharge)	1	1	0	2	2
Total Inpatient (current in-patients only)	1	1	0	2	2
Total under 18 (across entire Trust) <i>(HPFT NOTE: Total CAMHS deaths reported)</i>	0	0	0	0	0

4. **A) 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.**
B) Please also provide a further breakdown of all deaths reviewed and their PRISM Score 1-
5. **Please provide these breakdowns for each category A-D**

Number of "deaths considered more likely than not due to problems in care" based on the PRISM Score ≤3 or equivalent measure.	2017/18	2018/19	2019/20	2020/21	2021/22
Total (entire Trust)					
Total Community (outpatient)					
Total Inpatient (including within 6 months of discharge)					
Total Inpatient (current in-patients only)					
Total under 18 (across entire Trust)					

Category D:

PRISM Scores of Deaths of Inpatients (current in-patients only)	2017/18	2018/19	2019/20	2020/21	2021/22
Score 1 - Definitely avoidable					
Score 2 - Strong evidence of avoidability					
Score 3 - Probably avoidable (more than 50:50)					
Score 4 - Probably avoidable but not very likely					
Score 5 - Slight evidence of avoidability					
Score 6 - Definitely not avoidable					

We are unable to answer question 4 and 5 because this information is not recorded on our systems.

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](#).

