

## Board of Directors (in Public) Item 2.1\*

**Subject:** Learning from Deaths Dashboard  
**Date of meeting:** Tuesday 28<sup>th</sup> April 2020  
**Prepared by:** Dr Raphael Perry, Medical Director  
**Presented by:** Dr Raphael Perry, Medical Director  
**Purpose of Report:** For Note

BAF Ref	Impact on BAF
1.1;1.2	Avoidable patient harm, reputation, financial penalties

### 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 2019/20 (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.

The mortality review policy was updated in February 2019 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 Q4 2019/20**

There have been forty-four deaths in the trust between January and March 2020. For comparison the total number of deaths in the trust for Q3 2019/20 was forty-five. In Q4 thirty-nine 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 Q4 one death (2.6%) has been classified as greater than 50:50 chance of avoidability – probably avoidable (>50:50) – RCP 3.

Of those less than 50:50 in Q4 three deaths (7.7%) were classed probably avoidable but not very likely; two deaths (5.1%) classed as slight evidence of avoidability; thirty-three deaths (84.6%) were classed as definitely not avoidable.

### **4. Conclusion**

The Trust complies with national guidance and populates the mortality dashboard. There was one death with some evidence of avoidability during Q3 2019/20. Actions from the MRG process are being taken forward by the appropriate division.

### **5. Recommendations**

The Board of Directors is asked to note the dashboard data.