The Shrewsbury and Telford Hospital NHS Trust

Paper 12

Recommendation ☐ **DECISION** ☑ **NOTE**	The Trust Board is asked to note the contents of the report
Reporting to:	**Trust Board**
Date	25 October 2018
Paper Title	Trust Mortality Casenote Review Dashboard
Brief Description	As part of the National Quality Framework ' Learning from Deaths', Trusts are required to publish data on the number of Mortality reviews conducted into patient deaths within the Trust. Enclosed is the data for Quarter 1 2018-19. The number of in-patient deaths for July and August 18, are shown on the graph at this time, for information only. The number of casenote reviews has fallen in June due to annual leave. Returns are usually delayed at this time of year, and the figures will be updated with Quarter 2. There were 2 x CESDI 3 cases in Quarter 1 2018. Both have been reported as Serious Incidents and the families informed. One patient had Learning Disabilities, and the investigation has been undertaken with an Independent reviewer from the LeDeR programme. This patient's death will be subject to Inquest in November. The Root cause analysis investigation is still on-going for the 2nd incident which concerned the delayed diagnosis of a patient with a sub-arrachnoid haemorrhage. In order to promote accurate grading of deaths, all deaths with a potential CESDI score of 2 or 3 after initial review, will have a summary sent to the Senior Medical Leadership team for a final decision on grading, and escalation if appropriate.
Sponsoring Director	Dr Edwin Borman, Medical Director
Author(s)	Tracey Lloyd, Mortality Lead
Recommended / escalated by	Quality and Safety Committee
Previously considered by	Trust Mortality Group
Link to CQC domain	○ **Safe** ◉ **Effective** ○ **Caring** ○ **Responsive** ○ **Well-led**
Link to strategic objectives	SAFEST AND KINDEST - Develop innovative approaches which deliver the safest and highest quality care in the NHS causing zero harm

Link to Board Assurance Framework	**RR 423** If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale & patient outcomes may not improve
Outline of public/patient involvement	
Equality Impact Assessment	◉ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** *** EIA must be attached for Board Approval** ○ negative impacts have been mitigated ○ negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	◉ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

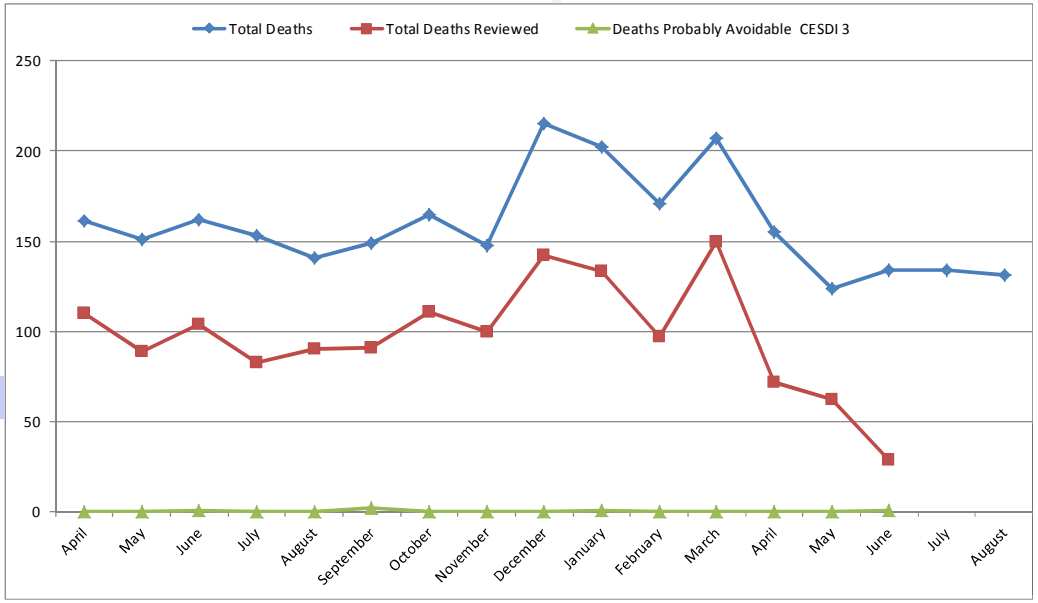
Summary of total number of deaths and total number of cases reviewed under the Trust Casenote Review Methodology

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 (CESDI 3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
134	124	29	62	1	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
413	580	163	380	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
413	2025	163	1300	1	4

Total Deaths Reviewed by Methodology Score

CESDI 0 No sub optimal care		CESDI 1 Some sub optimal care which did not affect the patient's outcome		CESDI 2 Some sub optimal care which might have affected the patient's outcome	
This Month	23	This Month	2	This Month	0
This Quarter (QTD)	140	This Quarter (QTD)	8	This Quarter (QTD)	2
This Year (YTD)	140	This Year (YTD)	8	This Year (YTD)	2



Summary of total number of deaths of patients with a Learning Disability and, the total number reviewed under the LeDeR and Trust methodology

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 by Trust or Reported Through the LeDeR Methodology		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
3	2	3	2	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
3	13	3	13	1	0