

## Board of Directors (in Public)

### Item 2.5

**Subject:** Learning from Deaths: Quarter 2 Report  
**Date of meeting:** 31<sup>st</sup> October 2017  
**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.

### 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 two report from the new learning from deaths guideline. There have been ninety-nine deaths in the trust since April 2017 with forty-one deaths in Q2. In total ninety-two deaths have been through the mortality review process, thirty-four in Q2.

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 three deaths have been classified as greater than 50:50 chance of avoidability; two deaths were classed as probably avoidable (2.2%) and one definitely avoidable (1.1%). Of those less than 50:50 four deaths (4.3%) were classed probably avoidable but not very likely; five deaths (5.4%) classed as slight evidence of avoidability; eight deaths (87%) were classed as definitely not avoidable.

Any underlying trends are being explored. Actions from the MRG are with the divisions.

#### **4. Conclusion**

The trust complies with national guidance and populates the mortality dashboard. There are three avoidable deaths 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 updated action plan and consider if additional quarterly information is required on the learning from deaths process.