Keele University Teaching Trust

NHS
North Staffordshire Combined Healthcare NHS Trust

Our Ref: NG/RM/25104
Date: 8th April 2025

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Reception: 0300 123 1535

Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 14th March 2025**.** Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:

I am writing to request information under the Freedom of Information Act 2000 regarding your compliance with the Leaming from Deaths Guidance issued by NHS England (2017) which ensures your trust complies with the National Health Service (Quality Accounts) (Amendment) Regulations 2017.

This requires every NHS Trust to annually report (with a quarterly breakdown) the number of patients who died during the reporting period, how many case record reviews or investigations took place, and estimate how many deaths were determined to be likely due to problems in the care provided. It also requires the reporting of a summary of lessons learnt, what actions have been taken as a result, and what the impact of these actions has been.

Included in the Quality Accounts should also be the number of case record reviews and investigations relating to deaths in the previous reporting period that were only concluded in the most recent period and an estimation of how many of those deaths were due to problems in the care provided.

Please provide answers to the following questions for the most recent reporting period (2023/24):

1. Policy and Governance
   a) Does your Trust currently comply with the requirements of the Leaming from Deaths Guidance? **Yes, the Trust does comply with the requirements of the Learning from Deaths Guidance.**

   b) If not do you have plans to comply with it and if so by when? **N/A**

2. Reporting
   a) How many deaths were reported within your trust during the reporting period (2023/24)?

Deaths requiring a Comprehensive Safety Review (CSR) ,formerly Serious Incident (SI)	**37**
Deaths where Mortality Review was completed (Natural Causes but under 75)	**69**
Deaths where Mortality Review was completed and reported to LeDeR (no age limit)	**31**
Deaths confirmed as Natural Causes (over 75 not requiring a Mortality Surveillance Review)	**43**
Deaths reported where deceased was not open to any services	**13**
Total	**193**

b) How many of these deaths were reviewed, and how many were judged more likely than not to have been avoidable? **From the reviews there have not been any that were considered avoidable.**

c) Have you published quarterly reports on learning from deaths on your website, as required by the guidance? Please provide links to the most recent reports. **The reports are not published on the Trust website.**

d) Is information on learning from deaths included in your latest Quality Account? **Numbers are published in the Quality Account.**

3. Family Involvement
   a) Are families and carers involved in the review process where appropriate? **For CSRs/SIs families are offered the opportunity to be involved in the review, however, this offer is not always taken up.**

   b) Please provide the number of deaths that were reviewed in this period (2023/24) where families and carers were involved and engaged in the review. **This data is not collected centrally.**

4. Actions and Learning
   a) Please provide a summary of all actions taken as a result of the learning from deaths process in the last reporting period.
   The actions that are taken as a result of our internal Patient Safety Incident Review Framework (PSIRF) responses are monitored according to our governance process. Oversight is provided by the Patient Safety Incident Investigation (PSII) oversight and learning leads in line with our Trusts policy and plan.

   These are for internal learning and are not shared externally except for LeDeR reviews where this remains a requirement of the process of mortality reviews for learning disability patients. Providing the actions alone would be

in conflict of this and without the context of the incident would not provide much context into rationale for these.

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

Nicola Griffiths
Deputy Director of Governance