

Board of Directors (in Public)

Item 2.3

Subject: Learning from Deaths: Quarter 3 Report
Date of meeting: 30 January 2018
Prepared by: Dr Raphael Perry – Medical Director
Presented by: Dr Raphael Perry – Medical Director

| BAF Ref | Impact on BAF |
|---------|---------------|
| 1.1 | None |

1. Executive Summary

- New 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 year to date (Appendix 1)

2. Background

The new guidance has a strong emphasis on organisational learning from all deaths rather than from just preventable deaths. The definitions of preventable deaths have been revised. 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).

There continues good progress against the action plan and the trust is on target implementing the new guidelines.

3. Key Issues

This is the 2017 quarter three report from the new learning from deaths guideline. There have been one hundred and fifty deaths in the trust since April 2017 with fifty-one deaths in Q3. For comparison the total number of deaths in the trust for the period April 2016 – March 2017 was one hundred and eighty three. Since April 2017 total one hundred and thirty nine of the deaths have been through the mortality review process, forty in Q3.

In interpreting the attached spreadsheet it should be borne in mind that there may be an adjustment of the previous quarters (Q1) 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.

For the year to date six deaths have been classified as greater than 50:50 chance of avoidability; three deaths were classed as probably avoidable (2.2%), two deaths classed as strong evidence of avoidability (1.4%) and one definitely avoidable (0.7%). Therefore a total of 6 deaths (4.3%) had some evidence of avoidability.

Of those less than 50:50 ten deaths (7.2%) were classed probably avoidable but not very likely; eleven deaths (7.9%) classed as slight evidence of avoidability; one hundred and twelve deaths (80.6%) were classed as definitely not avoidable.

Initial underlying trends have been explored. Of the eighteen deaths that have been through the MRG since April 2017 the following possible themes have been identified. Four deaths were related to poor communication; four deaths have led to suggested changes in policy and one to a combination of communication/policy; three deaths were due to rare and one off complications; three deaths were attributed to actions from referring hospitals; two deaths were secondary to technical issues and one to choice of procedure.

Actions from the MRG are with the divisions to take forward. And feedback will come through the Operations Board after divisional governance. In the near future the divisions will be provided with an action spreadsheet derived from mortality data which will facilitate tracking and closure of action plans arising from learning points.

4. Conclusion

The trust complies with national guidance and populates the mortality dashboard. There are six deaths with some evidence of avoidability year to date and actions from the MRG process are with the appropriate division.

5. Recommendations

The Board of Directors is asked to note the dashboard data, the attached updated action plan and progress with the learning from deaths.