Executive Corridor

Darlington Memorial Hospital Hollyhurst Road Darlington DL3 6HX

Switchboard Tel: 01325 38 0100 Foundation Trust Office: 01325 74 3625

Corporate Records Office: 01325 74 3700

Request for Information Reference: 06.21.44

FOI Direct line: 01325 743700 Email: cdda-tr.cddftfoi@nhs.net

Email only

15 July 2021

Freedom of Information Act 2000 – Request for Information

Thank you for submitting a request for information which we received on 18 June 2021 in relation to County Durham and Darlington NHS Foundation Trust (the Trust). Your request has been processed under the provisions of the Freedom of Information Act 2000 and I am now able to provide you with a response.

Your request was in relation to Death caused by Care and I am providing the following information in response to your specific questions:

With reference to the <u>following reporting guidelines set out by NHS</u> <u>Improvement</u> (see page 15, prescribed information 27.1 to 27.5).

1. Please tell me <u>separately</u> for 2019/20 and 2020/21 the number of patients who have died during the reporting period

2019/2020 - 1986 2020/2021 - 2421

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

2019/2020 - 866 2020/2021 - 903

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.

The below numbers are the total mortality reviews with a Hogan score of 4 or over (4-Probably preventable, greater than 50-50, 5-Strong evidence for preventability, 6-Definitely preventable)

2019/2020 - 52020/2021 - 5

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.

Please see below for a high level Patient Overview for five cases from 2020/21:

Patient A

Patient with multiple comorbidities died following surgery.

Patient B

Patient with multiple comorbidities who was receiving treatment in hospital died following delayed procedure due to the Covid-19 pandemic.

Patient C

Incorrect interpretation of test results.

Patient D

Following surgery a patient with multiple comorbidities developed Covid-19 and died.

Patient E

Following surgical intervention the patient developed Covid-19 and died.

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

High Level Learning Themes:

- Advanced Decision Making and Recognition of Dying: The Specialist Palliative Care Team are leading on an education programme with Lead Clinicians to improve recognition of Dying and the approach to early decision making. This is being supported by the introduction of a Treatment Escalation Plan which aims to improve documentation of treatment decisions and optimise patient focused discussions about what treatment they would prefer and what could be available to them in the event of deterioration.
- Infection Prevention & Control: Under direct guidance of Public Health England and NHS England, the Trust has adhered to Infection Prevention & Control guidelines throughout the COVID-19 Pandemic. In December 2020 CDDFT took



- a decision to stop cohorting of COVID-19 patients (nationally agreed practice) unless exceptional circumstances which would be an executive decision.
- Senior Decision Making: Patients readmitted within 72 hours should be reviewed by a Senior Clinician within the Emergency Departments. This is usual process, however in response to a recent Serious Incident and to affirm this process is happening the report has been shared with ED Colleagues through local and care group governance forums.

In line with the Information Commissioner's directive on the disclosure of information under the Freedom of Information Act 2000 your request will form part of our disclosure log on the Trust's website. However please be assured that we anonymise all responses prior to adding them to the disclosure log.

I hope that this response has provided you with the information you had requested. If you have any queries or wish to discuss the information supplied, please do not hesitate to contact me by telephone or in writing. If however, you are dissatisfied with the way in which your request has been handled and would like an internal review, you will need to contact me in writing at the above address or via cdda-tr.cddftfoi@nhs.

If you remain dissatisfied with our response following an internal review you have the right to appeal to The Information Commissioner at Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF. More information is available on their website; www.ico.gov.uk.

Yours sincerely

Corporate Records & Freedom of Information Facilitator