

Board of Directors (in Public)

Item 2.1

Subject: Learning from Deaths Dashboard: Q4
Date of meeting: 30th April 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. Quarterly reports have been presented to the Board of Directors since.
- 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 Q4 18/19 (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 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 Q4 2018/19

This is the 2018/19 quarter four report and also the end of year report. In patients undergoing RCP methodology review there have been one hundred and seventy eight deaths in the trust since April 2018 with forty eight deaths in Q4. For comparison the total number of deaths in the trust for the period April 2017 – March 2018 was two hundred and fifteen. Since April 2018 total one hundred and sixty nine of the deaths have been through the mortality review process, thirty nine in Q4. In addition there have been three deaths in patients with an identified learning disability who have undergone LeDeR, one in Q4.

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 (Mortality Review Group) and vice-versa.

There have been no deaths in Q4 classed as avoidable. For the year to date five deaths have been classified as greater than 50:50 chance of avoidability (four RCP and one LeDeR); three deaths were classed as probably avoidable (1.8%), one death classed as strong evidence of avoidability (LeDeR) (0.6%) and one definitely avoidable (0.6%). Therefore, a total of five deaths out of one hundred and eighty one (2.7%) had some evidence of avoidability during 2018/19.

Of those less than 50:50 in Q4 no deaths were classed probably avoidable but not very likely; seven deaths (17.3%) classed as slight evidence of avoidability; thirty three deaths (82.5%) were classed as definitely not avoidable. The respective annual numbers for less than 50:50 chance of avoidability are six (3.5%); twenty three (13.5%) and one hundred and thirty nine (80.8%) – a total of (97.8%) unavoidable deaths.

4. Conclusion

The trust complies with national guidance and populates the mortality dashboard. There are no avoidable deaths in Q4 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.