

Board of Directors (in Public)

Item 2.2

Subject: Learning from Deaths Dashboard
Date of meeting: 6th November 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	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 Q2 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).

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 Q2 2018/19

There have been forty seven deaths in the trust in Q2 2018. For comparison the total number of deaths in the trust for Q1 2018 was forty one. In Q2 2018 thirty seven of the deaths have been

through the mortality review process. There have been two deaths in patients with an identified learning disability 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 Q2 two deaths have been classified as greater than 50:50 chance of avoidability. Both deaths were classed as probably avoidable (5.4% 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 (3.9%).

Of those classified less than 50:50 in Q2 three deaths (8.1%) were classed probably avoidable but not very likely [YTD five (6.6%)]; two deaths (5.4%) classed as slight evidence of avoidability [YTD four (5.3%)]; thirty deaths (81.1%) were classed as definitely not avoidable [YTD sixty four (84.2%)].

One of the two deaths in patients with identified learning disabilities has been through the MRG process and was not considered avoidable. The second is still under review after screening.

4. Conclusion

The trust complies with national guidance and populates the mortality dashboard. There are two deaths with some evidence of avoidability in Q2 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.