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 2022/23-213

Date: 5th August 2022

Dear

I am writing to acknowledge receipt of your email dated 18th July 2022 requesting information under the Freedom of Information Act (2000) regarding Deaths.

The University Hospitals of North Midlands Trust is committed to the Freedom of Information Act 2000.

However, the NHS is facing unprecedented challenges relating to the coronavirus (COVID-19) pandemic at the current time. Understandably, our resources have been diverted to support our front-line colleagues who are working tremendously hard to provide care for our patients, and to those in need of our services.

We strive to be transparent and to work with an open culture. But at this time, whilst care of our patients and the safety of our staff takes precedent, it is likely that responses to some requests for information will be delayed. We apologise for this position in advance, and will endeavour to provide you with as much information as we can, as soon as we are able.

The Information Commissioners Office has recognised the current situation in the NHS.

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, link here: https://www.england.nhs.uk/wp-content/uploads/2020/08/Detailed_requirements_for_quality_report_-update.pdf)**

1) Please tell me in the reporting period 2021/22 the number of deaths that occurred at your Trust 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.

NOTE: By 'more likely than not' caused by care, I mean given a score of 3 (probably avoidable), 2 (strong evidence of avoidability) or 1 (definitely avoidable) on the inpatient structured judgement reviews (SJR), as assessed using the Royal College of Physicians avoidability of death criteria. If you do not use this system, please ignore this note.

A1 There were 11 individual Structured Judgement Reviews completed on deaths occurring in 2021/22 that identified 'Problems in Care' that resulted in harm ('Yes' responses to 'Did the problem cause harm' sections below). Each review may identify more than 1 problem:

1. Problem in assessment, investigation or diagnosis

5 SJRs identified where harm was caused

2. problem with medication

1 SJR identified where harm was caused

3. Problem related to treatment and management plan

4 SJRs identified where harm was caused

4. Problem with infection management

3 SJRs identified where harm was caused

5. Problem related to operation/invasive procedure

6 SJRs identified where harm was caused

6. Problem in clinical monitoring

2 SJRs identified where harm was caused

7. Problem in resuscitation following cardiac or respiratory arrest
n/a

8. problem of any other type not fitting the categories above
n/a.

Q2 Please provide me with a brief overview of the FIRST FIVE incidents in 2021/22 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.

A2 See below: note that the reviews do not ask the reviewer to state if the problems in care caused the death, or were more than likely to have caused death

1. started on fluids appropriately on admission

2. no documentation on initial clerking re appearance of [redacted] legs ; given iv fluids to correct dehydration
3. waited > 4 hours in A and E ; pressure relief on sacrum may not have been while waiting
4. no issues
5. [redacted] was admitted via [redacted] GP with ? pleural effusion, weakness and breathlessness and abdominal pain following catheter change. [redacted] was rapidly assessed and care planned to ascertain the cause of the effusion and deterioration and a chest drain was placed within the first 24 hours.

Q3 Finally, can you please summarise what the Trust learnt and what actions have been taken as a result of the aforementioned cases/investigations.

A3 Actions taken are that cases are discussed in Mortality and Morbidity meetings and the learning shared with relevant teams. In addition:

Case 1: the harm related to a patient fall; this identified the following learning:

- The Panel sitting to hear the Falls Root Cause Analysis felt that the ward had acted appropriately in preventing the fall by making sure that well-fitting footwear was worn and risk assessments were carried out on admission. They were also happy that your family were kept informed.
- However, the Panel wanted the ward to ensure that lying and standing blood pressure readings are done promptly – this is to rule out a drop in blood pressure on standing that can contribute to falls. We did not have the chance to do this with the patient as he fell within an hour of arrival on the ward, but I would like to assure you that this request is being complied with unless the person is immobile on arrival. The Panel also raised the issue of ensuring comfort rounds are being done two-hourly to prevent falls, and we would like to assure you that as much as possible these are being done as required. Training is in progress yearly to ensure staffs comply with manual handling procedures – this is on-going.

Case 2: Discussed at July 2021 Elderly Care M&M meeting and learning shared:

- Discussion centred on risks vs benefits of starting anticoagulation before a scan result.
- This patient's leg appeared to look atypical for a DVT , from what is documented in the notes and in retrospect the Doppler result should have been seen before anti – coagulation was considered

Case 3: An RCA has been done re the sacral pressure sore

- new mattresses have been purchased for the ward
- patients with pressure sores will be advised to have longer periods of bed rest and to sit out only for short periods
- Ward team reminded that ortho-geriatricians should be asked to review patients sooner , if there are on-going problems with a sacral break that will not heal
- it is not clear however , even if this review had taken place, whether it would have altered the outcome

Case 4: A Serious Incident was reported following the SJR re missed anticoagulation. The RCA records the following:

- Maintain a list of patients presenting on anticoagulants on a white board in the office – to be led by orthogeriatricians
- Surgeons to agree to prioritise patients on anticoagulants for surgery

- Surgeons to give clear directions in the op notes as to when to re-start anticoagulants post operatively
- Orthogeriatricians and ANPs to monitor the number of days a patient has been off anticoagulant since admission and assess the need for bridging therapy if surgery is delayed
- Revising the A-Z hip fracture guide
- Making the new junior doctors aware of the presence of A-Z hip fracture guide on intranet on their Trust induction
- Start a dialogue with clinical leads in T&O and Elderly Care to negotiate increased sessional time for orthogeriatrics from 5 per week to a minimum of 7.
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Case 5: the harm related to a patient fall. An RCA was completed and action plan completed to address the issues identified:

- Ensure the patients mobility assessment is updated post fall to reflect the changes in the patients mobility
- Registered nurse to review the multifactorial assessment and interventions within 6 hours of admission and to document this has been done
- Actual position of the patients bedrails must be according to the bedrail assessment and that all staff are aware of the bedrail assessment outcome
- Where patients are identified as having falls risk factors request a pharmacy falls medication review and to document the review in the notes

*Please note that any individuals identified do not give consent for their personal data to be processed for the purposes of direct marketing.

UHNM NHS Trust is a public sector body and governed by EU law. FOI requestors should note that any new Trust requirements over the EU threshold will be subject to these regulations and will be advertised for open competition accordingly.

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

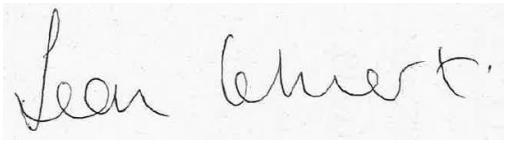
still not satisfied, you are entitled to approach the Information Commissioner's Office (ICO) and request an assessment of the manner in which the Trust has managed your request.

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