Our Ref: 112

FEB 2025

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Freedom of Information Act Request

Under the Freedom of Information Act, I would like to request the following information:

Dear Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust,

As of 2017, data detailing the number of patients who have died due to problems in care is required to be published by NHS trusts in England. This is set out in this press release: https://www.gov.uk/government/news/nhs-becomes-first-healthcare-system-in-the-world-to-publish-numbers-of-avoidable-deaths and in this reporting guidance: https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-deaths-in-the-nhs/.

Under the Freedom of Information Act please could you provide the total number of deaths considered to have been due to problems in care in Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust for the periods:

1. 1st April 2019 to 31st March 2020
2. 1st April 2020 to 31st March 2021
3. 1st April 2021 to 31st March 2022
4. 1st April 2022 to 31st March 2023
5. 1st April 2023 to 31st March 2024

To clarify, this is not a request asking for the total number of deaths but is specifically concerning those which are deemed to be due to problems in care.

After reviewing our records, we can confirm that data for the periods prior to 1st April 2022 is difficult to definitively identify due to variations in DATIX reporting and subsequent changes in how incidents have been recorded over time. Retrieving and analysing this information would require a manual review of individual case records, which would exceed the cost limit set out under **Section 12** of the Freedom of Information Act 2000. Under this section, a public authority is not obliged to comply with a request if the estimated cost of doing so would exceed £450 (equivalent to 18 hours of staff time at £25 per hour).

However, for the most recent periods, where data is more easily identifiable due to the introduction of the Patient Safety Incident Response Framework (PSIRF), we can provide the following figures:

- **2022/23:** 9 reported incidents
- **2023/24:** 6 reported incidents

The implementation of PSIRF has improved the identification and categorisation of deaths due to problems in care. This framework aligns with national priorities and ensures that incidents meeting the criteria for a Patient Safety Incident Investigation (PSII) are reviewed

by the Trust panel, which determines whether a death is deemed more likely than not to have resulted from problems in care.

If you are not satisfied with the handling of your request, you have the right to request an internal review. Requests for an internal review should be submitted within 40 working days from the date of this response, and should be addressed to d.wraith@nhs.net.

If you remain dissatisfied after the internal review, you have the right to appeal to the Information Commissioner's Office (ICO). The ICO can be contacted at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Tel: 0303 123 1113
Website: https://ico.org.uk/make-a-complaint/