

Reporting Learning from Deaths to Board

Learning from Deaths Dashboard Quarter 3 2019/20

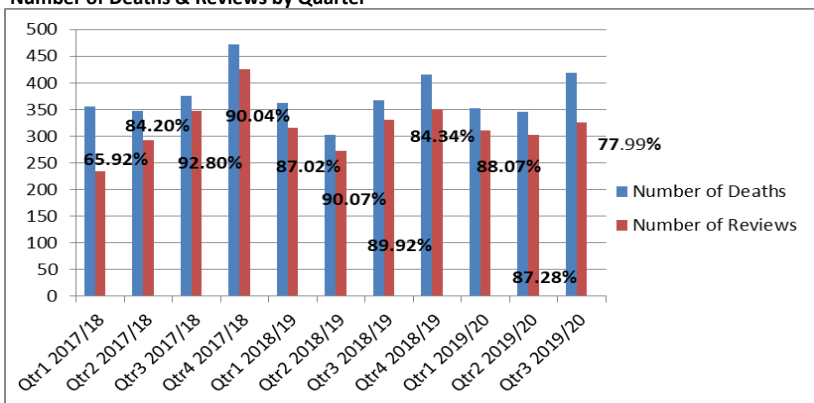
Inpatient & Emergency Department Deaths	Total	Reviews completed	% Reviewed	Avoidability Assessments
Oct-19	121	98	80.99%	5
Nov-19	134	113	84.33%	6
Dec-19	163	115	70.55%	6
Qtr 1	352	310	88.07%	7
Qtr 2	346	302	87.28%	17
Qtr 3	418	326	77.99%	17
Qtr 4			#DIV/0!	
Year 19/20	1116	938	84.05%	41
<i>Year 18/19</i>	<i>1446</i>	<i>1267</i>	<i>87.62%</i>	<i>11</i>
<i>Year 17/18</i>	<i>1550</i>	<i>1300</i>	<i>83.87%</i>	<i>21</i>

Deaths in groups under special focus Qtr 3 2019/20

Group	Total
Learning Disability / Mental Health Patients	2
STEIS SI	0
Internal Investigations	5
Investigations opened by the Coroner	11
Investigations converted to Inquests	3
Inquests opened without prior investigation	3
Investigations closed without Inquest	6
Concluded Inquests	9

Summer2019

Number of Deaths & Reviews by Quarter

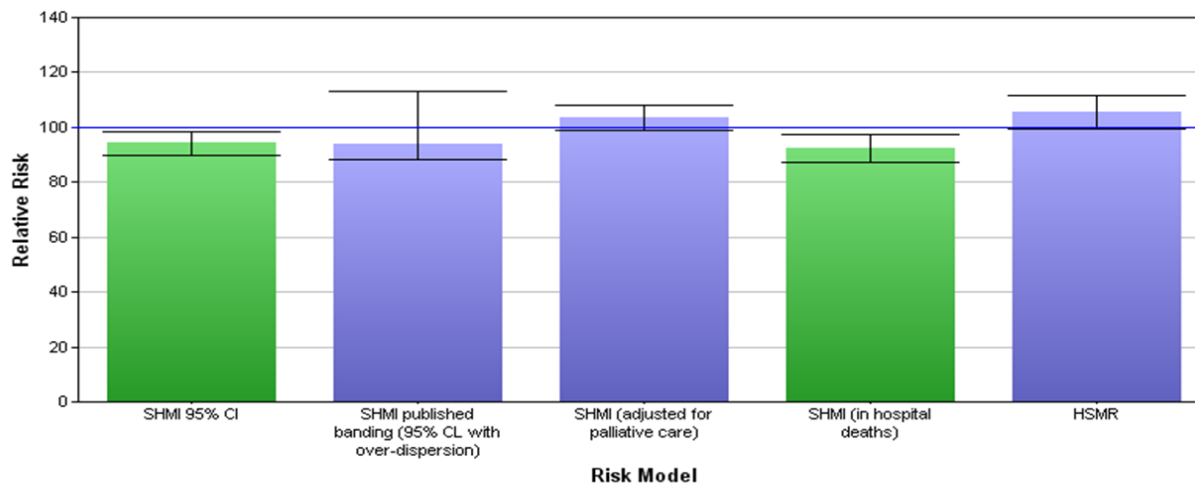


Key Learning/Themes identified

1. Paediatric Febrile Seizure	Learning identified relating to the provision of advice Acute Abdominal pathway now agreed and implemented
2.. Acute Abdominal Pathway	
3. DKA awareness/response	DKA now monitored through the Deteriorating Patient Group

Summary Hospital Mortality Index (SHMI)

SHMI (with adjustments) and HSMR for Sep 2018 to Aug 2019



% of deaths with Avoidable Factors

