St Helens and Knowsley Teaching Hospitals NHS Trust

Ref. No:	144210621
From:	Public
Date:	21/06/21
Subject:	Deaths caused by care

REQUEST

1) Please tell me **separately for 2019/20 and 2020/21 t**he 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.

RESPONSE

	2019/20	2020/21
Number of deaths	1756	2019
Number of reviews	533	503
Poor outcome SJR's	*<5	*<5

Please note in the response above you will see that *<5 has been added where the number of patients is 5 or less, this information has been redacted to protect patient confidentiality and to ensure that patients cannot be identified.

Lessons Learned / Action Taken

- Task and finish group led by senior doctor to improve systems and processes for the management of the deteriorating patient
- Raise awareness of sepsis and implement into the safety huddle
- Prescribing blood flow chart communicated to all doctors