Meeting title	Quality and Safety Committee	Date: 7 March 2018
Report title	Learning From Deaths Dashboard	Agenda item: 3v
Lead director	Tony Snell - Interim Medical Director	
Report author's	*Chris Giles – Assistant Director for Contracts and Performance* *David Griffiths – Information Analyst*	
Executive summary	This is the second Trust "Learning from Deaths Dashboard" under the new Trust "Learning from Deaths Policy". NHSI's 'National Guidance on Learning from Deaths', published in March 2017 which states, 'community trusts should ensure their governance arrangements and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. Trust should also ensure that they share and act upon any learning derived from these processes.' The Trust will report separately for adults dying in the Teddington War Memorial Hospital and the community as well as for Learning Difficulties, through the LeDeR process, managed by the CCGs. The following are the definitions used for inclusion in the reporting dashboards: Adults Services • All deaths of patients in our inpatient care or who have been recently discharged within 30 days are to be screened once the service becomes aware of the death. • All deaths occurring while services were being provided in the carrying on of a regulated activity or have, or may have, resulted from the carrying on of a regulated activity (e.g. wrong dose of medication given) are to be screened once the service becomes aware of the death. (These deaths would be reportable to CQC) • In addition to the mandatory list above the Trust intends taking a pragmatic approach to identifying other groups that would require review. This list is not exhaustive and may be added to at any time and does not exclude other examples or events. Front line clinicians and managers need to identify any case that might warrant review and where learning would be beneficial; Cases on the adult caseload: • Where there is any concern that management could have been better compared to what we would expect for a relation of our own. • Where the GP, pharmacist or any other relevant health professional requests a review • Where patient family or friend raise issues or concerns • Where individual members of clinical team wish for a review to take place • The Trust has determined that it will record the total number of deaths across the service that were currently on the services caseload, where we are informed of the death. These deaths may be entirely unrelated to the services the Trust provide, e.g. road traffic accident, deaths from	

<table>
<tr><td></td><td>unrelated causes, e.g. stroke in a wound management patient, etc. On reviewing this data in twelve months' time, the Trust will determine the workload resource associated with screening and reviewing these cases and what, if any, learning would be achieved by doing so.
• two dashboards have been provided;

The first 'Whole Trust' dashboard displays deaths of patients that appear on the organisation total caseload.

<table>
<tr><th>Month (and deaths)</th><th>Quarter (and deaths)</th></tr>
<tr><td>December (172)</td><td>Q2 (464)</td></tr>
<tr><td>January (282)</td><td>Q3 (282)</td></tr>
</table>

The second dashboard displays 'Inpatients Only' activity for Teddington War Memorial Hospital.

<table>
<tr><th>Month (and deaths)</th><th>Quarter (and deaths)</th></tr>
<tr><td>December (1)</td><td>Q2 (0)</td></tr>
<tr><td>January (0)</td><td>Q3 (4)</td></tr>
</table>

No reviews or investigations have taken place as the criteria were not met.</td></tr>
<tr><td><u>Purpose:</u></td><td>For review</td></tr>
<tr><td>Recommendation(s)</td><td>The committee is asked to:

i. receive and discuss the mortality dashboard before it is considered at the April Board meeting;
ii. no conclusions, trends or learning can be identified at this time as numbers are very small;
iii. we await the report from the CCG regarding the learning disability deaths.</td></tr>
<tr><td>BAF/TRR</td><td>Q1/Q2</td></tr>
<tr><td>Report history</td><td>Quarterly report to committee; quarterly thereafter</td></tr>
<tr><td>Appendices</td><td>Appendix 1: Learning from deaths dashboard</td></tr>
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