University Hospitals of North Midlands NHS Trust

Royal Stoke University Hospital
Data, Security and Protection
Newcastle Road
Stoke-on-Trent
Staffordshire
ST4 6QG

Email foi@uhnm.nhs.uk

Ref: FOIA Reference 2021/22-170

Date: 30th July 2021

Dear

I am writing to acknowledge receipt of your email dated 18th June 2021 requesting information under the Freedom of Information Act (2000) regarding deaths caused by care.

As of 1st November 2014 University Hospitals of North Midlands NHS Trust (UHNM) manages two hospital sites – Royal Stoke University Hospital, and County Hospital (Stafford). Therefore the response below is for the two sites combined from that date where appropriate.

Q1 **With reference to the following reporting guidelines set out by NHS Improvement (see page 15, prescribed information 27.1 to 27.5).**

1) Please tell me separately for 2019/20 and 2020/21 the number of patients who have died during the reporting period

A1 I can confirm that the Trust holds information regarding this question, but feel this information is exempt under section 21: *information reasonably accessible by other means*. This is because the information is available via the Trust's public website at the following link: FOI ref 087-2122 May 2021-22

http://www.uhnm.nhs.uk/about-us/regulatory-information/freedom-of-information-publication-scheme/freedom-of-information-disclosure-log/

Q2 **The number of deaths included in 2019/20 and 2020/21 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient**

A2 Initial Mortality Reviews (does not address Problems in Care)

2019/20

	Mortality Rev Present/Not Present		
	Not Present	Present	Grand Total
#	352	3047	3399

2020/21

	Mortality Rev Present/Not Present		
	Not Present	Present	Grand Total
#	1219	2774	3993

Structured Judgement Reviews (not required for all deaths – identifies Problems in care where relevant)

Financial Year	2019/20
	# SJRs Completed
Yes	541

Financial Year	2020/21
	# SJRs Completed
Yes	477

Q3 An estimate of the number of deaths in 2019/20 and 2020/21 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

A3 The SJR reviewers list any problems in care identified and answer whether the problems did, or probably did, lead to harm:

The problems in care sections are as follows:

- Problem in assessment, investigation or diagnosis
- Problem with medication
- Problem related to treatment and management plan
- Problem with infection management
- Problem related to operation/invasive procedure
- Problem in clinical monitoring

- Problem in resuscitation following cardiac or respiratory
- Problem of any other type not fitting the categories

The reviewer examines the available notes for the patient and decides whether or not there were any problems fitting into these categories and, if so, whether harm was caused. NB – each patient can have more than one problem in care identified.

SJRs where Problems in Care Identified

19/20 deaths = 541 SJRs completed:
46 patients were identified as having problems in care which it is felt did, or probably did, lead to harm (68 problems in care for these 46 patients were recorded)

20/21 deaths = 477 SJRs completed:
42 patients were identified as having problems in care which it is felt did, or probably did, lead to harm (57 problems in care for these 42 patients were recorded)

Q4 Please provide me with a brief overview of the FIRST FIVE incidents (in 2020/21 preferably or from 2019/20 if this is not yet available) identified in question 3 (i.e. cases of deaths that were more likely than not caused by problems in care), withholding any identifying information that would run into a Section 40 exemption.

A4 I have listed the first 5 SJRs completed for deaths in 2020/21 where problems in care were identified that did, or probably did, lead to harm

See separate attachment- note:

Some information within the response has been redacted. This is because it is exempt under section 40(2) of the FOI Act: *personal information*. The information could be used to identify individual patients and/or their representative and therefore has not been released.

Q5 Finally, can you please summarise what the Trust learnt and what actions have been taken as a result of the aforementioned cases/investigations.

A5 See below;
#1:
With appropriate [redacted] care patient could have died at a more appropriate place such as home/hospice rather than in an acute care setting.
If medical records can be shared electronically even out of hours between trusts, it will improve patient safety.

#2:
Effective communication between multi-disciplinary teams to ensure appropriate response to changing clinical situations
Handover between in ICU on admission is a must and must be documented in patient notes
More [redacted] training on the equipment set up and commencement to ensure timely set up of [redacted] when patient requires it.
See Datix Inc ID: [redacted] – learning identified from this incident:

The patient at the heart of this incident was an extremely critically ill [redacted] on admission to hospital and was clear that this was most likely an unsurvivable event.
The findings in this report have revealed that there were definitely shortfalls within this patient's journey through the hospital but the outcome of this patient would not have changed due to [redacted] underlying [redacted]. However, the findings need to be explored and learned from in order to prevent these events happening in the future.

- On-going treatment that is started needs to be continually reviewed and rationalised at every investigation.
- It is essential that there is a medical to medical handover and this is documented within the patients' medical notes.
- Allocation and skill mix is reviewed and adhered to in the ever changing critical care environment according to patients clinical condition.
- More staff are trained regularly with the set up and commencement of [redacted] therapy.

This incident was classed as a Serious Incident and subject to a Root Cause Analysis (RCA) with a subsequent action plan developed addressing the above points

#3:

1. Delay in Transfer to the ward needs investigating further.
2. Regular drugs prescribed on drug chart should not be missed while in ED
3. [redacted] should be repeated in case of clinical deterioration in patients with moderate to severe [redacted]

These points have been conveyed to Emergency Department via Datix feedback.

#4:

This has been discussed and further enquiry will be done relating to the procedural complications - see Datix Incident ID: [redacted]. This incident is classed as a Serious Incident and is due to be presented at Risk Management Panel.

#5:

Although immediate clerking might not have changed the outcome for patient, there are lessons to be learned in terms of handing over and escalating unwell patients who are electively admitted. See learning from Datix Incident ID[redacted]
It might have been more appropriate for the paramedics to send the patient to A&E from the car park in view of the [redacted].
This might have provided stability to patient and prompt clinical review before transferring to the ward [redacted].
The patient's [redacted] had requested an ambulance as [redacted] was worried regarding running out of [redacted]. There were no observations recorded in the paramedic EPR sheet in the car park which might have resulted in a missed opportunity to identify the [redacted] and admit the patient to A&E. Finally, it might be better for elective [redacted] to be clerked by the roving medical registrar out of hours due to their complex needs. Learning from Incident ID [redacted]: Junior trainees should seek help and guidance to prioritise tasks including timely review of acutely unwell patients from on-call registrars or on-call

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An anonymised copy of this request can be found on the Trust's disclosure log, please note that all requests can be found at the following link: http://www.uhnm.nhs.uk/aboutus/Statutory-Policies-and-Procedures/Pages/Freedom-of-Information-Disclosure-Log.aspx

This letter confirms the completion of this request. A log of this request and a copy of this letter will be held by the Trust.

If you have any queries related to the response provided please in the first instance contact my office.

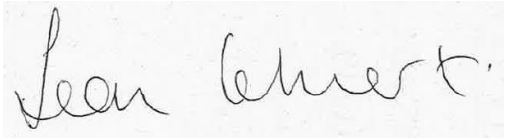
Should you have a complaint about the response or the handling of your request, please also contact my office to request a review of this. If having exhausted the Trust's FOIA complaints process you are still not satisfied, you are entitled to approach the Information Commissioner's Office (ICO) and request an assessment of the manner in which the Trust has managed your request.

The Information Commissioner may be contacted at:

Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF or via www.ico.org.uk.

If following review of the responses I can be of any further assistance please contact my secretary on 01782 671612.

Yours,



Jean Lehnert
Data, Security & Protection Manager

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