A lifetime of specialist care

Royal Brompton & Harefield NHS
NHS Foundation Trust

Mortality Review Policy

QUALITY AND SAFETY

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Contents

1. Introduction

In December 2016, the Care Quality Commission (CQC) published its review 'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England[1]'. The CQC found that none of the twelve Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

The Secretary of State for Health accepted the report's recommendations and in a Parliamentary statement made a range of commitments to improve how Trusts learn from reviewing the care provided to patients who die. These are documented in the *National Guidance on Learning from Deaths*, published by the National Quality Board in March 2017 and include regular publication of specified information on deaths, including those that are assessed as more likely than not to have been due to problems in care, and evidence of learning and action that is happening as a consequence of that information in Quality Accounts from June 2018.

Learning from deaths has been a key focus in the Trust since 2000, and it is at the heart of the Trust's ethos to ensure patients, families and carers are at the centre of everything we do. Reviewing the care provided to people who have died helps improve care for all patients by identifying where care could be improved, how this relates to outcomes, and working to understand why these occur so that meaningful action can be taken.

The Trust board has a role in providing visible and effective leadership to ensure the organisation addresses significant issues identified in reviews and investigations; and staff, patients, families and others are encouraged and supported to engage with and raise any questions or concerns about the Trust's approach to learning from deaths.

2. Scope

This policy applies to all staff whether they are employed by the trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trust's behalf.

[1] https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

3. Purpose

The Royal Brompton & Harefield NHS Foundation Trust will implement the requirements outlined in the Learning from Deaths framework as part of the organisation's existing procedures to learn and continually improve the quality of care provided to all patients.

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of Royal Brompton & Harefield NHS Foundation Trust.

It describes how Royal Brompton & Harefield NHS Foundation Trust will support people who have been bereaved by a death at the trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the trust supports staff who may be affected by the death of someone in the trust's care.

It sets out how the trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients.

This policy should be read in conjunction with the related Trust documents listed at Appendix A.

4. Roles and responsibilities

This section describes the specific responsibilities of key individuals and of relevant committees under this policy.

Roles and responsibilities for incident management, complaints handling and Serious Incident management, quality improvement and other relevant processes are detailed in the documents listed at Appendix A.

Role	Responsibilities
Chief executive	Overall responsibility for implementing the policy
Non-executive directors	The Chair of the Risk & Safety Committee has a specific role as the lead non-executive director in taking oversight of progress in implementing the Learning from Deaths agenda Through this Committee the non-executive directors have specific responsibilities relating to the framework[2] which include: • understanding the review process: ensuring the processes for reviewing and learning from deaths are robust and can withstand external scrutiny • championing quality improvement that leads to actions that improve patient safety • assuring published information: that it fairly and accurately reflects the organisation's approach, achievements and challenges.
Medical Director	The Medical Director has a specific responsibility as the executive board-level leader acting as the director responsible for the learning from deaths agenda.
Lead Clinicians for Clinical Risk	Oversight of the mortality review process across all divisions Advice and support for mortality review groups

[2] Annex B of the *National Guidance on Learning from Deaths* - https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf

	in relation to compliance with this policy Liaison with HMC once an investigation has been initiated Coordination of review of deaths identified as more likely than not being due to problems in care and any linked serious incident investigation
Divisional Directors	The Divisional Directors have responsibility for ensuring that the mortality review process operates efficiently and effectively across all teams in the Division; that relevant learning points are shared across the Division and wider Trust; and that actions resulting from mortality review are tracked and completed in a timely manner.
Bereavement team	The Bereavement team is responsible for providing practical and emotional support to bereaved families and carers following an inpatient death. They also have responsibility for registering all inpatient death on the mortality database. The bereavement team is responsible for documenting any comments or concerns raised by the families of deceased patients onto the mortality database; and producing a regular report for the mortality review groups of these comments

Committee	Responsibilities
Trust board **(via Risk &**	Whilst the Board has overarching responsibility for the above; the detailed review and support will be provide through the Risk and Safety Committee, a delegate sub-Committee of the Board.

Safety Committee)	The *National Guidance on Learning from Deaths* places particular responsibilities on boards, as well as reminding them of their existing duties[3]. The board is responsible for ensuring the Trust: • has an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress; • pays particular attention to the care of patients with a learning disability or mental health needs; • has a systematic approach to identifying those deaths requiring review • adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDR programme[4]) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented; • ensures case record reviews and investigations are carried out to a high quality, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur; • ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised; • ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, where possible and reported in annual Quality Accounts; • shares relevant learning across the organisation and with other services where the insight gained could be useful; • ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths; • offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death; • acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases

[3] Annex A of the *National Guidance on Learning from Deaths* - *https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf*

[4] LeDR – Learning Disabilities Mortality Review

	where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved; and, • works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services.
Governance & Quality Committee	The Governance & Quality Committee has operational responsibility for overseeing the Trust's approach to learning from deaths. This forum will be used to share relevant learning points between Divisions and Departments and to monitor and request investigation of any trends or themes that may emerge.
Divisional Quality & Safety Groups	The divisional Quality & Safety Groups have operational responsibility for overseeing the mortality review process for the specialities within their area.
Mortality review groups	The mortality review groups are responsible for holding a regular, clinician-led review of at least all inpatient deaths. The review process must be identical for all patients, should grade the death according to the Bristol Mortality Grading System, and must document - the grade of death[5] - a summary of the discussion - any learning points identified - any specific actions to be taken The above information must be entered onto the mortality database, and learning points/actions should be shared as appropriate, and will be monitored by the Divisions.

[5] Using the Bristol Mortality Grading System

5. Definitions

Bristol Mortality Grading System
The Trust uses the Bristol Mortality Grading System:

- Grade 1: < adequate care - different management would have made a difference to outcome
- Grade 2: < adequate care - but different management might have made a difference to outcome
- Grade 3: < adequate care - but different management would have made no difference to outcome
- Grade 4: Adequate care

Death certification
The process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.

Case record review
A structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong as well as identify good practice. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.

Mortality review
A systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.

Serious Incident
Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of

healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information.[6]

Investigation

A systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.

Death due to a problem in care

A death that has been clinically assessed using a recognised method of case record review, where the reviewer(s) feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'. In most cases, a death where there has bene a problem in care will equate to a Serious incident.

Quality improvement

A systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.

Patient safety incident

A patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

[6] https://improvement.nhs.uk/resources/serious-incident-framework/

6. The process for recording deaths in care

The Trust has a Mortality Database in PATS/Intellect; which is use to record details of all inpatient deaths, including the mortality review process. This database has been in use for many years and is regularly reviewed and revised as required to ensure it is up-to-date with latest guidance on best practice in learning from deaths and any national requirements.

Certification and registration of deaths:

The bereavement team are responsible for starting the entry into the Trust PATS Mortality database. They will register details about the patient, whether they had a learning disability, the cause of death as described on the death certificate, whether the patient is undergoing a post-mortem; whether the death has been referred to the coroner and the outcome; plus details of the storage of the body, and any relevant family wishes or concerns. The bereavement team has a core responsibility in supporting the family of the deceased through the process. Relatives and carers of all deceased inpatients should be given the opportunity to express views and any concerns on the care provided by the Trust. This will occur as part of the service offered by the Bereavement Team.

Deaths will typically be registered on the day of death; and all inpatient deaths will be registered by the end of the next working day. Where the Trust is notified from external sources (such as coroner, family, other healthcare provider) that a patient has died after discharge, a decision will be made whether to add this patient to the mortality database so that the mortality review process is triggered. This decision will be taken by the clinical team in corroboration with the Lead Clinicians for Clinical Risk and will be decided on a case by case but will take into account factors such as cause of death, length of time since discharge from Trust.

Once an inpatient death is registered, this will trigger the process for informing the GP and other relevant parties.

Informing the HMCoroner. It is the responsibility of the clinical team caring for the patient at the end of their life to inform HM Coroner if appropriate using the standard reporting template which must be completed / reviewed by the relevant consultant prior to submission. This information is recorded on the mortality database, alongside the coroner decision and any request for post-mortem by the Bereavement Team, as part of the initial

death registration. If a death is accepted by HM Coroner for investigation , this will be recorded on the mortality database, and the Lead Clinical for Clinical Risk will take over liaison with HM Coroner's office.

Additional points about registering deaths:

- people with a learning disability who die as an in-patient must also be reported to the Trust Learning Disability Lead, so that the national Learning Disabilities mortality Review (LeDR) process[7] can be completed.
- There are additional requirements for the registration of deaths of children and young people; This is managed by the clinical teams in Children's Services. Maternal deaths must be reported by the relevant adult clinical team[8].

7. Selecting deaths for case record review

The Trust has a long-standing policy of ensuring all inpatient deaths undergo case record review. This includes all the special categories of deaths outlined in the national guidance[9]:

In addition, some post-discharge deaths may be identified as appropriate for case record review. Selection is by the clinical team in conjunction with the Lead Clinicians for Clinical Risk, and is decided on a case by case basis. Once agreed that they are for review, they are registered on the Trust mortality database and follow an identical process as for review of inpatient deaths. Where appropriate, the review of these deaths should include collaboration with other providers involved in the care of these patients.

8. Review methodology

Case record review is a method used to determine whether there were any problems in the care provided to a patient within a particular service. It is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can

[7] See Annex D of the *National Guidance on Learning from Deaths* for details of this process
[8] See Annexes F and G of the *National Guidance on Learning from Deaths* for details of these process
[9] *National Guidance on Learning from Deaths*

help identify problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families/carers or staff raise concerns about care.

All Divisions of the Trust conform to these principles in their case record review, although there is some leeway for different clinical teams to tailor the approach to suit the type of patients they care for, and the typical reasons for death.

Every death reviewed must:

- be given a grade 1-4, according to the Bristol Mortality Grading System[10]
- have a summary of the discussion documented
- have any learning points documented,
- Have any actions documented,
- Any leaning or action points must be shared through the relevant Q&S groups cross site as appropriate
- Ensure all of the above information is recorded on the Trust mortality database within 1 month of the mortality review meeting

The new national focus on Learning from Deaths, has also identified some best practices which are new or different to the current practices in all or some areas of the Trust. During this first year of the policy, mortality review groups are encouraged to work towards meeting these recommendations. Further versions of this policy will require some or all of these to be in place.

New or different practices to work towards:

- ensuring multidisciplinary membership of the mortality review group
- trial use of the Royal College of Physicians structured judgement review tool for reviewing inpatient deaths[11]
- trial use of the new scale for grading deaths (pending publication of more national guidance and training on how to use this scale)

A table of the approach currently taken by each area of the Trust is in the table overleaf.

[10] Bristol Mortality Grading System can be found here:
[11] A guide to the RCP Structured Judgement Review can be found here - https://www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20clinical%20governance%20guide_1.pdf?token=AS-qWBcA

Patient group	Approach to mortality review	Frequency of review	Where info/outputs will be saved and shared
Harefield (all patients)	Mortality review group meets monthly to discuss deaths from previous month. All deaths are graded. A summary of discussion, grade, learning points and any actions are documented and recorded on the mortality database. Actions and learning points are monitored by the Harefield Quality & Safety meeting. Deaths where there is key learning are presented at the next Clinical Governance Day session, open to all staff. The mortality review group considers all patients; some appropriate cases will be sent for presentation at the transplant MDT (where the issues are specific to the specialty) Improvements required: • Look at developing more multidisciplinary involvement in the mortality review group	Monthly	Mortality database; and reported to Heart Division Q&S meeting
RBH Heart Division	Multidisciplinary peer review of every death at the mortality grading group which meets monthly to discuss the previous month's death (xcept August and December) . Attended by representatives from Quality & Safety, adult cardiology, adult pulmonary hypertension., adult cardiac surgery , adult thoracic surgery, anaesthesia and critical care (medical and nursing) and palliative care. A standard review preforms is in use All deaths are graded. A summary of discussion, grade, learning points and any actions are documented and recorded on the mortality database and circulated to all consultants and senior nursing staff. Care groups are asked to review any deaths specific to the care group to ensure local review and learning Actions and learning points are monitored by the Heart Division Quality & Safety meeting. Improvements required: • Look at developing multidisciplinary involvement in the mortality review group • Aim to present any deaths where problems in care identified or where specific educational issues are identified to the wider Heart division on Clinical Governance days • Coordinate care group reviews with grading group review sequence	Monthly	Mortality database; and reported to Heart Division Q&S meeting

Patient group	Approach to mortality review	Frequency of review	Where info/outputs will be saved and shared
RBH Lung – thoracic Surgery	Mortality review group meets monthly to discuss deaths from previous month. A summary of discussion, grade, learning points and any actions are documented. Actions and learning points are monitored by the Lung Quality & Safety meeting. Improvement required: • Look at developing multidisciplinary involvement in the mortality review group • Put in place a local procedure to ensure that; • deaths are graded; • there is summary of the discussion, any learning points and actions; • this information is recorded on the mortality database.	Monthly	Mortality database; and reported to Lung Division Q&S meeting
RBH Lung – Respiratory medicine	Each death is peer reviewed by an independent consultant and a summary circulated to respiratory consultants in advance of the monthly M&M meeting. Monthly M&M meeting on clinical governance days with summary scanned into the PATS mortality database Any learning / action points are discussed at the monthly Clinical Governance meetings and monitored by the Lung Division Q&S group Improvement required: Put in place a local procedure to ensure that; • deaths are graded; • Ensure any lessons learned are shared across other divisions • Consider moving thoracic surgery deaths into the Lung Division	Monthly	Mortality database; and reported to Lung Division Q&S meeting
Paediatric Respiratory	Deaths are reviewed on an ad hoc basis as in-hospital deaths are extremely rare in this service. When required mortality Rrviews are undertaken in accordance with *Working together to safeguard children* [12] (2015) and the current child death overview panel processes.	Ad-hoc, due to very low number of	Mortality database; and reported to

[12] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Patient group	Approach to mortality review	Frequency of review	Where info/outputs will be saved and shared
	Improvements required: Put in place a local procedure to ensure ; • that deaths are graded; • there is summary of the discussion, • any learning points and actions; • that this information is recorded on the mortality database. • Ensure learning points are shared widely across Children's Services as the Trust, as appropriate. • Ensure actions are monitored by the Children's Services Quality and Safety meeting.	deaths[13]	Children's Services Q&S meeting
Paediatric Cardiac	Deaths in PCUI, Cardiology and Cardiac surgery are reviewed as a part of the multi-disciplinary Children's services Clinical Governance monthly meeting. A detailed presentation is given followed by a discussion. A summary of the discussion is documented, and learning points are shared and any actions are monitored by the Children's Services Q&S meeting . Reviews of these deaths are undertaken in accordance with *Working together to safeguard children* [14] (2015) and the current child death overview panel processes. Improvements required: Put in place a local procedure to ensure that; • deaths are graded; • that the summary of the discussion, any learning points and actions is recorded on the mortality database.	Monthly	Mortality database; and reported to Children's Services Q&S meeting

[13] Last inpatient death was in 2013
[14] https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Patient group	Approach to mortality review	Frequency of review	Where info/outputs will be saved and shared
RBH AICU / ECMO	The mortality review group is multidisciplinary and meets monthly to discuss deaths in AICU from the previous month. Standard RBH review proforma is used.. All deaths are graded. Improvements required: • Ensure multidisciplinary input eg surgery when required • Put in place a local procedure to ensure that the summary of the discussion, any learning points and actions is recorded on the mortality database. • Ensure learning points are shared widely across the department and/or Trust, as appropriate. • Ensure actions are monitored by the AICU Quality and Safety meeting.	Monthly	Mortality database; and reported to Heart Division Q&S meeting

9. Selecting deaths for investigation

Where a review carried out by the trust under the process above identifies patient safety incident(s) that require further investigation, this will be managed in line with the trust Serious Incident policy. This policy details how the decision to declare a Serious Incident is made.

10. Reviewing outputs from review and investigation to inform quality improvement

Monitoring of any specific actions arising from the mortality review process is the responsibility of the clinical care groups and departments, overseen by the Divisions. Governance & Quality Committee is the forum where key learning points will be shared, and will review the overarching themes and trends resulting from the mortality review process. This Committee will be responsible for ensuring that all themes and trends are investigated fully and where appropriate, the findings are either immersed into a relevant existing the quality improvement project, or trigger a new quality improvement project to be undertaken.

Oversight and assurance of this process will be provided by the Risk & Safety Committee, a sub-Committee of the Board.

11. Presenting relevant information in board reports

At every Board meeting, the national reporting dashboard[15] will be presented, as part of the Clinical Quality report. Where required, additional commentary will be provided from both the Medical Director and Chair of Risk & Safety Committee, who have specific board responsibilities for learning from deaths. The national reporting dashboard requires deaths to be graded into the new scale of 1-6 (avoidable death-unavoidable death)[16]. For the time being, and until further information and training on how to use this scale is made available by the national team, deaths will only be graded this way to complete this report. At the mortality review sessions, deaths will continue to be graded using the Likert Scale

[15] National reporting dashboard
[16] As detailed in the *National Guidance on Learning from Deaths*

currently used across the Trust. Responsibility for grading the deaths according to the new scale will lie with the Lead Clinicians for Clinical Risk.

A more detailed report will be presented to the Risk & Safety Committee each quarter. This will provide a more holistic overview of learning from deaths, included lesson identified and monitoring of any actions being taken.

12. Supporting and involving families and carers

Supporting and involving families and carers following the death of a loved one, is covered in detail in other Trust policies and guidelines, and is only discussed form completeness here. The key staff involved are the clinical team(s) caring for the patient, the Bereavement Team, and if an investigation may be required, or the death was unexpected, the Lead Clinicians for Clinical Risk should be informed.

The Bereavement team will take a key role in supporting families and carers through the initial period, providing practical and emotional support. However, every effort should be made by all staff to provide timely, compassionate and meaningful engagement with the family where there are further queries or concerns. Some key documents in relation to this are the Being Open section of the Incident Reporting Policy (which includes responsibilities mandated by law around Duty of Candour) and the Serious Incident policy.

If the death is the subject of an inquest and/or serious incident, then the family and carer will be given multiple opportunities to meet and discuss what happened. All final reports will be shared with the family as a matter of course.

Feedback from bereaved families is routinely shared with the relevant staff by the Bereavement Team and PALS.

13. Supporting and involving staff

Most problems in care will derive from systems and processes, not individual negligence or reckless behaviour. However, support is available for staff affected by someone who has been in the Trust's care.

- There is a counselling service, which can be accessed through Occupational Health.

- The Trust holds Schwartz rounds for some deaths, which look at the
- If the death is part of a Serious Incident, inquest or other form of investigation, then there are additional support mechanisms available to staff who are involved. These are detailed in the relevant policies.

All staff are actively encouraged to be involved in learning from deaths. All clinical units provide feedback and discussion on learning points from deaths. These occur in many different forums, but often on Clinical Governance half-days to enable as many staff as possible to attend.

14. Equality impact assessment

An equality impact assessment is not required for this policy.

15. Appendix A: Links to other relevant Trust documents

Serious Incident Policy

Incident Reporting Policy

Complaints Policy

Inquest Guidelines

16. Appendix B – National Reporting Dashboard

NHS Anytown Foundation Trust: Learning from Deaths Dashboard - September 2017-18

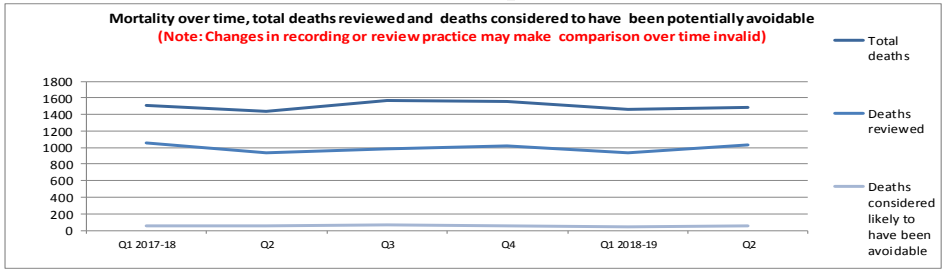
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
454	523	339	298	14	20
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
1436	1509	939	1053	50	54
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
6069	0	3991	0	227	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2



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	4	1.2%	This Month	10	2.9%	This Month	33	9.7%	This Month	65	19.2%	This Month	227	67.0%
This Quarter (QTD)	5	0.5%	This Quarter (QTD)	14	1.5%	This Quarter (QTD)	31	3.3%	This Quarter (QTD)	90	9.6%	This Quarter (QTD)	178	19.0%	This Quarter (QTD	621	66.1%
This Year (YTD)	30	0.8%	This Year (YTD)	65	1.6%	This Year (YTD)	132	3.3%	This Year (YTD)	378	9.5%	This Year (YTD)	754	18.9%	This Year (YTD)	2632	65.9%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR 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 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
10	2	10	2	2	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
16	24	16	24	3	4
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
75	0	75	0	19	0

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