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 2024/25-263

Date: 19th August 2024

Dear Sir/Madam

I am writing to acknowledge receipt of your email dated 3rd July, received into our inbox 10th July 2024 requesting information under the Freedom of Information Act (2000) regarding deaths

On 22nd July 2024 you sent in another request, we emailed you with the following:

UHNM has received several requests that are asking for similar information that we believe are from the same person/company, therefore we are contacting you to inform you that under section 12 of the FOI Act we were aggregating these requests on Medical Associate Professionals and deaths

Your new reference number for both is 263-2425

The section 12 exemption states:

The authority can combine related requests received within a period of 60 consecutive days from:
• The same person or
• People who appear to be acting in concert or in pursuance of a campaign.

Note that the clock re-starts on your previous request as of today

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.

Request #1

Q1 **1) Please tell me separately for 2022/23 and 2023/24 the number of deaths for which a case record review or investigation has been carried out leading to the conclusion that they were more likely than not to have been due to problems in the care provided to the patient.**

NOTE: I understand that one widely used method for determining this is the Royal College of Physicians' Structured Judgement Reviews (SJR) 1-6 system. If this system was used, by "more likely than not" I'm referring to cases with scores of 3 (probably avoidable), 2 (strong evidence of avoidability) and 1 (definitely avoidable).

A1 All inpatient deaths are expected to have an initial mortality review completed. These are rated using CEPOD A to E scoring. For patients who died 2022/23 and 2023/24 the results are below:

	Year of death		
CEPOD Score	**2022/23**	**2023/24**	**Grand Total**
A: Good Practice-A standard that you accept for yourself	2986	2550	5536
B: Room for Improvement-Regarding clinical care	142	115	257
C: Room for Improvement-Regarding organisational care	50	32	82
D: Room for Improvement-Regarding clinical & organisational care	24	14	38
E: Less than satisfactory-Several aspects of all the above	3	1	4
Grand Total	**3205**	**2712**	**5917**

NB: Structured Judgement Reviews are only carried out on specific criteria, <u>not all inpatient deaths.</u>

Overall SJR scores (1 to 5) for patients who died 2022/23 and 2023/24 as follows:

	Year of Death		
SJR Overall Score	**2022/23**	**2023/24**	**Grand Total**
5 = Excellent care	189	180	369
4 = good care	363	249	612
3 = adequate care	99	79	178
2 = poor care	33	14	47
1 = very poor care	1		1
Grand Total	**685**	**522**	**1207**

Our SJRs don't rate the avoidability of death. However, SJRs completed for patients who died in 2022/23 and 2023/24 that featured problems in care that are deemed to have caused harm are below (*cases may identify more than one problem per patient so the numbers below don't represent # of SJRs*)

Year of Death	Problem in assessment, investigation or diagnosis (including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)	Problem with medication / IV fluids / electrolytes / oxygen (other than anaesthetic)	Problem related to treatment and management plan? (including prevention of pressure ulcers, falls, VTE)	Problem with infection management	Problem related to operation / invasive procedure (other than infection control)	Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond	Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR))	Problem of any other type not fitting the categories above

						to changes)		
2022/23	8	2	6	2	3	4	0	1
2023/24	3	4	3	1	3	1	2	0

Q2 **Please provide me with a brief overview of the FIRST FIVE incidents (in 2023/24 preferably or from 2022/23 if the former is not yet available) identified in question 1 (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 There is no automatic link between incidents resulting in death being reported and problems in care identified in SJRs.

See separate spread sheets for overview and lessons learned from patient safety incidents where actual impact was death and incident has been approved and closed

Q3 **Finally, can you please summarise what the Trust learnt and what actions have been taken as a result of these five cases highlighted in question 2?**

A3 See separate sheets for overview and lessons learned from patient safety incidents where actual impact was death and incident has been approved and closed

Request #2

Q1 **With reference to the financial years a) 2021/22, b) 2022/23 and c) 2023/24, please tell me**

How many Never Events did your trust record in which one or more of the below Medical Associate Professionals was involved

Physician associate
Anaesthesia associate
Advanced critical care practitioner
Surgical care practitioner

Please break down the data by type of professional and financial year.

A1 UHNM is only able to determine answer where those specific job titles have been entered on any of the contact records attached to the incident.

Year	Professional and #
2021/22	0
2022/23	0
2023/24	Surgical Care Practitioner = 1

Q2 **For the 10 most recent events identified, please provide me with a detailed summary of the Never Event.**

A2 See attached incident summary

Q3 For each Never Event identified in question 1, please indicate the number of cases where the incident was judged to have more likely than not resulted in a patient death.

A3 0 incidents where 'Actual Impact' is 'Death caused by the patient safety incident'.

*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.

Where the Trust owns the copyright in information provided, you may re-use the information in line with the conditions set out in the Open Government Licence v3 which is available at http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/. Where information was created by third parties, you should contact them directly for permission to re-use the information.

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.

Yours,

University Hospitals of North Midlands NHS Trust

Rachel Montinaro
Data Security and Protection Manager - Records