

Board of Directors (in Public)
Item 2.2

Subject: Learning from Deaths Dashboard Q4 21/22
Date of Meeting: 26th April 2022
Prepared by: Dr Raphael Perry – Medical Director
Presented by: Dr Raphael Perry – Medical Director
Purpose of Report: For Noting

BAF Reference	Impact on BAF
BAF 1	Possible avoidable patient harm

Level of assurance (please tick one)

To be used when the content of the report provides evidence of assurance

<input checked="" type="checkbox"/>	Acceptable assurance Controls are suitably designed, with evidence of them being consistently applied and effective in practice	<input type="checkbox"/>	Partial assurance Controls are still maturing – evidence shows that further action is required to improve their effectiveness	<input type="checkbox"/>	Low assurance Evidence indicates poor effectiveness of controls
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1. Executive Summary:

- Guidance on learning from deaths was published by the National Quality Board in March 2017 and was presented to the Board of Directors in May 2017. Quarterly reports have been presented to the Board of Directors since.
- Deaths are categorised as to the likelihood of being avoidable or not (on balance of probability >/< 50:50) and the data collected centrally each quarter
- This quarterly report presents the mortality dashboard for Q4 21/22 (Appendix 1) and the cumulative annual end of year data.

2. Background:

The threshold of defining preventable death is on the basis of more likely than not encompassing the categories of definitely avoidable, strong evidence of avoidability and probably avoidable (greater than 50:50). Deaths are classified using the RCP (Royal College of Physicians) methodology unless they occur in individuals with an

identified learning disability. In those individuals LeDeR (Learning Disability Mortality Review) methodology is used and a full review carried out without prior screening.

The mortality review policy was reviewed and updated in October 2021 and the robust mortality review process continues.

All deaths have an initial review by the Deputy Director of Nursing to assess any issues raised by families and carers. In addition, the Medical Examiners and Medical Examiner Officer discuss issues raised by families at the time of death certification. Any concerns raised by the families after a period of reflection are responded to and where appropriate investigated. If the death is considered avoidable or classed as an incident full duty of candour is exercised and the resultant RCA discussed with families.

3. Dashboard Q4 2021/22

There have been sixty-five deaths in the trust between January and March 2022. For comparison the total number of deaths in the trust for Q3 2021/22 was sixty-one. In Q4 fifty-one of the deaths have been through the complete mortality review process. There have been no deaths in patients with an identified learning disability. The total quarterly number of deaths remains higher than average and this was driven by a high number of out of hospital cardiac arrest patients and critically ill primary PCI patients in January as in Q3 .

In interpreting the attached spreadsheet, it should be borne in mind that there may be an adjustment of the previous quarter's assessment of avoidability. This is because some of the returned full reviews will subsequently have been recalibrated by the mortality review group at their monthly meeting. Some cases rated by reviewer as less than 50:50 may have been deemed avoidable by the MRG and vice-versa.

In Q4 21/22 one death has been classified greater than 50:50 chance of avoidability by the mortality reviewer and the MRG. This was classed as strong evidence of avoidability (RCP2).

Of those less than 50:50 in Q4 one death (2%) were classed probably avoidable but not very likely (RCP4); six deaths (11.8%) were classed as slight evidence of avoidability (RCP5); forty-three deaths (84.3%) were classed as definitely not avoidable (RCP6).

Annual deaths:

The figures for the 21/22 year are a total of 223 deaths, 208 have been through MRG and there are fifteen yet to complete the full MRG process. There were six avoidable deaths in the year; two classed as definitely avoidable (RCP1), two classed as strong evidence of avoidability (RCP2) and two classed as probably avoidable >50:50. Of those that have gone through the MRG process the six avoidable deaths constitute 2.8% of deaths.

In 20/21 there were a total of 191 deaths compared to 189 deaths in 19/20.

The total number of avoidable deaths during 20/21 was nine; one definitely avoidable (RCP 1), three with strong evidence of avoidability (RCP 2) and five probably avoidable (more than 50:50 – RCP 3). This constituted 4.7% of all deaths that year.

In 19/20 there were eight potentially avoidable deaths constituting 4.2% of all deaths.

4. Conclusion:

The trust complies with national guidance and populates the mortality dashboard. Organisational learning from deaths is embedded through the divisional boards, audit day and will be part of the OL database/sharepoint.

Actions from the MRG process will be taken forward by the appropriate division.

5. Recommendations:

The Board of Directors is asked to note the dashboard data for Q4 21/22.