

Board of Directors (in Public)

Item 2.2

Subject: Learning from Deaths Dashboard
Date of meeting: 4th September 2018
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	None – the paper provides assurance that the Trust's processes are compliant with national guidelines on learning from deaths

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 for Q1 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).

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

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 2018/19

There have been forty one deaths in the trust since April 2018. For comparison the total number of deaths in the trust for Q4 2017/18 was sixty five. Since April 2018 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 Q1 one death have been classified as greater than 50:50 chance of avoidability. This death was classed as probably avoidable (2.6%), There were no deaths classified as definitely avoidable or with strong evidence of avoidability.

Of those less than 50:50 in Q1 two deaths (5.1%) were classed probably avoidable but not very likely; three deaths (7.7%) 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 is one death with some evidence of avoidability in Q1 2018/19 and actions from the MRG process have been taken forward by the appropriate division.

5. Recommendations

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