

Board of Directors (in Public)

Item 2.2

Subject: Learning from Deaths Dashboard Q1 21/22
Date of Meeting: Tuesday 27th July 2021
Prepared by: Dr Raphael Perry, Medical Director
Presented by: Dr Raphael Perry, Medical Director
Purpose of Report: To Note

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

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 Q1 21/22 (Appendix 1)

2. Background

The threshold of defining preventable death is now 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.

There is a mortality review policy in place 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. 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.

3. Dashboard Q1 2021/22

There have been 55 deaths in the trust between April and June 2021. For comparison the total number of deaths in the trust for Q4 2020/21 was 58. In Q1 42 of the deaths have been through the mortality review process. There have been no deaths in patients with an identified learning disability.

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 Q1 21/22 one death has been classified greater than 50:50 chance of avoidability by the mortality reviewer.

Of those less than 50:50 in Q1 no deaths were classed probably avoidable but not very likely (RCP4); 4 deaths (9.5%) were classed as slight evidence of avoidability (RCP5; 37 deaths (88.1%) were classed as definitely not avoidable (RCP6).

Annual Deaths

The YTD figures for this year, 21/22, are as Q1 data above.

In 20/21 there were a total of 191 deaths compared to 189 deaths in 19/20. Of the 20/21 deaths 14 have yet to complete the mortality review process.

The total number of avoidable deaths during 20/21 was 9; one definitely avoidable (RCP 1), 3 with strong evidence of avoidability (RCP 2) and 5 probably avoidable (more than 3 – RCP 3).

In 19/20 there were 8 potentially avoidable deaths.

4. Conclusion

The Trust complies with national guidance and populates the mortality dashboard. The one death with evidence of avoidability during Q1 21/22 (to be ratified by MRG). 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.