Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 6803

Please reply to:
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Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Deaths caused by care.

You asked:

1) Please tell me separately for 2019/20 and 2020/21 the number of patients who have died during the reporting period
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
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.
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.
5) Finally, can you please summarise what the Trust learnt and what actions have been taken as a result of the aforementioned cases/investigations.

Trust response:
1) Under Section 21 of the Act we are not required to provide information in response to a request if the information is already reasonably accessible to you. The information you requested is available from the following link: https://digital.nhs.uk/data-and-information/publications/statistical/shmi
2) Case record reviews known as structured judgement reviews (SJRs) for 2019/20 = 79 and 2020/21 = 99.

3) Deaths where an investigation has been carried out (outside of the SJR / Medical examiner review) 10 for 2019/20, SJRs for 2019/20 = 25 and for 2020/21 = 11.
4)
2019/20
Treatment delay meeting SI criteria
VTE meeting SI criteria
Slips/trips/falls meeting SI criteria x3
5)
Case 1
Review of admission process – particularly in patients where stroke not confirmed. Presentation at Medical governance – highlighting importance of full medical assessment when stroke disproved – i.e. to look for alternative diagnosis and importance of formal handover process and escalation within medical review
Case 2
Risk of falling assessment needs to be more robust to accurately reflect the patient's needs.
Enhanced care plans to be re-assessed when patient behaviour/condition changes Documentation of patient mobility and aids if required, ensuring these are consistently available and appropriate for use, audit availability of aids against the patient handling assessment document Staff training to use falls alarm devices and management of device failure Patients who are at risk of falls to have lying and standing blood pressure taken on admission
Case 3
To ensure high risk patient's either have 1-1 care or are observed at all times Daily assessment of staffing levels and patient demand by the nurse in charge will ensure breaks are adequately covered.
Ensure all falls monitoring equipment is checked daily to ensure functionality
Case 4
All care or interventions must be clearly documented and evidenced within the patient's medical records. Staff reminded to complete observations as per medical plan.
If unsafe staffing levels are identified this should be escalated by the senior nursing team and site practitioner to arrange for cover. Unsafe staffing must also be reported on the Trust's incident reporting system.
Redefined definition of inclusion criteria for CDU protocol, Department protocol to be reviewed to ensure that this includes escalation process of closure of the unit when no staff available.
Case 5
Feedback to multi-disciplinary teams the importance of following policy and procedure for VTE and implementation of IPCD and care plan VTE risk assessment to be completed on admission and within 24 hours as per policy
Learning shared at board round and presentation at clinical governance and shared in trust wide newsletter. Learning shared with staff members involved with patients care.
Stroke specific checklist for all new stroke patients implemented Training implemented for IPCD and Stroke Pathway