NHS
University Hospitals Plymouth
NHS Trust

Freedom of Information Act Disclosure log - Reply Extract

File reference	W21FOI151
Key words	2019-20 & 2020-21 Deaths Subject to a Case Record Review or Investigation
Date of release	15/07/2021
Attachments	No

You asked

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.

Year	Total
2019/20	1881
2020/21	1819

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

From a Mortality review perspective;
01/04/2019 – 31/03/2020 = 25 + 67 from the COPD Dr Foster alert + 30 from the Stroke Dr Foster alert
01/04/2020 – 31/03/2021 = 40 have been returned with a score out of 140 identified.

From a Serious Incident perspective;
01/04/2019 – 31/03/2020 = 13
01/04/2020 – 31/03/2021 = 14

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.

From a Mortality review perspective;
The Trust use the Structured Judgement Review (SJRs) methodology to complete an in-depth case record review of a patient's death.
Of the SJRs completed, the Trust judge that five or fewer cases were more likely than not to have been due to problems in the care provided to the patient.

From a Serious Incident perspective;
The Trust use the Root Cause Analysis methodology to investigate Serious Incidents. Please note, 1 investigation reported in March 2021 is still ongoing and therefore a conclusion in response to this question cannot be given at this time.
Of the 26 completed Serious Incident investigations, the Trust judge that five or fewer cases were more likely than not to have been due to problems in the care provided to the patient.

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 Trust is refusing to disclose this information as it cannot be provided without revealing the details of Q3 which constitute personal information.

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

From a Mortality review perspective;
Learning from completed Structured Judgement Review are shared at Mortality Review Group meetings.

From a Serious Incident perspective;

- Review case via discrepancy meeting to share learning within the service line as per departmental policy.

- Feedback outcome of discrepancy meeting to reporting radiologist for personal reflection.

- Feedback outcome of discrepancy meeting to referring clinician/clinical team for consideration of next steps.

- Ensure compliance with the national standard which stipulates a bi-annual report is completed to identify trends and themes in discrepancies. This currently done biennial within Imaging.

- Case should be reviewed at the respiratory medicine M&M meeting to highlight lessons.

- Guidelines, based on the latest EASL guidance, should be published making it clear whose responsibility it is to check HBV status, who should be referred to Hepatology and who should monitor HBV viral DNA titres where appropriate.

i. The guidelines should remain the property of Hepatology to review and update.
ii. The guidelines should be promoted among all specialities prescribing high risk immunosuppressive regimes.
iii. The guidelines should be easily accessible across the local health community.

- Patients who test anti-HBc positive, receiving high risk immunosuppressive regimes should have specific risks of HBV reactivation explained to them with the requirement for regular monitoring. This should be documented in the medical notes.

- When it comes on-line, e-prescribing should ask all physicians to sign electronically that they have checked the guidelines and that the treatment is compliant with them. To facilitate this, guidelines need to be easily accessible.

Legal notes
University Hospitals Plymouth NHS Trust is confirming in accordance with section 1 (a) of the Act that it holds the information requested and is supplying it in accordance with section 1(b) unless otherwise specified because it is personal information.

Please find the answers to your questions noting that we have redacted the data set where numbers are five or fewer. Our approach avoids a breach of the first two Data Protection Act principles and the general right to object to processing, whilst providing you with as much detail as possible. This is in accordance with section 40.-(2)(a) and (b) by virtue of the first and second condition.

Attachments included: No