

## Board of Directors (in Public)

### Item 2.3

**Subject:** Learning from Deaths Dashboard  
**Date of meeting:** 5<sup>th</sup> March 2019  
**Prepared by:** Dr Raphael Perry – Medical Director  
**Presented by:** Dr Raphael Perry – Medical Director  
**Reason for report:** To 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.
- Deaths are categorised as to the likelihood of being avoidable or not and the data collected centrally each quarter
- This quarterly report presents the mortality dashboard for Q3 18/19 (Appendix 1)
- A report detailing organisational learning will be presented at Board of Directors (in Private).

#### 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).

The initial action plan is complete and the trust has implemented the new guidelines. The mortality review policy was updated in February 2019.

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 Q2 2018/19

There have been forty four deaths in the trust in Q3 2018/19. For comparison the total number of deaths in the trust for Q2 2018 was forty seven. In Q3 forty three of the deaths have been through the mortality review process. There have been no deaths in Q3 in patients with an

identified learning disability. There have been two deaths in such patients year to date; one in Q2 and one reclassified in Q1.

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 Q3 one death has been classified as greater than 50:50 chance of avoidability. This death was classed as probably avoidable – more than 50:50 (2.3% of all deaths). There were no deaths classified as definitely avoidable or with strong evidence of avoidability.

For the year to date a total of three deaths have been classified as probably avoidable (2.3%). Another death has been classified as definitely avoidable (0.8%).

Of those classified less than 50:50 in Q3 no deaths (8.1%) were classed probably avoidable but not very likely [YTD six (4.7%)]; nine deaths (20.9%) classed as slight evidence of avoidability [YTD fifteen (11.6%)]; thirty three deaths (76.7%) were classed as definitely not avoidable [YTD one hundred and four (80.6%)].

Both of the two previous deaths in patients with identified learning disabilities have been through the MRG process. One was not considered avoidable. The second was considered avoidable and an RCA has been carried out.

#### **4. Conclusion**

The trust complies with national guidance and populates the mortality dashboard. There is one death with some evidence of avoidability in Q3 2018/19 and 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.