

Freedom of Information Request

Reference Number: EPUT.FOI.22.2510

Date Received: 27.05.2022

Information Requested:

For each calendar year from 2017 to 2022, please provide:

- a) The number of serious incidents at the trust

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. This also will include no harm, low harm and moderate harm incidents, which were not routinely investigated under the Serious Incidents Framework in the same way.

SI's	2017*	2018	2019	2020	2021	2022**	Total
Inpatient	86	44	44	25	32	14	210
Community	561	442	497	509	473	25	2346
Total	647	486	541	534	505	39	2556

*Includes data between 01/04/2017 – 31/03/2017 which relates to former SEPT & former NEPT data, prior to the merger on 01/04/2017 to form EPUT.

**to 01/06/2022

- b) The number of unexpected deaths at the trust, specifying how many of those were suspected suicides and/or self-inflicted deaths

	2017*	2018	2019	2020	2021	2022**	Total
Unexpected Natural (UN1) Death from a natural cause (eg sudden cardiac arrest).	36	86	51	104	49	1	327
Inpatient	5	14	15	41	12	1	88
Community	31	72	36	63	37	0	239
Unexpected Natural (UN2) Death from a natural cause but didn't need to be (eg alcohol, drug dependency).	7	10	12	10	25	1	65
Inpatient	0	2	0	0	2	0	4
Community	7	8	12	10	23	1	61

Unexpected Unnatural (UU) eg suicide, homicide.	17	34	7	21	16	2	97
Inpatient	1	9	1	1	2	0	14
Community	16	25	6	20	14	2	83
Total	60	130	70	135	90	4	489

- c) The number of suspected suicides and/or self-inflicted deaths, within three months of contact with the trust, please provide figures for both inpatient and community settings

To establish the circumstances of death would require a manual trawl, taking a minimum of 5 minutes per record. This would exceed 18 hours and has therefore not been included in the response.

For all the above points, please break the data down by calendar year, and provide figures for both inpatient and community settings.

Please also adhere to the NHS England agreed definitions of 'serious incident' as specified below:

Serious incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, never events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

Please also include the definition of 'serious incident' and 'unexpected death' which is used by the trust.

The definition used by former SEPT, former NEPT and EPUT is the agreed NHS England definition, as detailed above. As of 1st May 2021, the Trust adopted the Patient Safety Incident Response Framework (PSIRF) which has replaced the Serious Incidents Framework; details of PSIRF are held within the public domain for viewing.

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>