Freedom of Information Request

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Information Requested:

As described on page 6 of the National Quality Board's National Guidance on Learning from Deaths, Trusts are required to collect specified information on deaths: <u>https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf</u>

Please may I receive the following data described in that guidance, on a monthly basis from the beginning of 2018 to the most recent month available:

- The total number of in-patient deaths (including emergency department deaths)

- The number of deaths subject to case record review

- Of these deaths subjected to review, the number that were judged more likely than not to have been due to problems in care

If data is not available at the beginning of 2018, please supply data from the earliest point after when data was collected.

	2018	2019	2020	2021	2022 (01/01 – 31/03)
Total number of inpatient deaths	62	45	60	46	9
Number of deaths subject to case record review *	12	12	7	6	4
Of these deaths subjected to review, the number that were judged more likely than not to have been due to problems in care	5	4	0 (6 deaths judged as <u>not</u> more likely than not to have been due to problems in care and one death falls under ** narrative below)	0 ** Please see below narrative	0 ** Please see below narrative

* these totals include deaths subjected to either a clinical case note review or a more detailed investigation under the Trust's Serious Incident / Patient Safety Incident arrangements.

** the Trust is an early adopter of the Patient Safety Incident Response Framework, which replaces the Serious Incident Framework. The purpose of patient safety incident investigation is to support system learning and continuous improvement in patient safety, rather than to address individual concerns, performance management issues and insulates against the retrospective assessment of "avoidability", predictability and liability. Therefore the Trust does not assess problem in care likelihood as part of the Patient Safety Incident Response process.



Publication Scheme:

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