

Cover page	
Meeting	Trust Board
Paper Title	Corporate Mortality Casenote review Dashboard
Date of meeting	30th May 2019
Date paper was written	13 th May 2019
Responsible Director	Dr Edwin Borman
Author	Tracey Lloyd
Executive Summary	
<p>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. Attached is the data for March and Quarter 4 2018-19</p> <p>The number of in-patient deaths recorded for 2018-19 is 1,816 which is over 200 less than the previous year 2017-18. This may be partially due to a better summer and milder winter. There were 100 less deaths in Quarter 4 this year compared to last.</p> <p>There has been 1 death graded as CESDI 3 this quarter. This was a patient who had a delayed diagnosis and treatment of bowel obstruction. This was reported as a Senior Incident in March 2019. The total number of deaths graded as potentially avoidable for 2018-19 is 4, compared to 5 for 2017-18. All these deaths have been reported to the Coroner, as Serious Incidents and the families notified.</p> <p>The percentage of completed reviews has fallen, but it is hoped that some of the backlog will be completed in the next few months. The Dashboard is updated with late completed reviews.</p> <p>Discussions are underway to examine how the new Medical Examiner process will compliment the Mortality case- note review process. At the current time, it is envisaged that the 2 systems will continue to run separately.</p>	
Previously considered by	Quality and Safety Committee, Trust Mortality group

The Board is asked to:			
<input type="checkbox"/> Approve	<input type="checkbox"/> Receive	<input checked="" type="checkbox"/> Note	<input type="checkbox"/> Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
<input checked="" type="checkbox"/> Safe	<input checked="" type="checkbox"/> Effective	<input type="checkbox"/> Caring	<input type="checkbox"/> Responsive	<input type="checkbox"/> Well-led

Link to strategic objective(s)	<p>Select the strategic objective which this paper supports</p> <ul style="list-style-type: none"> <input type="checkbox"/> PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare <input checked="" type="checkbox"/> SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care <input type="checkbox"/> HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities <input type="checkbox"/> LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions <input type="checkbox"/> OUR PEOPLE Creating a great place to work
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Link to Board Assurance Framework risk(s)	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
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Equality Impact Assessment	<ul style="list-style-type: none"> <input checked="" type="radio"/> Stage 1 only (no negative impact identified) <input type="radio"/> Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
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Freedom of Information Act (2000) status	<ul style="list-style-type: none"> <input checked="" type="radio"/> This document is for full publication <input type="radio"/> This document includes FOIA exempt information <input type="radio"/> This whole document is exempt under the FOIA
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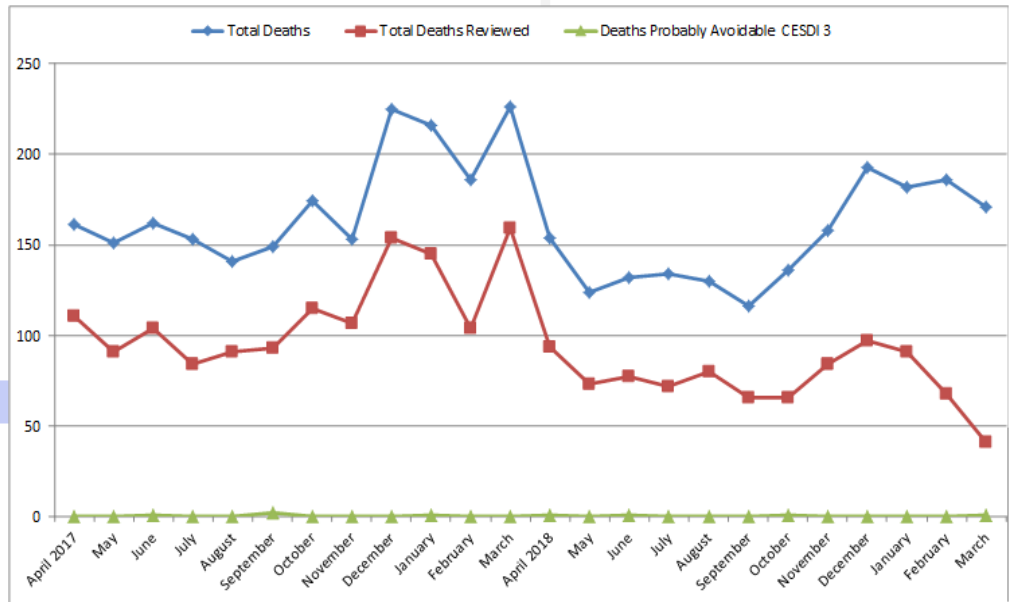
Financial assessment	No
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Summary of total number of deaths and total number of cases reviewed under the Trust Casenote Review Methodology



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
171	186	41	68	1	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
539	487	200	247	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1816	2097	909	1358	4	5



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	This Month	This Month
36	5	0
This Quarter (QTD)	This Quarter (QTD)	This Quarter (QTD)
177	22	1
This Year (YTD)	This Year (YTD)	This Year (YTD)
841	76	6

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
1	3	1	3	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
6	6	6	6	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
18	10	18	10	1	0

