

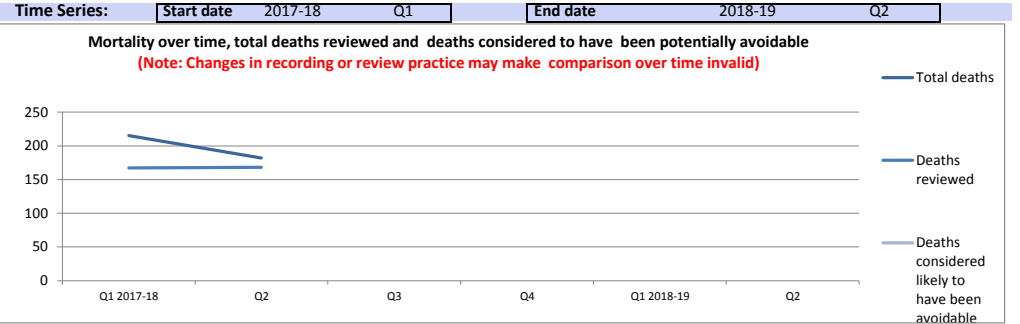
Description:

The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
41	73	36	65	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
182	215	168	167	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
397	0	335	0	1	0



Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Probably avoidable but not very likely	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
This Month 0 0.0%	This Month 0 0.0%	This Month 0 0.0%	This Month 0 0.0%	This Month 3 33.3%	This Month 6 66.7%
This Quarter (QTD) 0 0.0%	This Quarter (QTD) 0 0.0%	This Quarter (QTD) 1 5.3%	This Quarter (QTD) 0 0.0%	This Quarter (QTD) 5 26.3%	This Quarter (QTD) 13 68.4%
This Year (YTD) 0 0.0%	This Year (YTD) 0 0.0%	This Year (YTD) 1 3.3%	This Year (YTD) 0 0.0%	This Year (YTD) 6 20.0%	This Year (YTD) 23 76.7%

Four deaths were reviewed using Structured Judgement Review Methodology in Quarter 2 2017/18. The Trust reviews all deaths using a Death Review Questionnaire completed by clinician's and reviewed by Quality Governance Team. This questionnaire specifically asks if there were any concerns relating to care or treatment provided. Where concerns are highlighted, if the concerns are significant an in-depth Root Cause Analysis investigation is conducted.

An RCA report follows a national standard and does not specifically seek to establish the level of causation or assign a level of avoidability. However it does provide clear understanding of care and service delivery problems, contributory factors and root causes. For the purposes of completing this new national data requirement on the avoidability of a death, each RCA for the period in question is reviewed by the Quality Governance Team and the level of avoidability is assessed, based on the investigation findings.

Eighteen RCAs were completed one was assessed to have been Probably Avoidable 50:50. This was following the issue of a Prevention of Future Death Report by the Coroner. Actions are being taken to address the gaps identified by the Coroner and the learning has been shared within the organisation via the Monthly Learning Bulletin. 4 remaining RCA's, were reviewed as slightly avoidable and the learning from these RCA's has been shared with the Service Lines.

Description:

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Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

There was one death of patient with a learning disability. The patient developed Aspiration Pneumonia whilst in hospital.

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	0	1	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1	2	1	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	0	3	0	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1

