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Name:
Email:
Date: 09/09/2021
Ref: 21-22 170

Freedom of Information request

Firstly, please accept our sincere apologies for the delay in providing you with a response. Thank you for your request for information under the Freedom of Information Act 2000, which was received by the Trust on 18/06/2021.

Deaths caused by care

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

Year	Number of patients
2019/20	2219
2020/21	2448

2) **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.**
This question is exempt from disclosure under section 21 of the Freedom of Information Act 2000 (information is already reasonably accessible), this information is already published on the Trust's internet site and can be found by following the links below:

Page 17-18
https://www.porthosp.nhs.uk/about-us/publications/PHU%20Quality%20Accounts%202019-20.pdf

Page 15 – 17
https://www.porthosp.nhs.uk/Downloads/PHU%20Quality%20Accounts%202020-21_Final.pdf

3) **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.**
Please see answer in question 2

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4) **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.**

   The below cases are from 2020-2021:

   Case one: Patient died due to a hospital acquired venous thromboembolism (VTE). Prophylaxis had not been prescribed as per policy following the completion of the VTE risk assessment indicating this was recommended.

   Case two: A patient with delirium had an unwitnessed fall and hit her head.

   Case three: An elderly patient with dementia, a history of recurrent falls patient and a new diagnosis of cerebrovascular accident, had an unwitnessed fall and hit her head.

   Case four: A patient with a history of dementia and multiple falls had an unwitnessed fall six days post op following hemi-arthroplasty.

   Case five: A patient with terminal metastatic kidney cancer was given Pazopanib (anti-cancer treatment which may have prompted an acute admission, resulting in the patient requiring palliative care sooner than expected.

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

   The below cases are from 2020-2021:

   Case one: VTE Assessment has been moved to an electronic IT platform that only prescribers have access to. The VTE assessment rates of compliance at patient detail level is cascaded to clinical managers and consultants on a daily basis. The VTE assessment compliance rate has improved since the step process was mandated on the IT platform.

   Case two: A falls review was undertaken with the Multi-disciplinary team (MDT) and concluded the following key themes. The falls assessment and care plan had not been reviewed following ward moves and the most recent assessment did not identify the biggest risk which was the patient had an onset of delirium the bed rail assessment outcome advised use of bedrails and this is contrary to how the Trust manages patients with a delirium. The Trust has launched an education programme for all nursing staff, the programme includes bed rail assessments, how to assess if a patient is safe to get out of bed, mobility assessments and care of delirium 'pinch me'. The elderly care wards have been engaged in a quality improvement (QI) initiative called 'lower the rails, lower the harm'

   Case three: A falls champion was introduced for this ward. Education was provided by the fall's safety team for the mutli-disciplinary team within this clinical area. The team are also engaging with the quality improvement initiative described in the previous answer for case two

   Case four: An investigation found that there had been inadequate documentation and understanding of the falls risk assessments. Staff on the ward received focussed training in falls risk assessments and documentation. All patients to have a lying and standing blood pressure recorded.

   Case five: A patient with terminal metastatic kidney cancer was given a Pazopanib (anti-cancer treatment which may have prompted an acute admission, resulting in the patient requiring palliative care sooner than expected. Drug treatment chart to reflect up to date bloods prior to commencement of pazopanib, blood pressure and performance status to be assessed prior to commencing pazopanib and documented.

Please accept this letter as completion of your request. Please note that copies of this request will be held on file for three years before being confidentially destroyed.

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If you are dissatisfied with the outcome of your request, please contact our Head of Information Governance on Information.Governance@porthosp.nhs.uk or write to the above address and we will conduct an internal review. Upon review, if you are still dissatisfied, you may appeal our decision by contacting the Information Commissioner's Office; for more information please visit the ICO's website.

Please be aware, if we do not receive an appeal within 30 days of you receiving this letter, we will assume that you are satisfied with our response. If you have any further queries, please do not hesitate to contact us.

Yours sincerely

Freedom of Information Team

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