Southern Health NHS
NHS Foundation Trust

FOI1615- Concerning patient deaths.

We can confirm that Southern Health NHS Foundation Trust holds the information you require.

Please see below our response to your Freedom of Information request:

1a) total number of deaths that have occurred at the Trust in each of the last five years (please provide data broken down by year)

The below are the number of deaths reported in each calendar year via the incident reporting system.

Year	Number of Deaths that occurred
2012	499
2013	212
2014	178
2015	321
2016	792*
Grand Total	**2002**

* The Trust changed the reporting criteria for deaths on 1 December 2015. This therefore accounts for the increase in number of deaths reported via the incident management system in 2016.

1b) the number of these deaths that were classified as unexpected

The Trust does not use "unexpected" as a reporting category.

On 1 December 2015 a new revised Procedure for Reporting and Investigating deaths was introduced. The Trust made the decision to stop using the terms 'expected' and 'unexpected' to determine whether a death required reporting and investigating as an incident. This decision was largely due to the subjective nature of these terms even when best attempts are made to define them and the inherent risk of inconsistency in how they are applied.

The above mentioned procedure is available on our website and has specific guidance on which deaths require reporting using our Risk Management system- (please see attached copy for ease of reference).

2a) total number of deaths that have been referred to the Coroner by the Trust in each of the last five years

The below are the number of deaths, in each calendar year, reported to the Coroner where this has been recorded on the incident reporting system. This does not include all deaths that may have been discussed with the Coroner as this information is held within individual patient records, and we would therefore need to scrutinise each clinical record where a patient has died in order to establish the number of cases discussed with the Coroner.

Year	Deaths referred to the coroner
2013	5
2014	10
2015	216
2016	255
Grand Total	**486**

We are unable to provide information prior to 2013 because the system we now use for recording this information does not date back to before that date.

2b) of these, the number of deaths of patients with a learning disability referred to the Coroner

The information below is of deaths recorded on the incident management system, where the primary team providing care was known to be a learning disability team. Some learning disability patients may have been receiving care from a team other than a learning disability team at the time of their death, and therefore would not be included in this dataset.

Year	Learning Disabilities Services deaths referred to the coroner
2013	1
2014	1
2015	18
2016	17
Grand Total	**37**

We are unable to provide information prior to 2013 because the system we now use for recording this information does not date back to before that date.

3a) total number of deaths of patients with a learning disability that have occurred at the Trust in each of the last five years (please provide total number and indicate whether they were inpatients at the time of their deaths)

The information below is of deaths recorded on the incident management system, where the primary team providing care was known to be a learning disability team. Some learning disability patients may have been receiving care from a team other than a learning disability team at the time of the patients' death, and therefore would not be included in this dataset.

Number of Deaths that occurred in Learning Disabilities Services	Comm/Inpat		
Year	Community Deaths	Inpatient Deaths	Grand Total
2012	46		46
2013	17	2	19
2014	16		16
2015	32	2	34
2016	66		66
Grand Total	**177**	**4**	**181**

3b) of these, the number of these deaths of patients with a learning disability that were classified as unexpected

The Trust does not use "unexpected" as a reporting category.

On 1 December 2015 a new revised Procedure for Reporting and Investigating deaths was introduced. The Trust made the decision to stop using the terms 'expected' and 'unexpected' to determine whether a death required reporting and investigating as an incident. This decision was largely due to the subjective nature of these terms even when best attempts are made to define them and the inherent risk of inconsistency in how they are applied.

The above mentioned procedure is available on our website and has specific guidance on which deaths require reporting using our Risk Management system- (please see attached copy for ease of reference).

4a) total number of deaths at the Trust reported as an incident on the National Reporting and Learning System (NRLS) in each of the last five years

Number of Deaths Reported to NRLS as a Patient Safety Incident?			
Year	No	Yes	Grand Total
2012	406	93	499
2013	127	85	212
2014	97	81	178
2015	219	102	321
2016	415	377	792
Grand Total	**1264**	**738**	**2002**

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4b) total number of deaths at the Trust reported on Strategic Executive Information System (STEIS) in each of the last five years

Number of deaths reported on to STEIS			
Year	**Non-SI**	**SI**	**Grand Total**
2014	141	37	178
2015	249	72	321
2016	708	84	792
Grand Total	**1098**	**193**	**1291**

We are unable to provide information prior to 2014 because the system we now use for recording this information does not date back to before that date.

4c) if possible, please indicate the number of these that relate to patients with a learning disability

Number of deaths reported on to STEIS from LD Services			
Year	**Non-SI**	**SI**	**Grand Total**
2014	15	1	16
2015	33	1	34
2016	65	1	66
Grand Total	**113**	**3**	**116**

Please note that for Q4b and Q4c we have provided information for deaths of patients under the care of our Learning Disability services.

This data may not include patients who have a Mental Health primary diagnosis as well as a diagnosed learning disability due to the fact that this information cannot be captured within Ulysses and would require a comprehensive trawl of historic data relating to patients diagnoses. Therefore, we have collected this data based on the primary service that reported the death.

Where a patient is seen in the community, the Trust would not have been the primary care giver. The physical health care of individuals with a learning disability who are not in-patients within the Trust largely remains the responsibility of that individual's GP. In these circumstances the Trust may not have seen the individual for several months before their deaths and even then, this might have been for a matter unrelated to their subsequent death. The level and nature of involvement of the Trust prior to the death will determine whether an investigation was carried out by the Trust.

5a) total number of initial 72-hour reviews into deaths (as defined by the NHS Serious Incident Framework) in each of the last five years

Year	Number of deaths with an initial 48 hour review completed
Dec-15	94
Jan-16	98
Feb-16	67
Mar-16	79
Apr-16	61
May-16	63
Jun-16	56
Jul-16	63
Aug-16	54
Sep-16	55
Oct-16	61
Nov-16	67
Dec-16	68
Grand Total	**886**

We are unable to provide information prior to December 2015 because the system we now use for recording this information does not date back to before that date.

5b) total number of investigations into deaths (as defined by the NHS SI Framework) in each of the last five years - please provide data broken down by severity, Level 1 internal investigations, Level 2 comprehensive internal investigations, Level 3 independent investigations. Please also indicate whether the numbers refer to investigations opened or completed.

Number of deaths reported on to STEIS			
Year	Non-SI (level 1)	SI (level 2)	Grand Total
2014	141	37	178
2015	249	72	321
2016	708	84	792
Grand Total	**1098**	**193**	**1291**

We are unable to provide information prior to 2014 because the system we now use for recording this information does not date back to before that date.

All serious incidents (SI) have Level 2 Comprehensive Internal Investigations carried out.

Any investigations that proceeded (due to the nature of the incident) to a level 3 independent investigation would have initially been commenced by the Trust as a Level 2 investigation. This is because there is often a delay in Level 3 investigations commencing, particularly in the case of homicides, where it is necessary to await a conclusion of the legal process around these incidents.